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Zero Pain Is Not the Goal

Thomas H. Lee, MD, MSc

What should health care be trying to accomplish? This question becomes increasingly important as research advances, the population ages, and financial pressures intensify. Simple mea-



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does not mean the elimination of all spending or even 100% elimination of all wasteful spending. And compassion for patients does not mean the elimination of all pain.

There is, quite simply, no “getting it right” when it comes to pain. It is both undertreated and overtreated. It is ubiquitous, subjective, and sometimes feigned. Its experience is influenced by culture and varies among individuals, and its diagnosis easily distorted by bias. No wonder, then, that clinicians are concerned about being evaluated on their effectiveness in relieving patients’ pain, and policy makers are concerned about overuse of opioids contributing to narcotics addiction.

But pain is part of life and part of medicine, as are patients’ fears about what the pain means, whether it will worsen, and whether it will ever end. Clearly, giving sufficient analgesia to eliminate all pain for all patients is a wrong target—but so is treating pain insufficiently.

How do clinicians find a viable path forward—one that meets the needs of patients, the concerns of society, and the desire of clinicians to have a job that feels doable? The new Centers for Disease Control and Prevention (CDC) guidelines for prescribing opioids for chronic pain¹ published in this issue of *JAMA* should help, particularly if the recommendations are considered in the context of information about what matters

most to patients and the larger question of what health care should be trying to accomplish.

A simple and useful framework for thinking about health care in general and pain in particular can be drawn from Sinek’s famous 2009 TED talk, “How Great Leaders Inspire Action,”² which has been viewed more than 25 million times. In it, Sinek explores how leaders and organizations “can inspire cooperation, trust, and change”—reasonable goals for health care leaders and for individual clinicians.

Sinek recommends that leaders begin by asking the question, “Why?” What is the organization’s fundamental purpose? Why do they even exist? He offers the example of Apple’s goal of challenging the status quo by helping people to “Think different.” After thinking about why, organizations can turn to the question of “how” (eg, design devices that are beautiful, intuitive, and easy to use). Then and only then should they turn to the question of “what” (eg, sell computers, music players, and cellular phones). Sinek argues that conventional organizations often move in the opposite order: they focus on what, worry some about how, and often never get to why. Greatness comes from starting with why.

Great health care should begin with clarity about its purpose—and the why for health care has always been the reduction of suffering. This suffering includes physical pain and functional impairment, as well as fear, uncertainty, and confusion. Suffering is, of course, inherent to medicine; the word *patient* comes from the Latin for “one who suffers.” But some of that suffering can be avoided, much of it can be reduced, and there is no ambivalence in health care about the goal of reducing suffering.

The more difficult question is how, and even here there is broad agreement. Patients want clinicians whom they can trust—safe, reliable, and technically excellent, but also com-

passionate and coordinated. Clinicians want to feel pride in their work and respect for their colleagues.

Clarity on the why and the how makes it possible to grapple with the what of health care: the many different tasks that clinicians undertake to reduce their patients' suffering. They must give patients timely access and make accurate diagnoses. They must provide treatments that improve long-term outcomes and relieve shorter-term symptoms, including pain. They must decide when to watch and wait and use the test of time, when to intervene, and when to bear witness and provide support as nature takes its course.

The what of health care is more than difficult: it is complex. Multiple issues matter to patients, and clinicians must do their best to weigh values that are often in conflict. For example, when considering an invasive procedure, physicians must balance immediate risk against longer-term benefits. Zero cannot be considered an ideal surgical mortality rate, because surgeons who achieve it are probably overvaluing short-term risk over potential improvement in outcomes compared with their colleagues.³ Furthermore, clinicians must often weigh risks vs benefits of multiple potential strategies, and rarely have all options been compared in randomized clinical trials.

Guidelines and performance measures are helpful when evidence is clear on "the right thing" to do—for example, in increasing the use of β -blockers after acute myocardial infarction. But they might be even more valuable in the vast gray zones of medicine, where right and wrong answers do not exist. In these gray zones, guidelines and performance measures can help clinicians approach the decision making of their most experienced and knowledgeable colleagues.

Guidelines can define the issues for which there is not clear evidence and offer patient care strategies based on expert opinions to help fill the void. Both are useful. These recommendations may not define what is right or wrong to do for individual patients but provide some sense of "the norm" for clinicians who otherwise might feel lost in their decision making.

Similarly, performance data for which there is no "ideal" target can help clinicians understand if they are juggling the competing values in medicine differently from their colleagues. For example, there is no "right" rate of radiology test utilization, but physicians who have high rates should consciously reflect if they might be overusing these tests, and physicians with the lowest rates should wonder if they are underusing them. When 100% is not the goal, measures should not be used to classify physicians as "good" or "bad" or to rank them. However, these measures could be used by outlier clinicians to recognize when they might have an opportunity to learn something from their colleagues.

These perspectives are relevant to how clinicians respond to their patients with pain. Guidelines such as those reported in this issue of *JAMA*¹ reflect what is known from research, acknowledge gaps in knowledge, and offer experts' opinions on how best to fill those gaps. These guidelines make clear that prescribing opioids is far from the only effective response to patients' pain and that when these drugs are used, certain measures can minimize their

risk, such as avoiding concurrent use of benzodiazepines, using short- vs long-acting opiates whenever possible, and using the minimum dose that is likely to be effective. Guidelines such as these do not tell clinicians what to do with individual patients, but they offer a frame of reference. When clinicians deviate from these recommendations, they should give thought to why.

The same is true of performance measures, including patients' responses to questions about pain management. Physicians are used to pursuing perfection when they are being evaluated and are concerned that asking patients questions like "How often was your pain well controlled?" suggests that physicians may be penalized in some way if they see patients who are drug seekers and do not dispense opioids freely to them. There are, of course, drug-seeking patients, particularly in emergency departments and primary care settings, but these patients do not respond often to surveys and thus have little influence on physicians' overall ratings. Furthermore, organizations that attach financial incentives to patient experience data tend to focus on patients' overall confidence that they have received good care, rather than individual issues such as pain.

Clinicians can draw reassurance from analyses of survey data that consistently demonstrate that patients understand the difference between analgesia and care.⁴ These data indicate that patients want the same basic things in every setting of care. Patients want good clinicians, they want coordination, they want good communication, and they want compassion. After these factors are considered, issues such as pain control and waiting time are not drivers of patients' overall experience with their care and their likelihood of recommending hospitals and physicians.

This finding is consistent in data from patients who were hospitalized or seen in the emergency department or in physicians' offices. Patients want efficient relief from their symptoms, of course, but the picture painted from these data is one in which most patients place even greater value on good clinicians who are working well together, listening to and communicating with patients, and showing that they care.

In short, patients place greater emphasis on the how (whether they are receiving care that is compassionate, coordinated, and focused on optimizing their outcomes) than the what (whether their pain is completely controlled). Zero pain is not the goal. The reduction of suffering is—and that is something more complex than analgesia alone.

Pain management will never be easy or straightforward, but it is an intrinsic element of any effort to reduce patients' suffering. The problem is not inappropriate pressures exerted from measurement of patients' assessment of their pain control: it is the difficulty of knowing what to do with the information that patients are in pain. The CDC guidelines offer important recommendations for addressing that issue.

The data will never be perfect. The measures will never be perfect. The guidelines will never be perfect. And neither will clinicians and their performance. But by acknowledging these imperfections and trying to get better with the tools available, physicians can more effectively reduce the suffering of patients.

ARTICLE INFORMATION

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The CDC Guideline on Opioid Prescribing Rising to the Challenge

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In 2014, nearly 20 000 deaths due to overdose of prescription opioids occurred in the United States.¹ That same year, more than 10 million people in the United States reported



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using prescription opioids for nonmedical reasons, and close to 2 million people older than 12 years met diagnostic criteria for a substance use disorder involving prescription opioids.² This is the highest number of individuals considered to have opioid addiction since statistics began to be collected in the late 19th century.³ Four of 5 persons newly initiating heroin use now report starting with a prescription opioid, a near complete reversal since prior to 2000.⁴ Despite multiple, laudable efforts across the country aimed at curbing the opioid epidemic, there seems to be little relief in sight.

In the 1980s and 1990s, a body of evidence documented that patients commonly experience inadequately treated pain. Researchers found systemic health disparities in access to pain management.⁵ National authorities, including the Federation of State Medical Boards, called on health care practitioners to pay greater attention to pain.⁶ In 2000, the Joint Commission adopted pain as the “fifth vital sign,”⁷ a well-intentioned (albeit simplistic) policy to increase awareness of and interventions for pain.

These efforts to treat pain more effectively coincided with relentless and misleading marketing of prescription opioids by manufacturers, who minimized the risks of misuse and addiction.⁸ These efforts also coincided with the introduction of patient satisfaction surveys tied to physician performance and reimbursement in some areas, including the assessment of pain.

In retrospect, it is significant that this campaign occurred in the absence of substantial evidence for the long-term effectiveness of opioids in the treatment of persistent pain outside of active cancer and palliative care and without substan-

tial training, understanding, and acknowledgment of addiction as a preventable, identifiable, and treatable disease.

Without strong evidence or sufficient training, clinicians had to rely on their best clinical judgment influenced by opinion, beliefs, values, and past experience. However, prescribers proved to be as vulnerable as patients to conflicting messages and judgmental attitudes. For chronic pain management with prescription opioids, the benefit-risk analysis over the past 2 decades became so distorted that it led some clinicians to either miss or dismiss the presence of addiction in their patients, avoid discussing the possibility of this diagnosis, or stereotype patients with addiction and discharge them from care.^{9,10}

Once established, patterns of clinical care can be extraordinarily resistant to change. For instance, in 2012, US health care practitioners wrote more than 200 million prescriptions for opioids, double the number in 1998 and 10 million more than in 2008.¹¹ In addition, some evidence suggests that some physicians keep prescribing opioids to patients who have experienced serious harms such as overdose.¹² Furthermore, as illustrated in 2 research letters by Wunsch et al¹³ and Baker et al,¹⁴ respectively, in this issue of *JAMA*, patients are receiving more opioids than in the past for common surgical procedures¹³ and from practitioners such as dentists who previously may have recommended nonopioid medication for procedures such as dental extractions.¹⁴

Using a database of health encounters of 14 million commercially insured adult patients, Wunsch et al¹³ reported that 80% of 155 297 patients who underwent any of 4 low-risk surgical procedures (carpal tunnel release, laparoscopic cholecystectomy, inguinal hernia repair, knee arthroscopy) filled a prescription for any opioid. The percentage filling prescriptions increased for all 4 procedures during the study years. For example, 72.4% filled prescriptions after carpal tunnel release in 2004 compared with 76.1% in 2012.

Using a national database of deidentified Medicaid transactions from 2000 to 2010 for surgical dental extraction, Baker et al¹⁴ found that 42% of 2 757 273 patients filled a prescrip-