BY LESTER A. PICKER

Taming the Pain Monster

Lack of knowledge, fear of regulatory scrutiny, and diagnostic challenges can present hurdles to the treatment of pain. However, standards and tools exist that can help you practice and prescribe without undue fear of litigation.

ON A COOL FEBRUARY NIGHT in 2001, Dr. Wing Chin was called to the Emergency Room of Eden Medical Center in Castro Valley, California to examine William Bergman, an 85-year old retired railroad worker. Presenting a complex medical history with the strong possibility of a diagnosis of lung cancer, Bergman had reacted to the administration of morphine in the ER with life-threatening, depressed respiration.

Chin admitted Bergman, prescribed Demerol as needed, and ordered a series of tests. Throughout his six-day hospital stay, Bergman self-reported his pain as falling between seven and ten on a ten-point scale, although he never once complained that health-care providers did not treat his pain adequately.

At discharge, Bergman was given a pain-relieving drug by injection and prescriptions for oral and patch-released pain medications. Two days later a visiting hospice nurse called Chin to report Bergman in extreme pain. Chin referred the nurse to Bergman's family physician, who prescribed morphine. The next day, Bergman died.

Soon afterward, Bergman's relatives sued Chin for inadequate treatment of his pain under a unique feature of California law. Citing elder abuse, they won a surprising $1.5 million jury verdict against Chin, which was later reduced by the judge to $250,000. The parties have since settled out of court.

ILLUSTRATION BY SUSAN LEVAN

A chilling effect?

While some health-care providers are still not familiar with the Chin case, the verdict has reverberated throughout the medical community, already reeling from years of managed care woes, skyrocketing malpractice insurance rates, and increased litigation along the full spectrum of medical practice. Unlike the more typical overmedication lawsuits, the Chin case broke new ground and has upped the liability ante for physician practices.

"Physicians' practices in general seem to be coming under increased scrutiny on a number of fronts," says Michael Ashburn, MD, MPH, the director of the Pain Management Center at the University of Utah and a leading spokesman for the emerging field of pain management. "Their practices can be reviewed by the Drug Enforcement Administration (DEA). They can be reviewed by the Department of Justice or the state Medicaid system in regard to inappropriate billing. They are subject to civil litigation for allegations of undertreatment or overtreatment of pain. They are also subject to criminal penalties for the reckless distribution of controlled substances for the treatment of pain. It shouldn't be surprising that some physicians feel that the threat of litigation weighs heavily on their minds."

Robert Slattery, a California attorney with McNamara, Dodge, Ney, Beatty, Slattery, and Pfalzer, LLP, agrees with Ashburn's assessment about the threat of litigation and the chilling effect it has had on medical practices. Slattery defends physicians and health-care facilities in medical malpractice litigation and was one of the attorneys in the Wing Chin case.

"Pain management is a big issue for physicians, especially in the context of the way this case arose. Dr. Chin was on the horns of a dilemma. The patient was in pain, but for medical reasons Dr. Chin felt he could not prescribe the one medication that, retrospectively, the family wished he had prescribed. However, Dr. Chin did treat the pain with medication and during the course of treatment he did not receive any indication from the patient or from any other source that he was under-treating the pain."

Implications for practice

Chin's case was a hot-button item for the jury, whose members were more concerned about the pain Mr.

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Bergman experienced than the potentially lethal consequences to him of excessive or inappropriate medication. "The response of the jury was very emotional to a well-reasoned medical decision," Slattery says in retrospect. "The implication for physician practice may be that the goal of being pain free may supercede the medical reasons for prescribing or withholding a particular form of medication."

Chin's defense experts stated that, in fact, Bergman could have lived at least six months longer. They testified that Bergman's untimely death was due to the medication that was administered subsequent to Chin's efforts and that led to a suppression of breathing. But, the jury did not consider that as noteworthy as Bergman's right to be relieved of pain. Groups such as Compassion in Dying, an Oregon-based patient advocacy organization that was involved in the Chin case, believe that medicating a terminally ill patient even to the point that the medications themselves cause death is acceptable medical practice, according to Slattery.

"Physicians shouldn't be exposed to undue scrutiny by the DEA for the use of controlled substances for the control of pain," says Michael Ashburn, MD, MPH, the director of the Pain Management Center at the University of Utah. "Physicians should be comfortable with the fact that their use of controlled substances will undergo some regulatory review because these meds are addictive and they can be misused."

A growing awareness

Despite significant advances in pain management over the past 10 years, most pain medicine specialists believe that the majority of physicians are not skilled in treating pain appropriately. As a result, pain continues to be undertreated in a number of different areas, according to Ashburn. "That's particularly true with acute post-operative pain and pain associated with trauma during

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hospitalization. A large number of individuals throughout the United States also suffer from poorly controlled chronic pain caused by many sources, the main ones being headache, chronic lower back pain, and arthritis."

Besides the fear of litigation and lack of knowledge, there are other reasons that pain is still inappropriately treated in the United States. Chief among them is the challenging nature of pain diagnosis and treatment. "Making a diagnosis in patients with chronic pain can be a challenge," says Peter Staats, MD, the director of the division of pain medicine at The Johns Hopkins University, and a leading expert who has developed a new theory of pain and its treatment. "There are many different things that can cause pain and physicians are often inadequately prepared to assess the broad variety of disease states that can cause pain."

Peter Staats, MD, the director of the division of pain medicine at Johns Hopkins University says, "About 10 years ago, in a study of state medical examiners—people who had the power to take away a physician's license—the researcher found that they didn't really know the law. They thought it was inappropriate to prescribe opioids."

Physicians are often unfamiliar with the variety of pain treatment options, many of them new and emerging. Staats, for example, recently completed a trial of intrathecal pumps versus maximal medical care for patients with cancer-related pain. The study found that patients using a pump to deliver medication directly into the spinal fluid had better pain control, less toxicity and increased survival (53.9 percent vs. 37 percent after six months).

Although well-documented for their effectiveness in pain control, some options, such as the use of narcotics, are met with great resistance from physicians. Some are concerned that they will turn patients into addicts or that DEA agents will come knocking on their doors. Established in 1973, the DEA is charged with enforcing the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Neither Staats nor Ashburn believes the DEA tries to tie the hands of physicians when it comes to pain manage-

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ment. Recently the DEA, the American Pain Society, the American Academy of Pain Medicine (AAPM), and other professional societies issued a joint press release calling for federal policy that strikes a balance between efforts to control divergence of medications for illicit use and their access for appropriate medical purposes.

"Physicians shouldn't be exposed to undue scrutiny by the DEA for the use of controlled substances for the control of pain," says Ashburn. "Physicians should be comfortable with the fact that their use of controlled substances will undergo some regulatory review because these meds are addictive and they can be misused. They should expect that their practices be run in accordance with national policies established by health-care professionals for the use of controlled substances for the management of pain."

But the DEA is not the only regulatory agency with which physicians must contend. Others are county and state review boards. Staats explains: "About 10 years ago, in a study of state medical examiners—people who had the power to take away a physician's license—the researcher found that they didn't really know the law. They thought it was inappropriate to prescribe opioids." Staats says that for the next eight years or so, there were fewer prosecutions, which led to more appropriate treatment.

"But in the last couple of years, ever since problems with Oxycontin arose, there have been new prosecutions of physicians, some of them obviously justified, and a heightened concern again by all physicians," Staats says.

'Opioid-phobia' is the term used to describe the current physician resistance to prescribing opioids, whether triggered by a fear of regulatory audits, concern over potential patient addiction, or the cultural issues involved in medical practice, such as peer disapproval. "There's still a belief that there's a ceiling to how much medication you should give to everyone," says Janet Selway, a certified Nurse Practitioner and a clinical instructor at the Johns Hopkins School of Nursing. "Some people may require more medication to relieve their pain than what the PDR says."

Still another fear that many urban practitioners have is that once word gets out on the street that a physician is willing to prescribe controlled substances, the practice may be targeted by those who want to divert the drugs for illicit use. These concerns, alone or in combination, have contributed to the under-treatment of pain today in America, according to experts.

A lack of training—and specialists

Perhaps the most important factor in the inappropriate treatment of pain is the lack of adequate physician training. As of a few years ago, on average, pain management took up a total of one or two hours of training in medical schools, a dismal statistic when one considers that a primary presenting complaint is pain.

However, the discrepancy between patient need and physician education is being remedied. Medical school curricula across the country are adding more training in pain management. The AAPM is developing a multi-hour CD-ROM—funded by Purdue Pharma, makers of Oxycontin and MS Contin—to be distributed to every medical school in the United States. Teaching hospitals such as Johns Hopkins are also developing their own computer-based training materials.

But, for now, the emerging field of pain management is plagued by a lack of specialists. "There are not enough pain management specialists around," says Selway, whose clinical practice has many patients with chronic pain. "When I worked in a private practice, it was sometimes six months before I could get a patient into a pain management program."

Time and money

Unfortunately, pain management is time consuming and expensive. For primary care practices that have to manage prescriptions, it typically costs them more to care for their patients than to refer them out. "To do this right, you have to spend lots of time with a patient with chronic pain," says Staats. "Managed care wants you to spend a few minutes. It takes time to understand the psychological co-morbidity and treat that while we treat the patient with medications. It costs a physician more to do it right than they get reimbursed. Physicians who take that time aren't getting paid for their work. It's not that reimbursement is inconsistent, it's that it is consistently bad."

The University of Utah's Ashburn adds, "Patients with chronic pain in general can be very complex. They can have concomitant medical disorders, like depression, sleep disorders, anxiety. Physicians can find themselves spending a lot of time with these patients and unfortunately society does not value the efforts necessary to care for such patients."

Selway says the management of some patients' pain is costly, both to the patient and sometimes the practice. "Many times the patient's pain is the result of trauma. They've lost their jobs, or they

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may have lower paying jobs and may be excluded from any type of insurance or medical assistance. In those cases, the practice may have to absorb the costs."

Looking toward the future

While effective pain management still faces barriers today, its future is promising. On the regulatory front, the physician community is working closely with the DEA to effect solutions.

"Neither physician groups nor the DEA wants to have addiction in America," says Staats of Johns Hopkins. "We both don't want under-treatment of our seniors and other citizens facing painful disorders. Where a physician over-prescribes, we may have an opportunity to educate at first, rather than prosecute. I suggested this when I testified to Congress (December, 2001) and there appeared to be receptivity by policymakers."

In the area of monitoring those who seek to divert drugs for illicit use, Congressman Frank Wolf of Virginia is exploring creating a nationwide monitoring system to determine whether a patient is going to multiple providers to get prescriptions for opioids, an approach supported by Staats and other pain management specialists.

If there is one pain management trend upon which most experts agree, it is in the interdisciplinary treatment model advocated by Ashburn. "Treatment of chronic pain goes well beyond the use of opioids. The best treatment modality for patients with complex, chronic pain problems is the use of an interdisciplinary team model." According to Ashburn, that model includes medical management, which may involve controlled substances, but may also include medications from several different classes. It also involves physical therapy, appropriate self-management techniques, education on healthy lifestyles, and sometimes interventional techniques such as nerve-route blocks or implantation technology.

Monitoring outcomes is rapidly being recognized as an essential method of improving patient care throughout the health-care system. In early 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued new Pain Management Standards governing patient rights, pain assessment and treatment, patient education, and continuum of care. Healthcare organizations are required to develop a process that allows them to monitor pain outcomes so they can use that data to implement improvements in their systems of care.

What can a physician do today?

Despite the threat of litigation and a lack of adequate training, there are concrete steps a conscientious physician can take immediately to alleviate a patient's pain and not fear regulatory review or deposition notices.

Practice Good Medicine. Ashburn tells physicians using controlled substances for patients with pain that the best defense against regulatory review and the threat of litigation is to understand the basic principles of pain assessment and therapy. "One of the answers is to practice good medicine," says Ashburn. "That's what I try to do. I make use of appropriate pain assessment. I provide controlled substances as part of an integrated interdisciplinary care plan in accordance with well recognized national standards. And, I don't worry about litigation."

Nurse practitioner Selway agrees. "The most important issue with pain is to control it immediately. One medication or strategy may not suffice. We often find that one pain medication is not enough. Some patients with chronic pain, for example, may also need an anti-depressant."

Both Ashburn and Staats recommend that physicians ramp up their pain management treatment by following the guidelines jointly published by the AAPM and the American Pain Society. (See "Internet Resources.")

Document. Litigation is a fact of life for many practitioners, according to attorney Slattery. "From my standpoint, the only thing that physicians must do to protect themselves is proactively document everything: the various medical choices, discussions with the patient and the patient's family, the reasons why you chose a particular treatment option."

Slattery suggests that physicians make careful notes for every patient contact, a point with which all experts seem to agree. The physician should assess and note something about the patient's pain, so she can say that each visit involved pain assessment that supported the eventual course of action. Model forms for pain assessment are available on line at *www.pain.com*. (See "Internet Resources.")

Reach Out. A key challenge for physicians is to recognize when they are beyond their pain management skills. "When I'm called in to review a physician's care," notes Ashburn, "this is the area that is most commonly the problem. Their intention is good, to try to take care of a patient who's extremely medically complex. But somewhere down the road they realize they are way over their heads. When they identify a patient who is outside their skill set, and every physician gets to this point some time, they need to reach out and

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ask for help."

Selway, for example, recognized long ago that some primary care providers were not well-versed in pain management. "Get friendly with a pain management specialist," she advises. "I'm fortunate because I can call physicians and nurse practitioner specialists in pain management at Hopkins to get advice on how to best manage my patients."

Stay On Top Of Your Game. There have been significant advances in pain medicine over the past ten years. "The scientific basis that pain medicine is built upon will grow tremendously in the years to come and will get more sophisticated," Staats observes. Experts recommend continuing education specifically for pain medicine, especially newer techniques in integrated management. California has mandated such education. Other states are considering it.

Additional education may not make a difference with some patients. "I don't think continuing medical education would have made a difference in the Chin case," attorney Slattery reminds physicians. "Dr. Chin was aware of the various medical alternatives and made a clinical judgment."

Be Savvy. Be aware of scams such as 'I lost my prescription again.' If you suspect drug abuse or diversion, insist on a drug screening or regular drug testing as part of the patient's pain management program. Get new patient records directly from the former physician's office. If you suspect a patient is abusing pain medications, call the pharmacy to check if they are bringing in prescriptions from other physicians.

Sign a Contract. Insist that patients with chronic pain sign a pain management contract that serves as a consent form and specifies expectations for both physician and patient. Contracts are increasingly common today. They cover important behavioral points, such as a pledge that patients will keep their appointments, will only get their pain medications from you, will only use one pharmacy, and will keep a pain diary. Sample contracts are available on line at professional societies.

Integrate Care. The time spent planning for integrated care is time well spent. Positive outcomes in terms of relieved patient pain and reduced litigation are commonly reported at facilities that have instituted an integrated pain management practice.

"At our pain clinic, we have pre-printed medication agreements that outline the process of care that we provide," Ashburn points out. "We have flow sheets to make sure that we follow our own procedures regarding monitoring those patients. Patients sign an agreement on medication use. As we integrated our process, we educated our support staff. As a result, we believe we provide more consistent care, which we believe increases the quality of care those patients receive. At the same time, the process is more efficient, so it's less costly." ■

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Internet Resources:

Web Sites for Pain Management

www.aapainmanage.org
American Academy of Pain Management's Web site. Lists all pain management professionals by state.

www.painfoundation.org
Official site of the American Pain Foundation, a resource for patients and their families. Includes a list of pain management facilities, support groups, counselors and other resources.

www.ampainsoc.org
Site of the American Pain Society. Search by state to find facilities that specialize in treatment of pain. Also has a copy of "The Use of Opioids for the Treatment of Chronic Pain," published with AAPM.

www.jcaho.org
Site of the Joint Commission for the Accreditation of Healthcare Organizations and their standards for pain management.

www.nurse.org/acnp
Includes excellent materials on end-of-life care and links to pain management experts by state.

www.pain.com
Professional site with access to hundreds of articles on pain management in its large library and model pain assessment forms. Also has continuing medical education programs and links to pain studies and other libraries.

www.stoppain.org
Department of Pain and Palliative Care at Beth Israel Medical Center's Web site. Has good information for lay people about types of pain and various treatments.