physician connection

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PROFESSIONAL SOLUTIONS INSURANCE COMPANY BRINGS YOU PRACTICAL TIPS FOR AVOIDING A MALPRACTICE ALLEGATION ISSUE 6 • 2012

Managing the Chronic Pain Patient

INSIDE THIS ISSUE:

Chronic pain management has been a hot topic recently. Because more patients present with chronic pain, more physicians are prescribing pain medications. An unintended consequence is the alarming misuse and abuse of prescription painkillers—particularly those classified as controlled substances.

Chronic pain management requires careful patient screening and assessment, individualized treatment plans and regular patient monitoring. Consider the following scenarios:

Scenario 1: Andy Romano, age 39, had been a patient of family practitioner Donald Franks, M.D., for more than 10 years. Being treated for chronic pain after he suffered a crushing right shoulder injury in a car accident, Andy had undergone several surgeries, but never regained normal use of his right arm.

Andy reported 24/7 pain when he first saw Dr. Franks, and the pain had increased to the point where he needed progressively stronger opiates for relief. More than once, Andy's wife had expressed concerns about her husband's long-term use of narcotics and the potential for addiction, but Dr. Franks tried to reassure her that other patients were on much higher levels of pain medications. Troubled by the prescription and its adverse effects, Andy's wife took her husband to a pain management specialist for a second opinion. After examining the patient, Andy was admitted to a drug rehab facility to wean him off the opiates.

After a long rehab, which included the use of acupuncture for pain relief and to improve his range of motion, Andy was able to get by with only the occasional use of ibuprofen. Andy and his family filed suit against Dr. Franks, alleging inappropriate prescription of narcotics that resulted in drug-dependence and physical disability.

Scenario 2: Shelly Rogers was 29 years old and had recently moved from another state when she presented to Thomas Riley, M.D., a family practitioner in a six-physician group. Her chief complaint was migraine headaches, which she had since she was a teenager. She said she had a copy of her medical records from her past physician's office and would drop them off in the next couple of days.

After his initial assessment, Dr. Riley suggested that she try a triptan, which he found to be a very effective pain reliever for some of his other migraine patients. Shelly said her former FP had specifically advised her not to take triptans because of a strong family history of stroke—a recognized contraindication for the use of triptans. She said she had been using Lortab 10, as prescribed by her former FP, with good success and no ill-effects. She had an empty pill bottle for Lortab 10, and Dr. Riley gave her a new prescription for a 30-day supply of Lortab 10. When she was seen one month later, she reported good relief of her pain and requested a prescription refill.

Several months later, Dr. Riley's office manager alerted him that Shelly had been calling in for refills of her meds—often a day or two after seeing Dr. Riley—to report she had lost the original prescription and needed another. One of Dr. Riley's partners had taken care of one of these requests while Dr. Riley was on vacation and noticed the pattern.

After investigation, Dr. Riley confirmed that Shelly had actually filled all the supposedly "lost" prescriptions in

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addition to their replacements at several local pharmacies. She always called the office on Dr. Riley's day off. She also had never provided her medical records as promised. Because the practice was transitioning to an EHR system, this ruse went unnoticed for some time. However, the next time Shelly called in for a Lortab 10 refill, she was told to make an appointment to see Dr. Riley to get the new prescription. She said she would call back to schedule, but she never did.

Change in Pain Management is Needed

These two case examples involve different aspects of chronic pain management and different medical-legal issues associated with the prescription of medications for pain relief. Much of the difficulty with pain management came to light in June 2011, when the Institute of Medicine released a report entitled *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*. This report found that widespread change is needed in how pain is perceived by patients and healthcare providers, due to a number of factors, including:

- 100 million Americans are affected by chronic pain, making it a significant public health issue.
- Chronic pain costs the U.S. more than $560 billion annually in medical treatment and lost productivity.
- Much of the chronic pain experienced by Americans isn't treated correctly or effectively for a variety of reasons, which include:
  - The individual and subjective nature of pain.
  - Uncertain and vague diagnoses.
  - The societal stigma, culture attitudes, biases and stereotypes often associated with pain.
  - A lack of or barriers to available and effective treatment within the healthcare system.
  - The potential for overdose, abuse or diversion makes some physicians choose not to prescribe pain medications even when they could be used safely and effectively.
  - Inadequate patient and provider knowledge about pain management.

Since then, several governmental and professional organizations have sought to improve the management of pain and to reduce the diversion, misuse and abuse of prescription painkillers, especially opiates. Opiates can be effective for managing chronic, non-terminal or non-malignant pain when prescribed appropriately, but they have a high risk of serious adverse effects and their street use is disturbingly high.

In November 2011, the CDC issued a report on *Prescription Painkiller Overdoses in the U.S.* (see Resources) that contained astonishing statistics about the use and misuse of prescription painkillers:

- Deaths from prescription painkillers have reached "epidemic levels," with more than 36,000 drug overdose deaths reported in 2008. Of these, 20,440 overdoses involved prescription drugs, and 73.7 percent, nearly 15,000 deaths, involved opioid-related pain relievers.
- Opioid-related pain relievers account for more overdose deaths than heroin and cocaine combined.
- In 2010, about 12 million Americans reported using nonmedical prescription painkillers in the prior year.
- Enough prescription painkillers were prescribed in 2010 to medicate every American adult *around-the-clock for a month*. Although most of these pills are prescribed for medical purposes, many end up in the hands of people who misuse or abuse them.
- Nearly one-half million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers, more than from the use of illicit drugs.

In July of 2012, the FDA published a *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics* to help ensure that the benefits of these opioid analgesics outweigh the risks, and that they are used safely and effectively to manage chronic pain (see Resources). This publication also targets manufacturers of opioid analgesics, who will now be required to put on educational programs and provide FDA-approved patient educational material to prescribers.

In its *Sentinel Event Alert* on the "Safe Use of Opioids in Hospitals" in August of 2012 (see Resources), the Joint Commission provides information to identify patients at a higher risk of suffering an adverse event related to opioids. The *Alert* also shares factors that can lead to accidental opioid overuse and the evidence-based actions that may prevent or mitigate the morbidity of these adverse events.

Many national specialty organizations have also issued clinical practice guidelines on chronic pain management.

What Can We Learn?

Treating patient pain—chronic or acute—is never easy. Pain is an inherently vague, subjective and multi-faceted concept that is individualized by each patient. Physicians must recognize that one patient's "2" may be another patient's "7."

The management of severe chronic pain has become even more difficult in light of the sheer number of people affected by pain and our society's increasing abuse and illegal diversion of these drugs. In light of these factors, it is important to pay particular attention to:

- **Patient risk assessment**. Take a thorough patient history with heightened awareness of:
  - Sleep apnea
  - Obesity
  - Past history or a family history of alcohol or street-drug abuse, tobacco use, pre-existing cardiac or respiratory disease
  - Age greater than 61 years
  - Medication history (for drug-drug interactions or previous adverse reactions to or intolerance of analgesic or sedating medications)
  - History of depression, anxiety or other mental illness

The presence of any of the above in a patient's history may contraindicate the use of a specific medication or increase the likelihood of an adverse event and subsequent patient harm. Taking the time to identify at-risk patients can help maximize the patient analgesic benefit and decrease the risk of drug diversion.

- **Care plans individualized** to each patient's specific medical circumstances, pain needs, past history and goals. *Is the patient hoping to reduce his pain from a "7" to a "2"? To be able to return to work pain-free? To treat pain without opioids or without any medications?* Knowing what each patient wants and expects should be the foundation of each patient's pain management plan. Patients will be more likely to comply if they are involved in the development of a pain management strategy. In addition, it will be easier to measure treatment outcome/success against defined goals.

- **Patient monitoring**. Aim for the lowest dose that provides effective pain relief for each patient, but recognize that it may take time to find the perfect dose. Monitor at more frequent intervals for early recognition of potential problems—patient sensitivities or side effects are more likely early on in a drug regimen—and reassess after adjusting a medication or dose. Office protocols for follow-up contacts and appointments with chronic pain patients can help detect signs of drug misuse or indicate or predict addiction. These behaviors include:
  - Requesting increased dosage or additional medication
  - Non-compliance with other pain relief therapies
  - Requesting a specific analgesic
  - Behavioral changes that adversely affect work or daily living
  - Repeated "lost" prescriptions
  - Use of multiple physicians, healthcare facilities and/or pharmacies to obtain medications

- **Patient education**. Good patient understanding of treatment, including the rationale behind that treatment and its potential risks and consequences, is particularly important to successful pain management.

  Written take-home patient education materials in addition to the physician's verbal explanation about the treatment or pain medication prescribed is important and reinforcing, thus increasing the likelihood of therapeutic success. This should include:
  - Dosing and administration information
  - Potential risks, side effects, and interactions with other drugs, food, or alcohol
  - Potential impact on the patient's daily activities, such as physical activities and driving
  - Any specifically contraindicated activities
  - Associated risks of misuse including dependence, addiction and/or withdrawal
  - The patient's responsibility to safely secure and store the drug

  Sharing this information with other family members, as allowed by the patient, can be extremely beneficial in building patient support and improving patient compliance.

- **Adherence to evidence-based practice guidelines**. Look to your specialty organizations or pain management specialty groups for clinical guidelines in chronic pain management. In the event of litigation, your use of established guidelines and nationally recognized standards of care will be extremely useful in your defense. Many of these guidelines contain:
  - Tools to assess patient pain
  - Templates for pain scales and to screen patients for opioid analgesia
  - Physician/patient pain management contracts
  - Patient educational materials on pain management and pain medications

- **Patient referral**. Know when to get a consult or refer the patient to a pain management expert.

Resources

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Committee on Advancing Pain Research, Care, and Education, Institute of Medicine. Washington, DC: *The National Academies Press*, 2011 www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx

Practice guidelines for chronic pain management. An updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. *Anesthesiology* 2010 Apr; 112(4):810-33.

FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics. U.S. Food & Drug Administration, July 9, 2012 www.fda.gov/downloads/drugs/drugsafety/ucm277916.pdf

FDA Medication Guide Templates for Opioid Analgesics. July 2012 www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm

Prescription Painkiller Overdoses in the U.S. *CDC Vital Signs*, November 2011 www.cdc.gov/VitalSigns/PainkillerOverdoses/index.html

Managing Pain Patients Who Abuse Prescription Drugs. CME activity www.medscape.org/viewarticle/770440?src=ememp

Safe Prescribing for Pain. CME activity www.medscape.org/viewarticle/770687?src=cmemp

The Joint Commission Sentinel Event Alert. *Safe Use of Opioids in Hospitals*. Issue 49, August 8 2012 www.jointcommission.org/sea_issue_49/

American Society of Internal Medicine, Pain Management Module. Guidelines, strategies and tools for physicians to make informed decisions about the treatment of pain. www.acponline.org/ebizatpro/ProductsandServices/Products/ProductDetail/tabid/202/Default.aspx?ProductId=16321

World Health Organization:

- **Treatment Guidelines on Chronic non-malignant Pain in Adults** www.who.int/entity/medicines/areas/quality_safety/Scoping_WHOGuide_non-malignant_pain_adults.pdf

- **Treatment Guidelines on Persisting Pain in Children** www.who.int/medicines/areas/quality_safety/guide_on_pain/en/index.html

Partners Against Pain www.partnersagainstpain.com/hcp/index.aspx

Screener and Opioid Assessment for Patients in Pain. Brief paper and pencil tool to facilitate assessment and planning for chronic pain patients being considered for long-term opioid treatment www.painedu.org/soap.asp

Physicians for Responsible Opioid Prescription "Cautious Evidence-based Opioid Prescribing" www.supportprop.org

Questions?

If you have any questions you'd like our **Connection** *experts to answer, please e-mail them to riskmanagement@psicinsurance.com*

Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain. 2010 Update. Washington State Agency Medical Directors' Group educational aid to improve care and safety with opioid therapy www.agencymeddirectors.wa.gov/opioiddosing.asp

Model policy for the use of controlled substances for the treatment of pain. Federation of State Medical Boards of the United States, Inc. www.fsmb.org/grpol_policydocs.html

CARES Alliance—Improving Patient Safety in Pain Management www.caresalliance.org

A Tool for Safely Treating Chronic Pain (Sample Medication Use Agreement). Teichman PG. *Family Practice Management*. Nov/Dec 2001:47-49 www.aafp.org/fpm/20011100/47atoo.html

Anatomy of an Epidemic: The Opioid Movie www.medpagetoday.com/Neurology/PainManagement/34650?utm_content=&utm_medium=email&utm_campaign=DailyHeadlines&utm_source=WC&xid=NL_DHE_2012-09-10&eun=g575465d0r&userid=575465&email=janeconley@comcast.net&mu_id=5703486

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