The Challenges of Pain
Doctors Frustrated by Fragmente

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Overview

Many physicians and dentists are frustrated by the lack of consensus in pain management for a patient population whose needs, expectations, and occasional excesses pose a broad range of clinical and liability risks. Lack of consistency in regulatory and professional guidelines contributes to this frustration.

Part of the reason for the lack of consensus in treatment may be associated with the varying degrees of patient demands. According to a recent study, an estimated 22.9 million pain medication prescriptions are written annually.[1] In addition, in 2010 alone, the sale of prescription pain medications reached $9 billion.

Some patients seek pain relief for every ache or pain, which may be reinforced by the deluge of direct-sell pharmaceutical ads. Also, an expanding body of research suggests that patients may become reliant on these drugs too easily and, in some instances, the drugs do more harm than good. However, even though over 20 million prescriptions for pain medications are written annually, more than 60 million Americans have been diagnosed with chronic pain. Therefore, some are not receiving any pain medications at all.

Patients' demands can put doctors between a rock and a hard place when determining the proper treatment for alleviating patients' pain.

Further, doctors may not always agree about pain treatment protocols. Some healthcare professionals today provide treatment for pain based upon "what the patient says it is."[2,3] Other doctors are more conservative in their approach to pain management, which may cause such doctors to be criticized in patient satisfaction surveys or find themselves named as outliers in quality evaluations.

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In addition to their own beliefs and the demands of their patients, doctors must be sensitive to other societal factors in the treatment of pain. For example, payors and regulators are generally concerned about the cost of pain management and the alarming increase in deaths associated with prescription pain medications. In 2011, the CDC announced that deaths caused by prescription pain killers have surpassed all other causes of accidental death,[4] and the number of prescriptions continues to soar.

Management:
ed Pain Management Standards

This article seeks to provide perspectives from a variety of sources to illustrate the various reasons for a lack of consensus between regulators and doctors.

Regulatory Oversight

FDA oversight: Since 2008, the FDA and other regulatory bodies have been trying to address the prescription drug epidemic. In April 2011, the FDA announced a Risk Evaluation and Mitigation Strategy (REMS) designed to fulfill three objectives:

1. Ensure consistency in the prescription and management of extended-release and long-acting (ER/LA) opioid analgesics;
2. Increase the required number of accredited Continuing Education courses for licensed providers via programs to be developed by pharmaceutical companies and aimed at improving understanding of the risks and benefits associated with these drugs; and
3. Improve cooperation between manufacturers and providers as a means of improving patient safety.[5]

These attempts to unify the system were not successful, as many of those affected by the new regulations felt that they missed the mark. As a result, there was significant opposition from organized medicine and patient advocacy groups.

State pharmacy oversight: Dr. James Huizenga is an emergency physician, and, aside from his day-to-day duties in a busy emergency department, he's also the developer of a program to help doctors assess the drug dependency risk of their patients. His experience has shown him that many healthcare providers are avoiding the pain assessment aspects of their patients' care. "I don't think this is intentional," Dr. Huizenga says. But, doctors may be reluctant to treat because of "increased scrutiny from state medical or pharmacy boards."

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Doctors may be reluctant to treat because state regulators are increasingly requiring that doctors who prescribe narcotics must first check with their state pharmacy prescription systems.[6] These systems are designed to reduce the likelihood that patients will be provided duplicate prescriptions by "shopping" between providers.

While this sounds like a good idea, in many states, Dr. Huizenga says, these systems are time consuming and can be cumbersome to use. "Only about 15 percent of doctors use their state pain databases," he says. "It's not really a case of disinterest on the provider's part; it's just that the entire system is full of challenges and, added up, they can hamper participation."

However, more states are implementing prescription drug monitoring programs and many are requiring that, under some circumstances, they be used by providers prior to writing a prescription for a controlled substance.

State Medical Boards have a role: More recently, physicians are being subjected to medical board rules that limit opioid prescribing and open the door to investigations of physicians for "improperly" prescribing opioids. It's important that providers understand the requirements in their states – some of which are also imposing opioid prescription education as a condition of licensure.

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actions leaving the provider (and the patient) stuck in a Catch 22."

Working with disciplinary and regulatory agencies: Many providers who refuse to provide pain medications are fearful of criticism from regulatory bodies. Some doctors have reported to Medical Protective's risk management team that they have been disciplined when their actions were within the guidelines established by pain management specialties.

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If there is a lack of understanding or consistency in interpretation of the current standards, then a national discussion may be the way to establish consistency, Dr. Huizenga suggests. "The key, I think, is to recognize that the pendulum is swinging back the other way – away from prescription with inadequate monitoring – and it needs to stop before it swings too far the other way.

"We need the same boards that are disciplining doctors for over-treating to work with doctors and find ways to help their patients. A combination of education and access to information probably offers the best approach.

"On the local level, health departments and boards of medicine need to be involved and, at a national level, the various professional associations who are advocates for their members need to be willing to take part in these discussions."

Provider Concerns

There is ongoing tension between patient satisfaction and patient safety when it comes to pain management, Dr. Huizenga says, and some of those issues are addressed below.

Care continuity concerns: "In the emergency department (ED), we often find ourselves evaluating chronic pain patients who are either in between pain management providers or who can't get in to see their current providers in a timely fashion. One of the greatest limiting factors is the inability to coordinate the care of a chronic pain patient after we care for them in the ED. We just don't have a great care referral system available to us for chronic pain patients."

"If we could have better systems to help us access the providers who are most responsible for managing patients' chronic pain, we'd be able to provide better temporary care and also help patients get follow-up care; in those circumstances, we'd be much more willing to act.

"In the ED, acute pain can be an emergency; but in all healthcare settings, pain is always an important symptom that needs to be addressed."

Dr. Huizenga points out that orthopedic surgery is a great example of how the ED and a specialist service can work together to provide a fluid care process for patients in acute pain. "When we see a patient with a broken arm on a Saturday afternoon, we know that we can splint and stabilize that fracture, provide several days' worth of pain medication, and refer the patient to the orthopedist on call, with an assurance that the patient will be seen in a time-appropriate manner."

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The analogous situation for chronic pain patients doesn't exist, Dr. Huizenga says. "It would be a big help if the ED had a chronic pain referral strategy that mirrored our orthopedic options."

"I believe that we have the tools to make a pain management care process work, but we're just not using them as well as we could," Dr. Huizenga says. "We have to build a better bridge to connect primary care, the ED, and the pain specialists."

Treatment and referral concerns: While primary care physicians and dentists should consider formalizing pain assessments in their patient interactions, such an assessment won't help unless there are resources for managing a patient's pain. According to Dr. Huizenga, some providers will manage the patient's pain themselves, at least for a while, while others merely tell the patient, "I can't help you with that."

In either case, if the patient's pain needs exceed the provider's ability or willingness to assist, then it makes sense

for providers to forge relationships with other doctors who can help – and to do it in advance.

Who are the pain specialists in the community? Where are they located? By contacting the specialist before they're needed, it may be easier for the referring physician or dentist to know how long it will take to help a patient be seen by a specialist. It may save the provider time – and improve the quality of patient care.

This delay of access to a pain specialist can be especially concerning for those physicians and dentists with patients who are having ongoing pain, and who lack the resources to get the patient seen quickly. The challenge, according to Dr. Huizenga, may be one of supply and demand. Pain management specialists are in high demand and seem to have overflowing schedules. "The patients I see in the ED routinely inform me that the soonest they can get an appointment is weeks away, and yet they are in severe pain right then and will be every day in between."

For discussions with a primary care provider – physician or dentist – a straightforward explanation can help prevent a patient's confusion, frustration, and non-compliance.

"I think it's important to encourage better communication between patients and their physicians and dentists. The ED doctor will often tell a patient, 'Ask your doctor explicit and direct questions about your treatment,' and then doctors should be prepared to give patients the information they need. It might include saying something like, 'Your condition is such that you are likely to be in pain for at least the next several weeks.' There needs to be a plan at this stage. The patient can't exist in a state of suspended animation.

"Merely referring the patient without acknowledging the length of the bridge between the referral and the patient's actual appointment won't work, and the patient will once again end up in the ED, receiving medication from a physician who doesn't know the patient as well as the other doctor does. The patient needs to be told 'here's the plan.' It's a short-term intervention – a bridge – that can get the patient through until he feels better or can get in to see the specialist."

Dr. Huizenga also fears that for every patient who is referred, there are others who are on their own. "Patients sometimes tell me that their primary care provider refuses to treat them for pain or won't make a referral. In those cases, I wonder if some of the information is missing, maybe part of the story that I'm not privy to – possibly a history of substance abuse or a mental illness – the kind of information that influences the primary care provider's understanding and decision."

In those instances where the provider is unwilling to manage the patient's pain, even on a short-term basis, it's important that they have the conversation with the patient, Dr. Huizenga says. Otherwise, the patient is caught in the middle without resources. "Don't be afraid to tell a patient, 'I believe it's in your best interest not to provide narcotics for you at this time and there are reasons why' – and then explain why."

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For discussions with a primary care provider – physician or dentist – a straightforward explanation can help prevent a patient's confusion, frustration, and non-compliance. Patients need to understand the parameters of suggested treatment or the reasons behind the treatment decisions.

Documentation of these conversations also serves as a sound risk management strategy to prevent allegations that the patient didn't understand the doctor's intentions or that the doctor ignored the patient's pleas for help.

Liability concerns:

Potential liability is another challenge that discourages providers from pain management treatment. Lawsuits related to prescriptive practice range from failure to identify the at-risk patient (thus enabling addictive behavior), to failure to address pain management, thus allowing the patient to suffer unnecessarily. Therefore, some doctors have been accused of contributing to addictive behaviors, while others have been accused of failing to recognize and address their patients' pain. It's difficult and time-consuming for doctors to identify into which category a patient might belong. Even if the doctor can manage this kind of assessment, it may still be difficult for doctors who aren't pain specialists to manage patients with chronic pain issues over the long haul. And, it may be equally difficult to find specialists to whom the patients can be referred.

Risk management tip

Education is essential if patients are to both understand and trust their doctors' recommendations.[7] Physicians and dentists might benefit from asking themselves if they have formal policies and processes for conversations with:

a) patients whom they suspect might have drug problems;
b) patients who are asking for pain treatment the doctor is unable to provide;
c) patients who are asking for pain treatment the doctor is unwilling to provide; and,
d) patients who should be referred for pain management treatment.

Not only are these conversations an essential part of the doctor-patient relationship, but their occurrence and their documentation attests to the doctor's concern for the patient.

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Conclusion

Pain is ubiquitous. Its management is part of the ethical duty of healthcare providers, regardless of their training and specialty. Unclear standards and restrictions can be as dangerous to patient care as casual prescription practices or refusal to take action on a patient's behalf. Groups of providers cannot establish the "bridges" that Dr. Huizenga recommends without the open and willing participation of the regulatory and administrative bodies who also must share in the search for a middle ground. ■

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