



SPS NEWS

The Official Publication of The Southern Pain Society

January 2004

SAVE THE DATE!

SOUTHERN PAIN SOCIETY
ANNUAL MEETING
IN CONJUNCTION WITH
THE MISSISSIPPI PAIN SOCIETY



Beau Rivage Casino Resort
July 30–August 1, 2004
Biloxi, Mississippi

Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

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SPS News is the official publication of the SPS, provided quarterly to its members. SPS may publish material dealing with controversial issues. The views expressed are those of the authors and may not reflect those of the SPS. No endorsement of those views should be inferred unless specifically identified as the official policy of the SPS. Submissions are welcomed. Publication is based on editorial judgment as to quality of material, timeliness, and potential interest to members.

Editor's Desk

Jonathan D. Cole, Ph.D.

Just looking in the headlines, we can find many concerns about pain management. It seems every other day there is a news story about someone who is arrested, addicted, or dead because of pain medication. In my state of Kentucky, this is particularly bad. Issues with the eastern part of our state, have gotten so much national press attention. It has led to a fear of treating patients in chronic pain by many physicians, causing a gross under treatment of pain. It has led to some patient's fear of asking for or receiving treatment for their pain. It has also led some conservative groups to scrutinize pain management providers, suggest narcotics are only appropriate for terminal pain, and want to investigate providers that prescribe significant narcotics. As pain management providers, we cannot (stick our heads in the sand) regarding this issue. We are the experts and need to educate the public in appropriate pain management treatment.

In order to appropriately educate and earn the public's trust, we have to be truthful. We cannot (sugar coat) the negative side of narcotic use. There have been physicians who have acted criminally in the past and ran a prescription "drug mill." Addiction, diversion, and/or abuse occur with narcotics about 7-15% of the time. I have read other pharmaceutical literature suggesting that it is much lower. However, being a pain psychologist and having seen over 2000 pain patients in 3 states, I can tell you the 7-15% is more accurate. Many of our patients personally know or know of someone with a narcotic problem, which further supports this figure. We must address the risks of narcotic uses as well as its benefits.

In addressing the benefits, point out that the majority of patients do not become addicted to their pain medication. Also mention that improvement of quality of life is a major factor in considering narcotic treatment. Finally, let the public know there are other means of treating pain besides narcotics, such as interventional procedures, physical therapy, pain psychology, and massage. Some of my patients are not aware on their first visit that there is treatment other than pain medicine available to help their pain.

In order to educate others there are a variety of things you can do. Volunteer your time to be on a local radio or TV talk show, talk with your local paper, or send out a newsletter to physicians in the area. Volunteer to speak at professional meetings or hospital grand rounds. If your state or area does not have a district of the Southern Pain Society, look into forming one. Talk with your legislature about pain management issues.

I am charging you, as the pain expert, to educate the public about appropriate pain management in the best way you know how. If we do not advocate for our patients and our field, who will?

As the plane was circling to land at Bluegrass Airport in Lexington, I looked out the window over a landscape dotted with horse farms and trees dressed in fall colors and asked myself what I knew about Kentucky. Daniel Boone, Jim Bowie, thoroughbreds, and the Kentucky Derby came to mind. It was a short trip, one night and back to Mississippi. The day of my departure, I attended the Kentucky Pain Society's first Annual Scientific Meeting, which richly added to my fund of information about Kentucky. The people I met were warm and gracious, and seemed dedicated to improving pain treatment in their practices. Approximately 100 individuals attended the meeting, including physical therapists, physicians, psychologists, and nurses. If I had not known this was Kentucky's first meeting, I would have thought they had been organized for several years. The speakers were outstanding and they had 21 exhibitors supporting the meeting. Congratulations to Ballard Wright, current President, and others who are moving pain treatment to the forefront in Kentucky.

Recently, the American Pain Society (APS) formed a Regional Sections Task Force to find out information about the Regional Societies. In an e-mail that I received about their charge, it was stated that little is known about these organizations and the Task Force is to "better define these groups, their relationships with APS and develop a plan for the future that is mutually beneficial for all groups." It is interesting that APS is finally taking an interest in SPS and other regional sections. We have received little support or interest from APS, other than being listed on the APS website and provided a meeting space at the APS annual meeting. Also interesting is that as President of SPS I received information about the task force second hand through a second hand e-mail.

Only speaking for the Southern Pain Society, our regional organization has long carried forward the mission of the American Pain Society. As I have pointed out in other articles, there are many practitioners who attend SPS and District educational meetings that are not informed about APS and are not members. Many who attend District educational meetings are unaware of SPS as well. However, through these meetings, newsletters and networking, issues related to pain treatment, education and research are addressed on a state level. The Kentucky Pain Society's first meeting was modeled after the Mississippi Pain Society's educational meetings. This came about because a member of the Mississippi Pain Society (MPS) recently moved to Kentucky and was instrumental in organizing that District. Mississippi received its charter from SPS in 1997 and modeled its first meetings after the SPS Scientific Meetings. I have long been a member of APS but never really felt involved until I was asked to accept the position of newsletter editor for SPS. I believe that many people who have had an opportunity to become involved on a District level would never

have had an opportunity to become actively involved in SPS or APS. Most of the individuals who are members of District Societies are practitioners and are on the front line in battling pain. They are hungry for information and it has been my impression through the years that they readily embrace the concept of a multidisciplinary society.



Mississippi has approximately 200 members, SPS 264. With the exception of the MPS Board, most MPS members are not members of SPS or APS. Mary Alice Yoham, SPS Board Secretary, suggested several years ago that SPS amend its bylaws to increase its dues and incorporate Districts into the new dues structure. For example, MPS dues are currently \$25 and SPS \$60. Under the new dues structure, an individual joining MPS would pay \$75.00 and would automatically become a member of SPS. The pros and cons of this type of structure were discussed and the proposal was eventually tabled for future discussion. At the time, I was opposed to the proposed amendment. I felt that most individuals who attend District meetings are members of other organizations and would possibly not participate in another professional society if the dues were too high. We discussed the benefits of such an arrangement and I was also not convinced that SPS could provide the District members with more benefits than they were already receiving. I am now ready to revisit Mary Alice's proposal. I believe this is particularly important as I foresee the possibility that the APS Regional Sections Task Force may entertain such an idea. I would like SPS and SPS District Societies to poll their members about changing the SPS dues structure and how they see such a change benefiting them. I would also invite each of you to give us feedback and your ideas by writing a letter to our editor for our next newsletter edition. Lastly, I would like to invite the President of APS and other members of their Board to attend the SPS/MPS Annual Scientific Meeting in Biloxi, Mississippi, July 30- August 1, 2004.

What does SPS offer Districts? Having served as President of SPS and a District Society, I feel I have an advantage in addressing this question.

Benefit: SPS is inclusive and serves as a model to its Districts. Districts receive a charter and may incorporate under the umbrella of SPS.

When I was but a fledgling pain practitioner, I began attending APS and SPS meetings. I felt lost at sea when attending APS. Early on, I remember attending a John's Hopkins pain seminar and meeting Renee Rosomoff who was very approachable and encouraging. Her message was to get involved in pain organizations and she strongly supported the importance of multiple disciplines coming to the table with a common philosophy about pain treatment.

Continued on page 6

District News

Benjamin Johnson, M.D.

SPS Districts

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Kentucky Pain Society

Ballard Wright, M.D., President
(859) 278-1316

The 1st Annual Scientific Meeting of the Kentucky Pain Society by Jonathan D. Cole, Ph.D.

The Kentucky Pain Society had its first annual meeting on November 8th, 2003 in Lexington, KY. There were 112 participants from all over the state, representing a variety of specialties. The morning session included a talk on multi-disciplinary approaches to narcotics and pain. The morning included a talk on oral narcotics (Peter Wright, MD), intrathecal narcotics (William Witt, MD), psychological appropriateness for narcotics (Jonathan Cole, Ph.D.), and nursing aspects with narcotics (Barbara Vandervere, RN). We also had a presentation by David Sallengs, who is the director for the state's controlled substances database, KASPER.

Lunch consisted of a presentation by the president of the Southern Pain Society, Angela Koestler, Ph.D., and a talk on prescription diversion by Dave Haddox, MD.

The first afternoon session began with the multi-disciplinary treatment of oral facial pain by the University of Kentucky's oral facial pain clinic. It included a dentistry perspective (Reny DeLeeuw, DMD, Ph.D.), psychology (Charles Carlson, Ph.D.), and physical therapy (Ann Harrison, PT).

The last afternoon session was the multi-disciplinary treatment of low back pain. It included a physical medicine rehabilitation (Paul Brooks, MD), interventional procedures (Kendal Hansen, MD), psychological (Brian Monsma, Ph.D.), and physical therapy (Steve Marcum, PT) perspectives.

The meeting was opened and closed by the Kentucky Pain Society president, Ballard Wright, M.D. All participants

were signed up as members and we plan on having a meeting at least once a year. Overall, it was thought to be a successful meeting. I want to thank the University of Louisville for helping organize the meeting. I also want to thank all of the sponsors and speakers that made the meeting possible.

To form your own district of the Southern Pain Society contact SPS for a district application.

Election Results

We are pleased to announce the results of the 2003 Southern Pain Society elections. There were 2 at-large Board positions vacant this year.

Please join us in welcoming

Sunil Dogra, MBBS
Associate Professor Anesthesiology and Pain Medicine
University of North Carolina at Chapel Hill

and

B. Todd Sitzman, MD, MPH
Medical Director
Center for Pain Medicine
Hattiesburg, Mississippi

We are delighted to have their input and leadership as we move forward as an organization. Their 2 year terms will run through December 2005.

Opinion Column

In every issue we will print excerpts from opinions sent in to us regarding a topic presented the previous issue or another topic related to pain.

The topic for this issue: *malpractice pearls*. *What are your thoughts? We will take the pros and cons.*

Submit responses to Lori Postal at
Lpostal@southernpainsociety.org

Selection Criteria for Spinal Cord Stimulation: A Treatment Team Approach

Diane M. Novy, Ph.D. and Marilu Berry, Ph.D.

Department of Anesthesiology

**University of Texas-Houston Medical School and
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A quarter of a century ago Shealy (1967) introduced spinal cord stimulators (SCS) as a treatment for certain types of chronic pain. Before implanting a stimulator, however, Shealy (1975) considered medical and psychological patient selection criteria. In regard to psychological criteria, he focused on factors such as poor motivation and emotional instability as predictive of poor outcomes of SCS. Over the years corroborating evidence to support his selection criteria has come from numerous independent teams (e.g., De la Porte, 1993; Devulder et al., 1990; North et al., 1991, 1993). Only a few other teams (e.g., De Jongste et al., 1994; Eliasson et al., 1993; Meglio et al., 1989) have voiced disagreement with the inclusion of psychological selection criteria.

To help determine the current standard in the field, a national survey of multidisciplinary pain clinics was conducted in 1995. Resulting data indicated that the large majority of clinics utilized a team approach when considering SCS implantation (Nelson et al., 1996). The standard procedure involved evaluations by a pain-specialist physician and psychologist. Psychological screening criteria that were most commonly endorsed in the survey included active psychosis, homicidality, and suicidality, along with certain severe psychological diagnoses such as untreated major mood disorders. Behavioral difficulties such as substance abuse and significant maladaptive personality features also were considered screening criteria.

With regard to the psychological screening, the combination of a semi-structured interview and psychological testing is commonly used. Instruments such as the MMPI and the BDI may be used to screen for psychopathology, and scores that are clinically significant are cause for concern (Nelson et al., 1996). For example, moderate depression is indicated by scores over 25 on the Beck Depression Inventory or an extremely elevated scale 2 on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and these symptoms may need to be addressed prior to implantation. Utilizing the input from an interdisciplinary treatment team and incorporating the data from an in-depth, semi-structured psychological interview resulted in a higher success rate as defined by greater than or equal to 50% sustained pain relief (Kupers et al., 1994).

With the exception of major psychopathology, such as psychotic-type disorders, many psychological risk factors can be treated adjunctively and not in lieu of SCS, but in addition to

SCS (Olson, 1996). In this regard, Dr. David Williams' current approach to treatment at Georgetown Medical School deserves mention. Patients who are being considered for implantable pain technology at Georgetown are required to attend group meetings prior to implantation and after implantation. The pre-implantation data from the group are then used in the decision-making process, as well as providing a valuable adjunctive treatment modality. Such a treatment approach prepares and educates the patient, as well as optimizes appropriate involvement of the patient in the use of the stimulator.

Another useful current approach to psychological screening criteria comes from Gabor Racz's group at Texas Tech University Health Science Center. This group prefers to use psychological criteria, particularly in regards to trial SCS candidacy, as guidelines rather than exclusion criteria. Changes in the patient subsequent to a 5-day trial and month post-trial follow-up can then be applied against psychological selection criteria in judging appropriateness for permanent SCS implantation (Randolf & Racz, 1996).

Taking data on current standards and useful practices together, there appears to be support for the inclusion of medical and psychological criteria in the SCS selection process. Input from the patient during the pre-implantation period also appears relevant. Hence, a useful way to conceptualize the team approach to patient selection for SCS is to include a pain-specialist physician, psychologist, and the patient. Data from each of these sources provide useful perspectives in deciding an appropriate treatment approach.

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Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include biographical information and send to Lpostal@southernpainsociety.org.

Submission Deadlines

Winter edition-November 1; Spring edition-February 1; Summer edition-May 1; Fall edition-August 1.

President's Message continued from page 3

Some years later, I attended an SPS meeting held at the APS annual meeting with a physician friend. Renee Rosomoff welcomed us. I also met Stan Chapman and John Satterthwaite. All three encouraged us to organize a Mississippi District and Renee Rosomoff quite eloquently discussed the importance of such a move. Bert Ray was the contact person and walked Mississippi through the steps in becoming a District. All offered their support and were available to discuss whatever issues arose. When Mississippi held their first annual meeting with corporate sponsorship, Bert Ray attended.

Benefit: Newsletter, Networking, Pain Education

SPS publishes a quarterly newsletter that is informative and includes news from all Districts. Through SPS and District meetings, practitioners have an opportunity to come together and discuss pain issues relative to their own states and gain insight into what is happening regionally and nationally. They also have an opportunity to attend educational seminars that address treatment approaches and current research, as well as legislative and regulatory issues. They are able to obtain continuing education at their back door. Through its Districts, SPS extends its message and includes many practitioners who likely would not have become actively involved in a pain organization. SPS and Districts offer physical therapists, occupational therapists, physicians, psychologists, pharmacists, nurses, nurse practitioners, case managers, health administrators, chiropractors, and others who are involved in pain treatment and research a place at the table.

Epilogue:

Someone who is involved in the Kentucky Pain Society will move to another state. Having been actively involved in the Kentucky Pain Society and recognizing the importance of such an organization in advancing pain treatment, he or she will approach SPS for assistance in establishing another District. And, SPS will be readily available to assist in whatever way possible. A districting packet will be forwarded and guidance will be offered as requested on how to establish by-laws, incorporate, organize meetings, and network with other agencies and organizations. Someone who joins that newly established District will get involved and later move to another state. And with them goes the message, "to serve people in pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community."

As we move forward, let us not forget the Renee Rosomoff's and others who through their persistence, dedication, and encouragement have led the way. Thank you.

Malpractice Pearls

Joe Chen, MD Practice Editor

The state of Mississippi has had some interesting press this past year. We are known as the “Jackpot Justice” state. As with many other states, we have had a mass exodus of malpractice insurers. Tort reform in our state is a start to the malpractice woes that we have faced. A recent figure from the Medical Assurance Company of Mississippi reported that almost half of the physicians that they insured were currently being sued. A recent discussion with our state’s major malpractice carrier, Medical Assurance Company of Mississippi, provided me with helpful tips to help protect us all from future lawsuits. The following are some tips that sometimes slip our minds and could lead to a potential lawsuit.

Tracking of Diagnostic Tests

Once the physician has ordered any diagnostic test he/she has a duty to be aware of the results. By ordering the test the physician is indicating that the test is needed and the results will be used to direct the subsequent management of the patient.

System breakdowns that can result in diagnostic delays and cause potential risks include an ordered test not being performed, the test results not getting back to the office, and/or a test being filed in the patient’s chart without being seen by the physician. Another breakdown could occur if the patient is not notified of the test results. The importance of a well defined follow-up system in a busy office practice should not be underestimated.

The system should monitor that diagnostic testing is completed, the results are received and that they are reviewed by the physician before filing in the patient’s record. Follow-up systems can be manual or computerized, but should be simple and easily maintained.

Example of a Lawsuit

Mrs. Jones had a chest x-ray ordered by her physician. She went to have the x-ray performed that day. Mrs. Jones thought that no news from her physician meant that the test was normal. Mrs. Jones returned 6 months later after calling for an appointment. Her physician then noticed that the chest x-ray that he ordered was in her chart but showed a large mass that needed further evaluation for cancer. Mrs. Jones sued her physician successfully for malpractice.

Medical Assurance Company of Mississippi Pearl

Keep a spiral notebook with columns for the date, patient’s name, test ordered, and the lab or facility where the test is performed. You can use a column to show date test results are received and staff initials, or you can simply highlight the patient name when test results are received. Results should always be given to the physician to review. The physician should date and initial indicating that results have been reviewed. The staff should complete any instructions given before the report is filed in the patient’s chart.

Referrals and No Shows

Physicians are expected to play a part in ensuring that patients get appropriate care even though patients are also expected to take some responsibility for their own care. The doctor’s medical training gives them a better understanding of the consequences of various treatment options, as well as the consequences of delaying treatment. A physician is expected to encourage the patient to get the necessary consults. When a consult is completed the physician should at least make sure the patient knows what the results are, how they relate to the patient’s condition, and what might happen depending on the course of action the patient decides to take.

Once the physician has ordered a referral for consultation by a specialist, he/she has a duty to be aware of the results. By ordering the consult, the physician is indicating that the consult is needed and the results will be used to direct the subsequent management of the patient.

Because of the responsibility the physician has for guiding the patient’s care, each office should implement a procedure to ascertain compliance when the patient has been referred for consults. Specialty offices should use a form letter to notify the PCP when referred patients “no show”. All offices should have a procedure to ensure that a list or chart of all “no shows” are given to the physicians daily. The “no shows” should be documented in the chart. The doctor or staff should contact the patient to determine why they are not compliant and to urge the patient to do so. This contact or attempt to contact should be documented in the record.

The system should monitor that the consultation occurred, the results are received and they are reviewed by the physician before filing in the patient’s record. As with the tracking systems for diagnostic procedures, the follow-up system for referrals to specialists can be manual or computerized, but should be simple and easily maintained.

Example of a Lawsuit

Mr. Jones had annual checkup which showed an elevated BUN/Creatinine. He was referred to the nephrologist. The nephrologist ordered a 24 hour urine. Mr. Jones never showed for his test or follow up with his nephrologist. He developed renal failure and successfully sued his nephrologist for not following up with him.

Medical Assurance Company of Mississippi Pearl

You should make at least three attempts to contact the patient to stress the importance of the follow-up, consult, or test and document these contacts. I asked them if anyone had been successfully sued who had made and documented these three attempts, and the answer was “no”.

Hopefully this will be helpful in your practices. Our state has elected a new governor and supreme court justice. These changes will allow us to continue to move forward in healthcare malpractice reform. But the most important way to avoid a malpractice claim is by paying attention to the details with an organized system.



Southern Pain Society

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