



# SPS NEWS

The Official Publication of The Southern Pain Society

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## Essential Pain Management Education

Janice Livengood, PhD, HSP

“The inadequacy of education regarding pain management can lead, and has led, to the poor treatment of pain disorders, especially those of a chronic nature” (1).

So, how are we educating ourselves and future pain practitioners to effectively treat the complex nature of pain?

Last decade (2) I participated in a study of five major medical schools in the south east to determine the nature of their pain management curriculum. We surveyed graduating seniors regarding their exposure to diagnoses and treatment of both acute and chronic pain. The results were astonishing. Most of the graduates reported they were not taught to deal with patients who complained of pain - either acute or chronic. We then contacted the directors of curricula at each medical school and interviewed them regarding the nature of their pain didactics. Most responded quite defensively that they definitely addressed pain educational needs. Further probing revealed that the school providing the broadest curricula on this subspecialty offered graduating seniors a one-hour lecture followed by an opportunity to talk for one hour with actual pain patients. Students who happened to cut class that day joined the ranks of the other four medical schools who provided essentially nothing.

This decade (3,4) we surveyed members of the TN Pain Society to determine whether pain practices in Tennessee were training future pain specialists. Results indicated that none of those who responded to the questionnaire (N=33) were training residents at their pain practice and the majority were not training pain fellows. Few physicians reported having trained in a pain fellowship themselves and the majority were not engaged in continuing pain management education through international, national or regional (such as SPS) pain organizations. These findings raised startling questions, e.g., If this sample reflects the nature of pain practices throughout the country will there be a shortage of well-trained pain specialists in the near future? Will pain practices be staffed by those not trained to treat chronic pain?

By now you have hopefully made plans to attend the SPS Annual Scientific Conference in Louisville, KY, October 14-16, “Recent Advances in Evidence Based Pain Management”. If so, you are to be commended for engaging in continuing educational efforts ~ essential for staying current in this burgeoning multifaceted field!

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### **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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## **Brochures Have Been Mailed!**

### **Southern Pain Society Annual Scientific Meeting In conjunction with The Kentucky Pain Society**

**October 14-16, 2005  
Lexington, Kentucky**

We hope to see you at our annual meeting this year. If you have not received your brochure, please see the link on our website and register soon!

[southernpainsociety.org](http://southernpainsociety.org)

## **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. Send to [lpostal@southernpainsociety.org](mailto:lpostal@southernpainsociety.org)

### **Submission Deadlines**

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

# President's Column

Benjamin Johnson, MD, MBA

## Musings of a Frustrated Multidisciplinary Clinician



Being an indirect clinical descendant of John Bonica, via my mentor and former anesthesiology chairman, Dr. John Allen Dekrey, I am a committed multidisciplinary pain specialist. In spite of directing multidisciplinary pain centers in both academic and now private practice environments, I find myself frustrated at the inability to obtain the behavioral component of pain care that many of my patients need. Having discussed this issue with many of you and other pain specialists, I know that obtaining behavioral health benefits for chronic pain patients is a matter familiar to many, if not all, of the states in the Southern Pain Society.

From discussions with behavioral health providers, such as psychiatrists and psychologists in our SPS, several problems are at the root of the lack of access to needed behavioral health benefits coverage:

1. The lack of parity between medical and behavioral benefits coverage
2. The lack of understanding of the importance of behavioral therapy by patients
3. The paucity of pain-oriented behavioral practitioners
4. The failure of insurance providers to recognize the cost-benefit advantages to including behavioral modification in pain treatment strategies.

In my many discussions with pain-oriented behavioral health providers within the SPS, there is a long history of a lack of parity between medical and behavioral health benefits coverage. In some, if not all, instances, the behavioral health benefits management is outsourced to a separate behavioral health management firm; while the medical benefits are managed by the primary insurer. My personal explanation is the lack of appreciation for the beneficial effects of behavioral modification on chronic disease management such as chronic pain. Insurers and practitioners seem to give greater credence to “objective” medical pathology than to “subjective” behavioral pathology; even in an environment such as chronic pain, where a high percentage of patients are known to have psychiatric co-morbidity. Therefore it is easier to get a lumbar transforaminal injection approved than a series of psychological interventions.

As profit-maximizing entities, insurance firms should be the first to mandate behavioral evaluations and interventions if they realized the cost-savings inherent in a multidisciplinary therapeutic strategy. Estimated savings for such a strategy range up to 20%, according to the prevailing medical literature, when behavioral interventions are utilized. The cost savings result from:

- Identifying patients who have nonmedical reasons for “keeping” their pain complaints
- Identifying contraindications for opioid usage
- avoiding unnecessary procedural interventions in patients with behavioral problems such as somatization disorder
- identifying patients at risk for adverse experiences with procedural interventions, such as history of physical abuse, dissociative disorders, etc.
- increasing patient compliance regarding medication usage
- optimizing medical treatment expectations in regard to surgical and pain-related interventional procedures
- preparation of patients for return-to-work

As pain specialists, we must continue to advocate the cost-effectiveness of behavioral interventions, in order to give our patients the best chance of obtaining benefits coverage for this service. I especially emphasize this service to our workers’ compensation carriers, because of the tight relationship of return to work issues with pain management and disability issues.

Another obstacle that we typically encounter is the reluctance of the patient to consider behavioral interventions as a vital part of their pain therapy. This reluctance is manifested in several ways:

- patients may refuse to pay a copay for psychological therapy, yet pay the same amount for a “medical” visit
- patients may be a “no-show” for psychological appointments, yet show up promptly for a medical visit
- patients may object to being evaluated by a behavioral practitioner on the grounds that their pain is “real”, and not “in my head”.

The root problem in each of these scenarios is the lack of importance placed on the psychological aspect of pain management. A part of the blame may be on the pain specialist, who might not emphasize the importance of behavioral evaluation and intervention as much as emphasizing the treatment expectations of a procedural intervention. However, our society also denigrates the patient with pain and/or behavioral problems, therefore such a person may be reluctant to seek skilled help. It is socially more acceptable to have headaches and low back pain, than it is to have depression and somatization or abuse issues. As we well know, it is not uncommon for a person with psychosocial morbidity to wander through the medical system with needless interventional diagnostic and therapeutic interventions, until finally obtaining a psychological evaluation which reveals the relevant psychological or psychiatric problem.

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# Tenets of Evidence Based Pain Medicine: Study Designs

Ike Eriator, MD, MPH

The subjective nature of pain carries with it inherent variability in the response to the care we provide to our patients. Patients may improve in response to placebos (Beecher, 1955). We need to demonstrate that our interventions are effective. This is not only the right thing to do for our patients, but many payers for our services demand such proofs. Evidence Based Medicine (EBM) can provide us with an effective approach to caring for our patient's condition. Many payers and governmental bodies also use EBM as a basis for decision-making. To be done properly, evidence based practice require that you understand the tenets of study design and analysis in order to interpret and apply the findings of a study to the care of your patient. Assessing methodological quality of articles has been described in many places (Oxman et al., 1993, Giacomini and Cook, 2000, Sackett et al., 2000, Greenhalgh, 2001). Four preliminary questions that helps are; why was the study done? What hypothesis were they testing? What type of study design did they use? Was this study design appropriate for the intended research?

Study designs constitute the fundamental basis of the conduct and interpretation of research. That is why the method section is the most important part of any research paper (Altman, 1991). In fact, if you are trying to decide whether a paper is worth reading, you should do so based on the design of the study, and not on the interest value of the hypothesis or the potential impact of the results (Greenhalgh, 2001). The justification for data analysis lies not in the data collected, but in the manner in which the data were collected (Schoolman et al., 1968). Understanding the common types of study design used in pain research as well as their pros and cons will help you to judge the value of articles, the applicability of the findings and the integration of such findings into your practice. The common types are discussed below from the least to the highest in the hierarchy of EBM.

*Case Reports and Case Series:* These are simple description of the experience of a single patient (case report) or group of patients with similar diagnosis (case series). They deal with the unusual and thus help to recognize a new feature or disease. For instance, with the advent of transforaminal steroid injections, cases of associated paralysis began to appear in the literature (Huntoon and Martin, 2004). Case reports and case series can also help in formulating hypothesis, which can then be tested in a controlled study. The limitations of case reports include the absence of a comparison group, and chance cannot be discounted as a cause of the finding. Case reports and case series cannot be used to test hypothesis.

*Cross-sectional surveys* can be used to determine the status of an individual with respect to the presence or absence of both exposure and disease at the same time. Such studies are cheap and easy to do. They are geared to answer the question; what is

happening now? Stewart et al. (1992) collected data on migraine symptoms using a national sample of over 20,000 individuals aged 12 – 80 years and found that migraine prevalence was highest in the 35 – 44 year age group. The prevalence was higher in the low-income socioeconomic groups. 17.6% of females and 5.7% of males reported having migraine headache in the past one year. Unfortunately, cross-sectional surveys are associated with an ambiguous time relationship between the exposure and disease. In some cases, cross sectional studies may be repeated over time to obtain serialized data. Such follow up over time can produce data, which can further explain the associations found in cross-sectional studies. Von Korff and Simon (1996) found an elevated level of depressive symptoms at the time of initial visit for pain patients at the primary care level. However, longitudinal follow up showed that such depressive symptoms improved to normal levels in patients with a favorable pain outcome.

In *case-control studies*, the subjects are chosen on the basis of whether they have (cases) or do not have (controls) the disease of interest and the researcher looks back to see the proportions in each group that have the exposure of interest. Case control studies ask what happened? The proportion of subjects with the disease that were exposed to the risk factor of interest is compared with the proportion in the non-diseased group that was exposed. Rapkin et al. (1990) examined the contribution of prior physical and sexual abuse in women with chronic pelvic pain, and they observed that pelvic pain was unlikely to be specifically and psychodynamically related to sexual abuse, but that the pernicious nature of such physical or sexual abuse may promote the chronicity of painful conditions. Because of the direction of inquiry, case-control studies are sometimes referred to as retrospective. Advantages of this type of study design include the fact that it can be done relatively quickly and is relatively inexpensive. It can help in examining multiple risk factors and it is good for evaluating rare diseases or diseases with long latency. However, because of the historical perspective, time relationships can be difficult to establish. Bias can be a significant problem.

In *Cohort studies*, subjects are grouped on the basis of the presence or absence of exposure to a particular factor and then the two groups are followed up for a period of time to determine the development of the disease in each group. The rate of the disease (incidence) in the exposed subjects is then compared to that in the unexposed subjects and the relative risk of developing the disease due to exposure to the particular risk factor is obtained. Cohort studies can be confusing in terms of nomenclature. A cohort simply refers to a group of subjects with similar characteristics (for example, cohort of exposed people). Cohort studies have also been referred to as prospective studies, because these studies look forward in time and ask what will happen. Crook et al. (1989) followed up patients for two year and found that 13% no longer reported pain as a problem. Magni et al (1993) found that 32.5% of chronic pain patients were pain free over an 8 -year follow-up. Cohort studies are good for establishing temporal

relationship and for studying rare exposures. However, it can be susceptible to bias due to loss to follow up. It can also be expensive and time consuming to carry out.

The *experimental (interventional) studies* provide the most reliable evidence. In these study types, the investigator introduces a protective factor to persons at risk of a disease (preventive trial) or provides treatment to persons with the disease (clinical trial). Community trials are a form of preventive trial, in which a protective factor is introduced to all persons in a social unit, for example, using back brace in a work place, while a comparable social unit acts as control (Von Korff, 1999). The investigator allocates the exposure and the use of randomization controls for the effects of unrecognized risk factors. The groups, on the average, are identical, with the exception of the intervention. Therefore, any differences in outcome may be attributed to the intervention. In *Randomized Controlled Trials (RCT)*, subjects are assigned to the intervention group or control group by chance. Designing this with the subject and/or investigator not knowing what each subject is getting (blindedness) decreases the chance of bias. Randomized control trials also allow for adequate evaluation of a particular factor in an appropriately defined group and setting. Its prospective design allows for the collection of data on events as they occur. Data from such trials could be combined at a later date as part of a meta-analysis. RCTs remain the gold standard for research designs. However, RCTs can sometimes be impractical or inappropriate. For instance, where the intervention is harmful, it would be inappropriate to deliberately give it in a randomized fashion. RCTs may also have limited application due to the strict inclusion and exclusion criteria.

*Integrative studies* are becoming more common these days. Instead of wading through a series of articles and doing a methodological review of the primary studies yourself, you can start with other studies that have attempted to summarize and draw conclusions from such studies. *Systematic reviews* summarize primary studies using a predefined methodology. *Meta-analyses* pull together numerical data from several primary studies. Guidelines are put together, usually by a team, after reviewing several studies, to guide the approach to care. Your question may have been addressed by these sources. ACP Journal Club, Cochrane Central Register of Controlled trials, Cochrane Database of Systemic Reviews, Database of Abstracts of Reviews of Effects are available, and may even be accessed as a group through EBM Reviews, for those people with access to Ovid database. Bandolier is a summary journal with searchable index. The national Guideline Clearinghouse provides evidence based clinical practice guidelines.

Different study types carry different weights and are allocated different positions in the hierarchy of evidence. Systematic reviews and meta-analysis carry the highest weight, followed by randomized control trials. Cohort studies are less than RCTs, but higher than case-control studies. Cross-sectional surveys are ranked next, and come before case reports. However, not everything that counts can be counted. And not everything that can be counted, counts. A sloppy RCT usually carries less weight than a large well designed cohort study. Reasoning is needed in conducting studies, evaluating them and in applying them to your practice (Eriator, 1998).

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# Don't Tie Our Hands

Jennifer Bolen, J.D.

Don't tie our hands – a plea every pain physician should be making to the health care benefit plans (health plans) and Workers' Compensation programs (WC programs). Why? Nationwide, health plans and WC programs are issuing more directives or “oh, by the way” letters to physicians, telling them what they can and cannot do to manage a patient's pain. In doing so, health plans and WC programs look at numbers on documents instead of people and faces, so the end result of this interference with medical decision-making is more patients on the street in search of valid pain relief. Without question some patients are drug diverters and they should be dismissed from the system. However, the function of distinguishing between diverters, abusers, and simply patients with pain is best left to the physician who sees these patients rather than to a case manager who simply looks at dollars, drug type and quantity, drug combinations, and chronicity of prescribing. There are many reasons for the growing trend of prescription controlled substance abuse in the United States, and health plans and WC programs that seek to control medical decision-making in the area of controlled substance prescribing are often large contributors to this problem because they focus on cost and not the individual medical needs of the patients. I have limited my discussion to health plans in this paper because of the different tactical approaches physicians should use with WC programs.

Many health plans represent significant barriers to pain management because they use drug formularies and drug/resource utilization letters to direct your behavior (read that as make medical decisions for you). No doubt health plans should be given some latitude to establish boundaries to operate successfully in a manner that serves both patient and plan/program interests. BUT, health plans have no business tying your hands (I usually refer to it as “handcuffing” when I lecture) by asking you to do things that are outside accepted standards of care and legal/regulatory boundaries. While this may seem a classic case of Davy versus Goliath, there is a growing body of ammunition for Davy that derives from legal/regulatory materials on the use of controlled substances for the treatment of pain. I encourage you to learn about this ammunition and use it in an organized fashion, and with the backing of your own society and groups you often think of as against you – DEA and your state licensing boards.

Sound crazy? Think of it this way. How often have you faced the situation where a patient's health plan will not cover medically necessary treatment(s), but instead demands that you do what might harm the patient and what flies in the face of federal and state legal/regulatory guidance on the use of controlled substances for the treatment of pain – like use a drug that is or drug amounts that are contraindicated because of the patient's history? Or state Medicaid programs that limit enrollee prescriptions to four per month – period? Should a patient really have to choose between medicine that keeps

their blood from clotting, medicine that controls their diabetes, and medicine that stops pain that renders them immobile and not functional? Or how about health plans that do not cover, or severely limit your ability to make, behavioral or mental health referrals for your pain patients, especially when the laws/regulations on controlled substance prescribing for pain strongly encourage (or even require) you to do these things and accepted care standards demand these referrals? Worse yet are health plans that do not cover a procedure you want to use to return the patient to an active, functional (even working) status, and instead insist that you use medications – because they're cheap? Finally, and in many ways most troublesome, is the growing trend of health plans that tell you (1) what is and what is not a violation of your treatment agreement with the patient; (2) how long someone should need pain medication and what kind; and (3) that you cannot “use that drug off-label” (despite the fact that it is exactly what the patient needs and the use of the drug off-label might mean overall lower utilization of health plan resources if you can just get the patient past a few rough spots during the initial treatment phases). Often health plan directives like these put you in a precarious position and you must learn how to use legal/regulatory requirements to protect your license and your patients. So what should you do when you face these issues in your practice? Here are a few suggestions you can use to draft your responses to health plans using general legal/regulatory principles nationwide.

## *Understand the DEA's Position*

It is important for you to first understand the U.S. Drug Enforcement Administration's (DEA) position on prescribing controlled substances for the treatment of pain. DEA understands that pain must be treated and that opioids frequently are part of the treatment process. DEA believes most physicians prescribe appropriately for legitimate medical purposes within the course of professional practice. As with any profession, however, DEA knows some physicians operate illegally, making illegal profits from the inappropriate use of their DEA numbers.

In November 2004, DEA took formal agency action and published an *Interim Policy Statement (IPS)* in the Federal Register. In doing so, the DEA used the *IPS* to correct statements it made in an informal August 2004, agency publication called *Prescription Pain Medications: Frequently Asked Questions and Answers* (the FAQ). DEA will publish a final policy statement in the Federal Register in the near future and physicians should expect DEA to use its authority to clarify or set more formal boundaries regarding the use of controlled substances for the treatment of pain. I do not believe DEA will use its agency power to attempt to control the practice of medicine. By law, DEA cannot do this and federal judges have the ability to reverse DEA decisions that exceed its agency authority. Instead, I believe DEA is likely to define boundaries for the DEA registrant and to clarify what DEA perceives to be the federal law on using controlled substances to treat pain. I also believe DEA will identify those areas where states and their health-related licensing boards have first-line responsibility for establishing medical practice and controlled substance boundaries (laws/regulations/guidelines) and enforcing those who violate

these boundaries.

DEA used the *IPS* to make clear its position on the use of multiple Schedule II prescriptions prepared on the same date but with different fill dates – DEA believes registrants who issue these prescriptions are attempting to circumvent the federal law prohibiting the refill of Schedule II prescriptions. We all know that many of you have used “do not fill before” prescriptions to control your schedules and to preserve health plan resources while provide quality medical care for stable, trustworthy patients. For now, however, DEA believes this practice is illegal and you should not attempt to issue multiple Schedule II prescriptions with different fill dates. I realize DEA’s action here has wreaked havoc on your practices and health care in general, but I cannot say much more until DEA issues its final policy on this matter. I encourage you to use DEA’s comments in the *IPS* and your existing state legal/regulatory materials on controlled substance prescribing for pain management to guide your interaction with health plans.

#### *Understand your State’s Position*

It is important for you to understand your state’s position on the use of controlled substances for the treatment of pain. Most states have a basic body of materials on the use of controlled substances in general and the use of them to treat pain. You *must* take steps to obtain your state materials, put them in a notebook, and read them. In all, this will likely take you two to three hours and you can use our website and our program to facilitate your efforts.

Most states have guidelines or regulations similar to the Federation of State Medical Boards’ *Model Policy for the Use of Controlled Substances for the Treatment of Pain* (May 2004), which states, in part:

**History and Physical Evaluation** – You *must* evaluate the medical history and physical examination, including the nature and intensity of the pain, the current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on the patient’s physical and psychosocial function, the patient’s history of substance abuse (including alcohol), and the presence of one or more recognized medical indications for the use of a controlled substance.

**Treatment Plan** – You *should* use a written treatment plan (in some states this is a “must”) to state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function. You *should* also state whether you plan any further diagnostic evaluations or other treatments. *After treatment begins*, you *should adjust drug therapy to the individual medical needs of each patient*. Also, you *should* realize that other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associ-

ated with physical and psychosocial impairment.

**Informed Consent and Agreement for Treatment** – You *should* discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. You *should* require the patient to receive prescriptions from one physician and one pharmacy whenever possible. *If the patient is at high risk for medication abuse or has a history of substance abuse*, you *should* consider the use of a written agreement between physician and patient outlining patient responsibilities, *including (1) urine/serum medication levels screening when requested; (2) number and frequency of all prescription refills; and (3) reasons for which drug therapy may be discontinued (e.g., violation of agreement)*.

**Periodic review** – You *should* periodically review the course of pain treatment and any new information about the etiology of the pain or the patient’s state of health. You *should* remember the continuation or modification of controlled substances for pain management therapy depends on your evaluation of progress toward treatment objectives. Remember, satisfactory response to treatment may be indicated by the patient’s decreased pain, increased level of function, or improved quality of life. You *should* monitor objective evidence of improved or diminished function. *You should consider information from family members or other caregivers in determining the patient’s response to treatment. If the patient’s progress is unsatisfactory*, you *should* assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

**Use of Consultations** – You *should* be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. *You should give special attention to those patients with pain who are at risk for medication misuse, abuse or diversion*. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder *may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients*.

When you read your state materials, look for language that contains directives to you, the medical licensee. By this, I mean look for words like *shall*, *must*, *should*, and *may*. When you find a sentence containing a directive, highlight it and think about it in the context of a letter to a health plan. Here are a few final things to remember about state materials.

First, state materials come in three general forms: guidelines (sometimes called policies or position statement), laws (sometimes called acts), and regulations (sometimes called rules).

Second, look for specific state materials on prescribing controlled substances for the treatment of pain in Uniform Controlled Substances Acts, Intractable Pain Treatment Acts, Patient Bill of Rights, Medical and Pharmacy Practice Acts, Medical and Pharmacy Practice Regulations, and Licensing Board Guidelines and Newsletters. Your state should have a website for your licensing board, and, ideally, you should be able to find this information using the board's website.

Third, many states require health plan medical directors to be licensed in the state(s) where the plan does business/operates. This means you and the health plan medical directors have the same bottom line on the use of controlled substances for the treatment of pain (meaning you both must comply with federal and state legal/regulatory materials relating to controlled substances and pain management). The same statement applies with the minimum standards of care established by state licensing boards and accepted standards of care established by the pain management community as a whole – the experts either side hires to defend the medical-decision making. Thus, the playing field is a bit more even than it might appear and taking the steps mentioned in this article will serve you well as you look for ways to stand up against Goliath.

*Compare federal and state legal/regulatory guidance to health plan demands*

It is important for you to learn how to incorporate federal and state directives on using controlled substances to treat pain into your communications (hopefully written) with health plans. For example, let's say you get a letter from a health plan and it tells you that the patient's plan calls for the use of a mail order pharmacy whereby the patient must obtain a 90 days' supply of Drug A in one prescription. In your opinion, there are at least two accepted and legitimate medical purposes for the patient's use of Drug A, but he/she has a history of drug abuse and you believe it is proper under your state's legal/regulatory materials to limit the patient's supply of Drug A to 7 days, 14 days, or 30 days per prescription. What should you do? In this case, write a letter to the health plan and clearly state your position. In your letter, use language from your state materials on prescribing controlled substances for the treatment of pain. Look for language, as in Georgia and Tennessee, directing you to "control the drug supply." Look for language, as in most states, encouraging you to base your prescribing and treatment plan on "the individual circumstances of each patient." Finally, look for language, as in most states, telling you to use special control/monitoring measure with "patients who are at high risk for abuse." Remember, you can use legal/regulatory material in many ways, so think outside the box and make sure accepted care standards and your documentation support you.

*The problem will not go away over night, but ...*

Many patient and professional medical organizations are beginning to recognize how important the legal/regulatory frame-

ork for controlled substances is to pain management. Even the DEA understands there are disconnects in the health care system that curtail a physician's ability to comply with legal/regulatory terms. We cannot tackle this unfortunate reality of our health care system over night. The system is broken and it will take a great deal of effort from all the participating components to get things back on track. Fortunately for all of you, the laws and regulations governing the use of controlled substances are on your side and offer you plenty of ways to stand up to health plans attempting to limit your medical decision-making. Use the legal/regulatory framework surrounding the use of controlled substances to treat pain to guide your decision-making, to care for your patients as directed by accepted care standards, and to send a clear signal to health plans that you will not allow your hands to be tied when it comes to medical decision-making and pain management. Each of you has a voice, so use it professionally and with the intent of preserving your ability to make medical decisions for a legitimate medical purpose (one that is in *the best interest of the individual patient based on the nature of his/her legitimate medical condition*) and in the usual course of professional practice (based on accepted care standards). When you do so, pain management will take a step forward.

**About the Author**

Ms. Bolen is an attorney from Knoxville, TN. She served for nearly fourteen years as an Assistant U.S. Attorney with the U.S. Department of Justice, and she handled health care fraud and drug diversion investigations involving pain management issues. Ms. Bolen left public service in 2003, and started to educational effort known as "The Legal Side of Pain®". Ms. Bolen serves on the editorial board for *Pain Medicine News*, *Forensic Pain Medicine*, and *The Journal of Opioid Management*. She teaches nationwide and is dedicated to helping the pain management physician and supporting health care providers understand legal/regulatory concepts and use these concepts to provide quality health care to patients in pain. If you have more examples of system disconnects – between pain management and health plans and/or WC programs, email Ms. Bolen at [jbolen@legalsideofpain.com](mailto:jbolen@legalsideofpain.com). You may reach her website at [www.legalsideofpain.com](http://www.legalsideofpain.com)

## The Social and Cultural Dimensions of Pain: An Overview of the Southern Pain Prevalence Study 2004.

Arthur G. Cosby, Ph.D., et al.

The Social Science Research Center at Mississippi State University in partnership with the American Cancer Society (Mid-South Division) conducted a representative telephone survey to determine the social and cultural dimensions of pain in a Southern population. Interviews were obtained from 3,632 adults with the goal of obtaining a comprehensive set of information about 1) the prevalence and intensity of pain 2) attitudes, beliefs, and myths about pain and pain management 3) the underlying sources of pain 4) the impacts of pain on everyday life 5) the use of healthcare providers 6) the issue of dependency and 7) the medications and remedies used to treat pain.

The survey component of the Social and Cultural Dimensions of Pain Study was conducted in the summer of 2004 with telephone interviews in six Southern states. Stratified random digit dialing sampling procedures were used to collect 3,632 household interviews in Alabama, Arkansas, Kentucky, Louisiana, Mississippi, and Tennessee. The maximum 95% confidence interval for regional estimates was +/- 2.9%. The study was carried out by a research group led by Arthur G. Cosby, PhD, at the Social Science Research Center. Survey results were analyzed in terms of major demographic categories to include residence, gender, race, age, education, and state of residence.

### Prevalence of Pain:

Almost one-half of the respondents said that someone in their immediate family or household had experienced pain within the previous month. This pattern held true across all demographic characteristics.

At the individual level, pain was also widely reported. Well over one-third of the respondents (36%) reported that they had experienced pain during the last month. Severe pain was reported by 18% of the total sample, 50% reported moderate pain, and 31% reported mild levels of pain.

The survey suggests that pain prevalence in the six-state Southern region is estimated to be approximately 6.5 million individuals on a monthly basis. Of these, about 1.2 million are reported severe pain.

For many of the respondents, pain is a chronic condition. Well over one-half (55%) of those reporting pain said they experienced pain every day, and 75% reported having pain several times a week.

Seniors aged 65 years or older were twice as likely (66%) to report pain on a daily basis as young adults aged 18 to 24 (32%).

Dr. Arthur G. Cosby is Director and Research Fellow, Social Science Research Center and Professor of Sociology, Mississippi State University. His current research is being supported by the Bower Foundation, The American Cancer Society, The Robert Wood Johnson Foundation and the Office of Rural Health Policy. His research interests include the use of multidisciplinary approaches to the study of health, safety and security.



### President's Message continued from page 3

The final problem that I want to bring to light is the paucity of pain-oriented behavioral specialists. One certain cause of this is the lack of demand for these specialists. Since many of our pain management colleagues practice without our behavioral colleagues' expertise, the demand is low for these valuable practitioners. I have had the pleasure of working among superb behavioral consultants such as Janice Livengood, Robert Jamison, Stan Chapman, Dan Doleys, Jeannie Koestler, and others. As a result, I've made a conscious effort to include behavioral intervention as a part of my multidisciplinary strategy, having witnessed some of the near-misses of trying to practice pain medicine without the expertise of my behavioral colleagues. Another approach to creating demand for additional pain-oriented behavioral specialists is to encourage psychology externs to visit our practices. In this way, they can become familiar with the challenges and even conduct research projects for us in our field of pain medicine.

In summary, I remain committed to advocating the beneficial aspects of the behavioral components of pain medicine; and I look forward to hearing from my SPS colleagues regarding other strategies to enhance behavioral health benefits coverage and patient compliance.



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## Visit SPS's Website!

Stan Chapman, PhD  
Chair, E communications

You might really be surprised to find all of the helpful resources available on SPS's website, [southernpainsociety.org](http://southernpainsociety.org). You may not know that SPS is the only regional section of the American Pain Society that has its own independent website in addition to being a link within the APS website. Going to the website is a great way to stay in touch with SPS. It contains many features, and links, including copies of recent newsletters, a description and brochure of upcoming meetings, and a listing of officers and Board members, districts and their Presidents, and committees and their chairs. If you want to become more involved with SPS through participation in a district and/or with a committee, going to the website will help you get in touch with the right person. Furthermore, you might know of someone interested in membership. An application can be downloaded directly from the website.

The website not only includes information about SPS, but also lists literally hundreds of online resources related to health care, including major organizations, journals, search engines, grant opportunities and providers, medical dictionaries, a medical encyclopedia, and comprehensive information about medications. You owe it to yourself to explore and see what's there!