“Pain Management:

The Need, the Abuses and the Consequences”

Quest Club

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The Need for Pain Management

Consider your own pain experiences. Consider a small splinter or invisible thistle that may be in your fingertip. You repeatedly touch it to check the level of soreness, or to see if it has somehow departed from your finger. You go about your daily tasks more gingerly so as not to bump it unexpectedly until it can be removed. Some people say, "leave it alone", it will dissolve itself or work its way out. Some people say it has to come out now so it doesn't get infected. Some people attempt to remove it themselves, maybe disturbing healthy tissue in the process. Some may set a doctor's appointment or more rarely, actually go to the hospital because they don't have a personal physician.

Some people may never tell anyone that they have a small problem and will suffer in silence. Some people may tell everyone that they have a problem. Some will theatrically moan whenever there's a ready audience. I have met those people. Some people have a very high pain thresh hold and a painful condition is experienced much more of an irritant. Some people have a very low pain thresh hold and their lives are much more disrupted by a very similar irritant. Pain is a subjective experience that only the patient can identify. Everyone knows how distracting a small pain can be in daily life. Consider blisters and shoes that pinch your feet. Now imagine that the splinter or the blister has now become your spine, movement for your head in all situations, or movement with your legs impacted by your aching knees. There's not much that is accomplished until those pains are protected or alleviated. Think about how daily and persistent chronic pain changes your focus, filters your ability to concentrate and your attention to detail, your ability to accomplish advanced tasks, your ability to anticipate and participate in relationships, your ability to emotionally have appreciation for your situation and life. Pain

changes how we experience the time that is on the clock. Life goes by so much more slowly. How does anyone possibly avoid clinical depression with chronic pain?

In defining the level of need for pain management, one third of the adults in the United States, more than 100 million Americans, suffer from chronic pain. For doctors who specialize in pain management, primary presenting sites include locations around the spine involving the lower back, secondly in the upper back or neck area, and thirdly, the knees. The genesis of those physical issues are often related to structural issues that may source from birth, injury or trauma, disease, degenerative joints, or failed surgeries. Dr. Deborah McMahan, Allen County's Health Commissioner, identifies that most Americans believe that they can be asymptomatic and be pain free without doing the regular, dedicated work to be healthy. Often unrealistically, they seek total pain relief.

Strong scientific research serves as a basis of training for those physicians who are board certified by the American Academy of Pain Medicine. The vast majority of those physicians, approximately ninety percent (90%) are initially trained as anesthesiologists or physiatrists. Physiatrists are medical doctors who have completed training in the specialty of Physical Medicine and Rehabilitation (PM&R), and may be subspecialty certified in Brain Injury Medicine, Hospice and Palliative Medicine, Neuromuscular Medicine, Pain Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, and/or Sports Medicine. Physical Medicine and Rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. Specifically, PM&R physicians:

- Treat patients of all ages
- Focus treatment on function

- Have a broad medical expertise that allows them to treat disabling conditions throughout a person's lifetime
- Diagnose and treat pain as a result of an injury, illness, or disabling condition
- Determine and lead a treatment/prevention plan
- Lead a team of medical professionals, which may include physical therapists, occupational therapists, and physician extenders to optimize patient care
- Work with other physicians, which may include primary care physicians, neurologists, orthopedic surgeons, and many others.
- Treat the whole person, not just the problem area

Depending on the injury, illness, or disabling condition, some PM&R physicians may treat their patients using the following procedures/services:

- EMG (electromylogram or nerve conduction studies)
- Ultrasound guided procedures
- Fluoroscopy guided procedures
- Injections of spine
- Discography, Disc Decompression and Vertebroplasty
- Nerve Stimulators, Blocks and Ablation procedures—Peripheral and Spinal
- Injections of joints
- Prolotherapy (or prolongation therapy, which involves irritant injections into joints to stimulate growth of additional protective tissue)
- Spasticity Treatment involving toxin injections, pump trials, and implants
- Nerve and Muscle Biopsy

- Manual Medicine and/or Osteopathic Treatment
- Prosthetics and Orthotics
- Complementary-alternative medicine (i.e. acupuncture, etc.)
- Disability/impairment assessment
- Medicolegal consulting
(https://www.aapmr.org/about-physiatry/about-physical-medicine-rehabilitation/what-is-physiatry)

Often pain management specialists receive referrals and work with other physicians who have been involved with a long course of care for the patient: disease, trauma, or previous surgeries. Patients arrive with a menu of medications that they have been taking to alleviate pain, on dosages that may be more or less than effective. In recent times, Dr. Roth's practice has seen referred patients with lesser doses of prescription medication compared to previous years

Some of the pain management treatments and procedures have been lifesaving, allowing people to return to work, keep their homes, reduce depression, and appreciate a good future in before them. The Dupont chemical company long ago had an ad campaign, "Better living through chemistry". Significant advancements in pharmaceuticals has actually made the world a much better place for many patients to enjoy their lives when they are used well. A large classification of pain management medications, called opioids, has proven very effective in pain management, requiring specialists who understand and safely manage their administration. "Opioid" is a pharmaceutical term that is different from "opiate." Opiates infer that the product comes from opium and the poppy plant. The term "opiates" also tends to refer to illegal street drugs as opposed to FDA approved opioid medications.

The Abuses of Pain Management

The United States consists of just 5% of the world's population but consumes between 80 and 95% of the world's therapeutic opioid production. Prescription drug abuse

is being referred to and treated as a national epidemic by every known agency and organization. Opioids are the largest class of drugs that are taken and easily lead to abuse. Chronic exposure to drugs disrupts the way critical brain structures interact to control and inhibit behaviors. We all ask, "Why don't they just stop using?" Addicts lose the capacity for "better judgment" and can't make themselves logically stop. One woman working on her recovery said that if her drug of choice and her three year-old child were in a lane a traffic and a car was coming, there is no question that she would dive for that drug first. It is illogical to no- users but it's because the addict's brain function has been rewired by the drugs. Chronic use also leads to tolerance and the need for higher and higher doses, which may also lead to addiction, or death. Drug overdose deaths now exceed the national traffic fatality rates. More people are killed by drugs than by cars. According to studies involving PET scans of the brain, it takes nearly two years of abstinence from the addicting substance for the brain and the neurological systems to nearly return back to a functioning emotional and logical level.

In the late 1990's, a medical study was published, finding that healthcare was not doing a good job of controlling pain in terminal patients. Being good research scientists and caring professionals, physicians began prescribing pain management medications more actively. At the same time, managed healthcare was growing and insurers were requesting that single prescriptions be filled for longer periods of time, 30 or 90 days, in order to reduce repetitive costs. This practice allowed for more addicting pills to be in the patients hands on an unmonitored basis. Cancer patients with vast amounts of pain management needs, elderly who need treatment for multiple conditions at the same time are difficult to prescribe for and may find that a new prescription is not personally effective. A second, new replacement prescription is

needed and meanwhile there may be 80 days of medications that have been purchased and are not returnable.

While most prescribers were trying to help patients, there were a very few who created lucrative "pill mills". Some of the pill mills were intentional. In recent years a high profile practice by Dr. William Hedrick, had multiple locations in the region, with an army of mid-level prescribers assisting him. Authorities estimated that he had a caseload of 5,000 to 10,000 patients, many who were fully addicted to their medications, and they were left without care when he was arrested. Of those numbers it was assumed that perhaps twenty percent may initially have been drug-seeking individuals with little physical or medical basis for their prescriptions. Intentional pill mills may build diagnoses in patients that promote medication abuse, maybe in unneeded surgeries. Hallmarks of a pill mill include a lack of an adequate physical examination, seeing 80-100 patients per day for two minutes each, operating on a cash only basis, and prescribing opioids based on patient request only. When Dr. Michael Cozzi was suspended and under investigation in 2016, he was found to have prescribed more than two million doses of oxicodone and 1.2 million doses of hydrocodone in recent times. In 2015, he was the leading prescriber of Oxycontin in the state. Unintentional medication mismanagement may occur when caring physicians use too many mid-level practitioners to assist in their practice without adequate training and oversight to handle all of the cases assigned to them. Patients receive increasing dosages, or stay on them too long when other healthier interventions might be possible.

Today, one of the ways that our federal government saves healthcare dollars is through the Veteran's Administration healthcare system. Once our vets go through months of proper diagnostics and participate in treatment for the pain that they have, they receive mail order

shipments of large amounts of pain management meds on a monthly basis. Once a veteran defines him or herself as addicted, and seeks help for that addiction, it takes many more months of time and effort to get the shipments of temptation pills altered or stopped from being delivered to their home. Local police have been aware of at least one veteran with a lucrative income, selling the prescription pills that he receives for free from the V.A., and who has not yet been charged because federally supplied prescriptions are not required to be recorded on the state's prescription medication monitoring system, INSPECT.

In 1995, at the same time that caring physicians were trying to be more active with pain management for terminal patients who needed it, the FDA approved the arrival of Oxycontin (oxycodone) into the market, despite studies that found a lack of increased efficacy in pain treatment compared to older medications. The pharmaceutical company was prolific in marketing to a ready audience of caring physicians, responding to calls from the earlier research. This situation led to the perfect storm of caring physicians leaping to one of the strongest pain blockers as a first and frequent prescription. Patients offered few complaints. Visitors from other countries are amazed that the U.S. allows mass media advertising of prescription medications that are unheard of in other countries. "Ask your doctor about. . . .", is truly a foreign phrase to them.

During this same time, the American Pain Society introduced "Pain as the 5th vital sign" as a part of a responsible assessment. While the other vital signs of blood pressure, pulse, respiratory rate and temperature used concrete measurement tools, adding "pain" to the list made it the first and only subjective vital sign. At the same time, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), a leading national certification organization recognized by all governmental and insurance providers, also adopted pain

management as the fifth vital sign. In 2001, JCAHO issued the new standards and stressed the safety of opioids to healthcare prescribers. By the constant practice of being asked about pain, patients came to believe that they were entitled to full pain management and to be fully relieved of any pain at all. They demanded it. In reality, Dr. Roth tells us that a 30-40% improvement in pain levels is a good clinical result.

Another compounding variable that contributed to the national prescription drug abuse crisis is that during the 1990's healthcare was beneficially revamped into integrated healthcare systems, with physicians hired into larger systems. This effort also lead to more formal systems of measuring patient satisfaction, and tying those results to a portion of the employee performance reviews and compensation. On many fronts, from employers to the patients themselves, physicians felt pressured to prescribe opioids to patients upon request, despite physician reservations about the need for them.

Some of the pain management addiction to prescription pills is accidental. Dr. McMahan shared research that perhaps sixty to eighty percent of the patients who become addicted to pain pills after having had trauma, or surgery may have always been genetically predisposed to become addicted to their meds. Unknowingly, the chemical balances within their bodies feel like they have found their match when pain medications are given for a valid reason. Surprisingly well-educated, financially secure individuals with strong analytical skills, faith, and personal values may find themselves seriously addicted and in a life-changing situation. Dr. McMahan found that the current research is becoming closer to have a screening lab test to determine the genetic markers for addiction to pain medications.

Another key problem in pain management is that there are significant burdens on prescribers by insurance companies and payors to control costs. Private or insurance payors

usually require preauthorization for nearly every procedure related to pain management. Prescribers are compounding time, administrative, and clerical costs in order to practice good pain management medicine. Each state's Medicaid program has its own formulary and authorization processes. One physician was told by an Indiana state gatekeeper to increase the dosage of a highly addictive but also cheaper medication for a patient rather than approve a lower dose, the more effective, and newer medication that would lead to recovery.

The Consequences of Pain Management

Consuming more than 80% of the world's opioids puts a lot of medications in the hands of lots of people who use them recreationally. Enough medications are prescribed for every man, woman, and child in the United States to have a bottle of at least 200 pain medications on an annual basis. Medicine cabinets are overflowing as patients and families don't know what to do with so many extra medications.

Young people have some ideas about what to with them, recreationally. In this culture of entitled mood management with tobacco, alcohol, marijuana, cough syrups, and designer caffeine at young ages, young people have "skittles" or "pharm" parties. Everyone raids their parents, grandparents, or neighbor's medicine cabinets and brings a bottle of pills to put them loosely in a bowl with everyone else's potluck for an updated version of a "hairy buffalo" party. Youth mix alcoholic drinks and take a pill out of the bowl, maybe based on color and shape of the pill, and give it a try. It might be a laxative, or an opioid, or a cold tablet. If nothing happens they try another.

Teens and pre-teens seek prescription drugs from fellow students who appear injured on crutches or in casts. When they don't succeed, teens are willing to try heroin as an opiate alternative. Some entrepreneurial college students drive to pill mill locations and make some

extra expense money when they take it to sell back to the college campuses. Students buy Ativan and attention deficit drugs to help them be more alert for finals weeks. Illegal prescription drug use in Indiana is defined as anyone taking medications other than how the prescriber intended. Medications cannot be shared with another person, on a different schedule, or in a different manner. Skipping the end doses of a prescribed antibiotics regime may be defined as illegal drug use. In Indiana, it is a drug dealing felony to sell just a single tablet of prescription medication.

In Allen County, a 2015 survey of 7,000 sixth to 12th grade students reported that for high school sophomores 5.3%, or one in twenty, of them had illegally and regularly used a prescription drug within the last thirty days, compared to 3.9% reported in 2013. In 2015, the same group reported 4.4% in the state, putting Allen County high school sophomores about 20% above the Indiana state average. The same data set indicated that for high school seniors in Allen County, 1.4% had tried heroin at some point in their lives and alarmingly half of them, 0.7% reported monthly use indicating active addiction. There is significant damage and risk to the brain and nervous system if teens experiment before the age of fifteen years old. (Indiana Youth Survey, IPRC)

For adults, who find themselves accidentally addicted to prescription pain medication for a variety of reasons, it becomes difficult for them to maintain an addiction under the care of a responsible prescriber. Insurance runs out. Prescription drugs are expensive. In 2015, Indiana led the country in pharmaceutical robberies. Oxycodone/Oxycontin and Opana were largely sought. Street drugs and particularly, the heroin opiate, are much less expensive and easier to obtain than prescription drugs. In the 1960's, heroin was considered a drug for street derelicts or for eccentric artists.

Today heroin is very mainstream and pervasive with 75% of all heroin addicts beginning their addiction with prescription drugs. Today's heroin addict can come from any neighborhood, profession, be well-dressed, well-educated and is getting younger. Local treatment professionals report that young adults, 19-25 years old are voluntarily presenting for opiate addiction treatment, already having experienced years of addiction and recovery attempts. A serious and undeniable connection exists in the United States between the prescription drug abuse epidemic and the heroin epidemic. Neither problem gets solved without addressing the other problem.

On the street, prescription drugs, and in particularly opioids sell for $10 to $30 per pill. One dose of heroin with a longer lasting and higher quality of high costs $20 and is easier to get than prescription drugs. One of the problems is that the prescription drugs from the street may or more probably, may not have been approved under FDA guidelines. China and other illegal producers make look-alikes that contain harmful, and deadly drugs. Last year fake Xanax were being sold on the street and young adults died. On the street, it is impossible to verify the authenticity of the pills. Laboratory testing is required.

Heroin and other drugs are often laced with Fentanyl, which is ten times more powerful than heroin. It was medically designed for surgical anesthesia and has been used medicinally in the very last stages of terminal cancer patients to alleviate pain. Captain Kevin Hunter, Fort Wayne Police Department, Vice and Narcotics tells us that just two grains (think of salt) of Fentanyl laced into heroin is deadly to humans. By far, heroin is the most prevalent illegal street drug that is burdening parents, children, law enforcement, courts, healthcare systems, and child welfare services. Carfentanyl is an elephant tranquilizer that is being laced into heroin and other drugs and is 100 times more powerful than heroin. The Fort Wayne area, the “Crossroads of

America", is seeing some carfentanyl filtering up from the Cincinnati area. Ohio, our neighbor to the east, leads the country in heroin addiction and overdose deaths.

Those are some of the deadly consequences of prescription drug abuse and in particular opioids for pain management. There have been some good consequences as well. The stigmas about drug addiction are being reduced in favor of seeking to save lives. Indiana has been proactive in creating the statewide "INSPECT" program for hospitals, physicians, pharmacies, and law enforcement to register and monitor prescriptions that have been administered. The purpose is to catch patients who "doctor" and "clinic" shop, getting multiple prescriptions from multiple providers. Dr. McMahan actively convened many sectors of the community to increase the use of INSPECT, and to determine locally what prescribers can do when they have a "frequent flyer" presenting for drugs. Through those collaborative efforts, they created prescribing guidelines that were ultimately adopted by the Indiana State Medical Licensing Board.

Our recent Attorney General, Greg Zoeller, was very proactive in convening the state Task Force to Reduce Opioid Abuse and in creating a supportive website and program, "the Bitter Pill". Dr. McMahan is recognized as a leader in the state and has chaired the Education Committee since its inception. Dr. Roth and his practice manager also participates actively on the Task Force. Former Governor Pence commissioned a task force on Drug Abuse and Prevention. Current Governor Eric Holcomb has recently added a cabinet position for a Drug Abuse and prevention leader.

Former Attorney General Greg Zoeller has been active in getting naloxone or "Narcan" into the hands of more first responders. When police or EMTs come upon someone is non-responsive, and may be in an opiate overdose, Narcan is administered as a nose spray, blocks the

opiate receptors, and allows the patient to miraculously wake up. It doesn't promote recovery from addiction but it saves lives so that future recovery becomes an option. First responders talk about individuals who have been saved multiple times with multiple doses of Narcan, sometimes on the same day. It can now be purchased at local drug stores with administrations costing between $30 and $50. Some social service agencies are instructing older children on how to use Narcan in case they need to administer a dose to their parents or loved one. Some addicts have incorporated Narcan purchases into their drug using routines so that someone can save them when they choose to use drugs.

Every state and federal agency, professional medical association, and licensing board are tightening the reins collaboratively and firmly to reduce prescription medication abuse. In the last month, pain management has been removed nationally as an official vital sign. The DEA, other professional physician groups, and insurance payors are capping the amount of prescription medications that can be prescribed to lower levels, and reducing to a specific number of "morphine equivalencies". Physicians and prescribers are being trained and supported to begin a course of pain management with more gentle approaches, before escalating to the most powerful drugs.

The American Academy of Pain Medicine, in cooperation of multiple state associations and licensing boards have created new, stronger guidelines on what constitutes good pain management practice. I am grateful and impressed with the operation that Dr. Roth has built at Summit Pain Management that clearly demonstrates the implementation of these guiding principles for pain management practice:

1. A thorough evaluation of the patient, including psychological profiles to screen out those seeking medications for secondary gain: existing or forecasted addiction and disability

claims. The thorough evaluation also includes examination and history to determine and address what the primary source of pain generation is, and to be sure that previous pain management efforts have not missed the mark and might merely be addressing side symptoms. Dr. Roth has added a pain psychiatrist in his practice.

2. An active treatment plan that moves the focus off of the existing pain and allows attention to be placed on improving functionality and quality of life for the person. It helps the patient perceive their life as something much more than the pain that had been defining them in recent years. Many techniques and approaches, in addition to opioid pain management, are employed to reduce pain.

3. Informed consent and agreements for treatment which usually includes clear definitions about compliance and non-compliance with the prescribed treatment regimen. For Summit Pain Management and others, this includes regular urine screens and lab tests to assure that the patient is following professional guidance. Non-compliant patients do not receive assistance with their pain management.

4. Periodic review of the case and treatment plan that go well beyond a pill mill's practice of just relying on the patient's self-report of what they need.

5. Consultation with patients but also their team of physicians and health providers who are managing other conditions for the patient, some of which may have been the primary pain generator. Good pain management providers and programs are just one part of the team to maximize functionality.

6. Thorough and complete medical records. I have seen the stacks of written files in the office and I have seen the newer electronic medical record that have replaced them.

7. Compliance with Controlled Substances Laws and Regulations.

Despite the best efforts of modern medical science and so many caring individuals, pain problems are not always fully resolved. Some people live with some pain despite one's best efforts. Good pain management helps alleviate the pain that can safely be alleviated and helps patients with pain to more holistically live their best lives in spite of it.

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