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ETHICS CASE
Drug Seeking or Pain Crisis? Responsible Prescribing of Opioids in the Emergency Department
Commentary by Pamela L. Pentin, JD, MD

Dr. Jones is an emergency room physician in Baltimore. Late one afternoon, he sees a young woman named Marie who has come to the ER because of extreme abdominal and knee pain over the past 12 hours. Marie says that she is in great distress and rates her pain at a 10 out of 10. She says that the pain resembles that of her previous sickle cell crises and that only Dilaudid helped. She points to her abdomen and both of her knees as the sites of pain and refuses to allow Dr. Jones to touch them. Dr. Jones observes no overt swelling or redness.

Looking at her chart, Dr. Jones sees a long list of emergency department visits and admissions over the past 2 years. Marie, 25, has a diagnosis of sickle cell disease. On most ER visits, the peripheral blood smear reports were inconclusive for vaso-occlusive crisis. Notes from her hematologist comment that she is habitually noncompliant and that they have considered consulting psychiatry to help address her persistent chronic pain.

As he is leafing through the file, Dr. Jones is interrupted by his colleague, Dr. Kapoor, who recognizes the patient's name and quips, "Good luck with her—she's a pro at getting drugs."

When Dr. Jones reenters the room, Marie is tearfully pleading for pain relief.

Commentary
Between 1999 and the present, there has been a 300 percent increase in the prescribing of opiates in the U.S. The misuse and abuse of prescription painkillers results in approximately 500,000 emergency department visits annually [1]. In 2008 more than 36,000 Americans died from drug overdoses, most of them caused by prescription opiates [2]. More than 12 million Americans admitted using prescription opiates recreationally in 2010 [3].

How did this dilemma come about? My take is that we created it. We believed ourselves to be well-meaning, most of us having sworn to do our utmost to relieve suffering. Yet in an effort to do just that, we now find ourselves pawns in the play of a health care system in which pain complaints are managed with opiates despite enormous risks to the patient and a numerical pain scale rating carries more weight than a patient's level of function or even consciousness; a system in which a patient complaint of poorly managed pain quickly reaches the highest level of institutional

administration, and nonpractitioners tell us how to practice medicine. We joke with colleagues about "frequent flyers" for pain medications in the emergency department (ED), but we then let those patients convince us to prescribe the opiates we know will not really help them. We prescribe "a few" tablets to move patients out of our EDs, thinking that we are somehow doing less harm than prescribing "a lot" of opiates.

We had the best of intentions. In 1997, a collaborative project was initiated to integrate pain assessment and management into the standards of the Joint Commission on Accreditation of Healthcare Organizations (now the Joint Commission) [4]. High levels of uncontrolled pain were felt to be a public health problem, with significant physiological, psychological and financial adverse consequences to the patient and society. Patients' "right" to have their pain managed adequately was recognized. After review by many experts and committees, JCAHO pain standards were published in 2000, effective in 2001, requiring pain assessment and management at every initial patient visit. Pain became the fifth vital sign.

The JCAHO pain standards were a remarkable innovation in compassionate patient care. But our knee-jerk response to them was misguided. As a group, we rushed to meet those standards at almost any cost. I can still hear my then-institution's administrators when these standards first appeared, arbitrarily requiring every patient who rated their pain at 4/10 or higher, to be stopped at the exit door until their pain was better managed. Nutritionists were obliged to walk their stable, functional patients with arthritis to the ED for evaluation because their pain rating that day happened to be a "5."

Around the same time as the JCAHO pain standards appeared, the pharmaceutical industry formulated new, long-acting opiates. In the absence of other effective treatments for nonmalignant pain, opiates initially studied and widely adopted for the management of cancer pain filled the void. Once thought "unattractive" to addicts because of its time-released coating, OxyContin was formulated in much higher doses than previous immediate-release opiates, the idea being that it would provide smooth, long-lasting pain relief. But people found ways to crush the pills to snort or inject the oxycodone within. OxyContin in particular was heavily marketed to physicians in rural areas who had patients with severe pain, but little training in pain management or the recognition of addiction and few resources to deal with that addiction when it occurred [5]. Hence was born "hillbilly heroin," and with it a population of prescription opiate-seeking patients. By 2001 OxyContin was the bestselling name-brand opiate analgesic in the country [6].

In 2003, the FDA cited the manufacturer of OxyContin twice for misleading promotional advertisements to physicians, underplaying the addictive risks of the drug. In 2007, three executives of the company pled guilty to charges of misleading the public about the drug's safety and risk of abuse [7]. But the deed was done and the landscape was forever changed. (Incidentally, the misrepresentation of opiate safety by manufacturers is nothing new. Recall the early days of the twentieth

century when the manufacturer of heroin marketed it as a safe, nonaddictive cough suppressant in substitution for the more "addictive" morphine [8].)

The era of long-acting high dose opiates, and ensuing prescription opiate addiction, had arrived. Patient addicts quickly learned the diagnoses that could not be definitively confirmed or ruled out by examinations or test results but that precipitated rapid pain management with opiates. Patient addicts also learned that physicians had no "dipstick" to assess their pain and that their subjective reports had to be accepted. It was quite simple to claim an allergy to, or lack of relief from, nonopiate analgesics. "Headache," "backache," and "dental pain," are now common complaints used by drug seekers in emergency departments and urgent care clinics because the underlying etiology for the pain is often difficult to objectively confirm [9].

Even patients with quite legitimate pain sometimes exaggerate their pain for reasons of anxiety or pseudoaddiction. In pseudoaddiction, patients may amplify reports of pain for iatrogenic reasons, because their previous reports of very real pain were not believed and they fear that pain returning. Many of us have cared for patients who incoherently mumble a pain rating of "it's a 10, doc" as they drift into a deeply narcotized sleep. How many of us have stayed the hand of a well-meaning colleague from administering even more opiates to a sleeping "10 out of 10"?

So how do we balance the needs of patients who legitimately suffer from pain against the risks of the opiate addictions that we as practitioners have helped to create? We must start using the safety nets available to us, we must insist that our patients become our partners in their care, and we must say "no" to opiates when the risk of harm to the patient and the community exceeds the benefit to the patient.

Web-based prescription monitoring programs (PMPs) or legislation to enable them now exist in 48 states and 1 territory, allowing us to assess who else is prescribing scheduled drugs to the patients we see. Though it takes a few extra minutes of our time and the security requirements of some PMP websites make navigation slow, it is incumbent upon us to devote that extra effort to protecting our patients and the public. The information I glean from my state's PMP never ceases to surprise.

Once we recognize from the PMP a pattern of aberrant behavior, like frequent ED visits or other doctor-shopping, it is incumbent upon us to speak with our practitioner and pharmacist colleagues about shared patients at risk. Respect for privacy does not bar communication with other practitioners when the purpose is to protect the safety of the patient or the public. And there are clearly times, as with prescription forgery or theft, when the risk of harm to the patient or community outweighs any breach of confidentiality, and a call to the police is in order. I would rather face a judge to explain my decision to violate privilege than attend the funeral of a patient who has overdosed on opiates I prescribed.

The advent of the electronic medical record (EMR) has improved communication among health care professionals immensely, but as the old adage says: "garbage in, garbage out." If we do not carefully document what we learn about our patients, our efforts will be fruitless. We must feel empowered to enter terms such as "addiction," "substance abuse," "dependence," and "doctor shopping" in bold type, underlined with flashing lights if necessary, and descriptions of relevant behavior on EMR problem lists. And we who have access to these information-laden EMRs must take the time to actually read the entries and act accordingly.

Medical care of all types, including the management of pain, is a partnership between patient and physician. Controlled substance agreements are built upon this principle. In exchange for management of their pain with opiates, many such agreements appropriately require patients to be partners in their own care by seeing only one practitioner, using only one pharmacy, taking their medication as prescribed, and avoiding other substances of abuse or sharing medication. The provision of urine or blood samples to screen for substances of abuse and ensure a patient is taking medication as prescribed is another component of the care partnership. Agreements can also be used to ensure use of essential components of pain management, such as behavioral interventions and physical therapy, which may reduce a patient's reliance on opiates and other drugs.

In essence, we, the medical community, created patients like Marie. We swore to do our best to relieve her suffering. But we then compelled her to report her pain as a number, we taught her the number to report to trigger the flow of opiates, and we reinforced our teaching by opening the opiate faucet whenever she uttered the threshold number. We allowed pharmaceutical manufacturers to flood the market with new opiates for Marie and to mislead her and us about their safety and their risk of addiction. A critical lack of pain management resources for Marie and others, especially those who live in rural America, and our own lack of training to recognize and manage addiction, prompted us to prescribe more and more opiates to her.

Marie may have real, terrible sickle cell disease. But it is time to look beyond the surface of cases like Marie's. She must be a partner in her own care. For a patient with previous drug-seeking behavior and questionable reliability, a refusal to allow full physical examination or blood draws should be deemed a refusal of care and precipitate a polite decline to prescribe opiates. Urine toxicology screening may yield critical information for decision making and should be employed early and often. Test results unsupportive of a vaso-occlusive crisis in Marie's case should be reviewed with hematology colleagues before opiates are administered—acetaminophen and nonsteroidal anti-inflammatories can be used in the interim. A psychosocial inventory should be administered, yes, even in the ED, to determine whether Marie has other reasons, such as anxiety, depression, or life events, for coming to the ED seeking opiates.

It's also time to assess pain based upon function rather than a numerical score, even in the ED. Reports from triage staff that, for example, Marie was seen ambulating

comfortably and eating a hot dog before checking in to the ED should be given high credibility.

Use of electronic media, in all its facets, should be undertaken by ED staff to ensure the safety of prescribing opiates to Marie, and when EMRs are not available paper records should be requested by fax on an accelerated basis. Review of the records of other practitioners who have seen her, queries of state PMP websites and calls to her PCP and her pharmacist are all in order before administering opiates which may not be clinically indicated. Controlled substance contracts often set forth a plan for pain crises, and these should also be consulted by practitioners before acting whenever possible.

It is time to take back the management of pain with opiates from JCAHO, from administrators, and from the pharmaceutical industry and place it where it belongs—in the hands of cautious and well-informed practitioners. And sometimes the right thing to do to is just to say "no."

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