

## **Pain Management Misstatements: Ceiling Effects, Red and Yellow Flags**

Dr. Howard Heit does an excellent and accurate job in his piece, expressing the hope and disappointment many of us felt in advance of and following our opportunity to speak with the Drug Enforcement Administration (DEA) about the interim policy statement (IPS). I was also “in attendance” that day, but due to other commitments participated via telephone. I listened intently until it was my turn. Those who went before me described the negative effects of both aspects of the IPS and the pulling of *Prescription Pain Medications: Frequently Asked Questions and Answers* (FAQ) (of which I was one of the authors). It was hard to judge the mood in the room. The DEA representatives were in listening mode, so without seeing them, I could not easily tell how the reasoned arguments and statements being made (not just by those who prescribe controlled substances, but also by those who have seen the negative impact of the IPS on pharmacy and nursing practice) were being received. I was hoping for the best.

The FAQ was meant not as a policy statement but as a document to help DEA agents better understand the way pain medicine is practiced. It was a guide to foster a better understanding of the realities of pain medication prescribing—its complexities and some of its subtleties—to help begin to break down the myths that surround some of the simple-minded formulas like number of pills, number of prescriptions, and number of opioids to the same patient, and myths about addiction that have been historically and mistakenly applied in an effort to find the doctor-turned-drug-dealer. The FAQ document was meant to help agents get a sense of the phenomenology of the well-intentioned physician who struggles to treat pain and not contribute to drug abuse and diversion. How confusing the assessment of addiction and diversion can be when you are trying to treat pain. I remember expressing my doubts and cynicism on the very first conference call between the group of us who were to write the FAQ. I remember saying that even at a time of greater cooperation between the DEA and the pain community, I perceived a disconnect between the statements coming from the top and the actual practices on the ground. I remember that some from the DEA on that call

were (mildly?) offended at my comments; this was after all to be a new era. Greater balance, greater cooperation. And I was urged to press on and contribute in the name of education and the spirit of cooperation. The group worked hard on multiple drafts. No “misstatements” were made regarding the confusing realities of life as pain practitioner and its peculiar phenomenology.

It is my concern that misstatements are routinely being made, though, about pain practice in everything from high-profile court cases to the IPS. Proposing ceiling effects to opioid doses and obscuring the legality of prescribing to those with a history of drug abuse are two. But perhaps the one most offensive to me is the distortion of aspects of my work on potentially aberrant drug-related behavior. This model of clinical assessment and research has revealed that noncompliant behavior is common among those on opioids and stems from many different etiologies, from addiction and diversion to untreated pain and psychological distress, to name a few. My studies have found such behaviors in 45% of opioid-treated, chronic pain patients [1], and Lynn Webster has found the same [2]. Thus, these behaviors are common. Much more research is needed to better understand them and to calculate the probabilities that they are related to one cause or other or how many behaviors over time are related to addiction. These behaviors are not to be ignored—but they are NOT “red flags”—red flags implies that prescribing should be discontinued at the emergence of the behavior. They are “yellow flags” at best. Proceed with caution. Apply limit-setting, change management. Be thoughtful. Use your leverage as a physician to help the patient be compliant; maybe use the fact that they need pain management as an impetus to seek drug abuse treatment, too. In other words, react therapeutically, not punitively. I started this work to help physicians better understand addiction so as to increase their comfort level in prescribing and assessing their patients.

When the spirit of cooperation between the DEA and the pain community breaks down, there is little therapeutic “wobble room” in these situations. Physicians begin to assume aspects of the law enforcement role into their practices, and “one

strike and your out” policies begin to appear in pain clinics. Flunk a urine, kicked to the curb. Run out early, ditto. Complain too aggressively, ditto. Where might it end; the unjust discharge of half of patients on opioids? No pain treatment? The DEA says that they do not want to tell you how to practice medicine. But they don’t have to—directly. I am afraid that this is the upshot of the pulling of the FAQ and aspects of the IPS.

I have in the past and will continue in the future to advocate for physicians in legal and other (i.e., medical board) arenas. I am particularly motivated to set the record straight when the distortion of the realities of pain management is being used against them. And I will continue to do this work. The reason is simple: Without a proper understanding of these issues, patients suffer. When I left the Markey Cancer Center at the University of Kentucky, the Symptom Management and Palliative Care program unfortunately closed its doors. We tried for months to get all of our

patients to practitioners who would prescribe their opioids. Some of these patients were complicated, no doubt. Equally clear is the fact that central and south-eastern Kentucky are areas hard hit by prescription drug abuse and diversion. It was difficult and in some cases close to impossible—and these were people with cancer.

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#### References

- 1 Passik SD, Kirsh KL, Whitcomb L, et al. Monitoring outcomes during long-term opioid therapy for non-cancer pain: Results with the pain assessment and documentation tool. *J Opioid Manage* November/December 2005;1(5):257–66.
- 2 Webster LR. Predicting aberrant behaviors in opioid-treated patients. Preliminary validation of the opioid risk tool. *Pain Med* 2005;6(6):432–42.