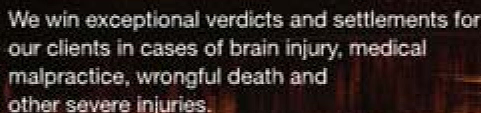
Getting the Best Medical Care: a Newsletter from Patrick Malone

PATRICK MALONE & ASSOCIATES, P.C.

From Tragedy To Justice - Attorneys For The Injured



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Our firm's website

Read an excerpt from Patrick Malone's book:

The Life You Save: Nine Steps to Finding the Best Medical Care -- and Avoiding the Worst

Managing Chronic Pain: It's Complicated

Coping with occasional pain is one thing, but long-term pain is an entirely different animal. It sits on top of you like a beast that won't be tamed. But if you don't tame it, your life could hang in the balance.

Living a functional life if you are in pain for a long time is a matter of management. This month, we examine what good pain management means, the dangers of mismanagement -- addiction, misery and even death -- and how to find the best medical care to help you -- or a loved one in pain -- to cope.

A Cautionary Tale

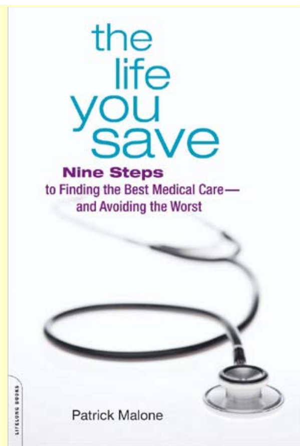
We'll call her Nancy. She was in her 50s, living in a mid-Atlantic state. Although she had been a youthful athlete who knew how to take care of her body, she also had a chronic disease -- alcoholism. Over the years Nancy had tried without sustained success to address her substance abuse, but still functioned relatively well as a wife, mother and small business owner.

Then, within the space of a couple of years, she experienced an empty nest, a broken marriage and a dissolved business partnership. She used alcohol to self-medicate her psychic pain. Then she fell down the stairs and broke her ankle, requiring two surgical repairs.

Three years later, the ankle pain remained, and Nancy's orthopedic doctor continued to prescribe oxycodone, a narcotic drug, or opioid, for pain relief. You might know this powerful painkiller as the active ingredient in Oxycontin, Percocet or Percodan.

Opioids disrupt normal brain function. They have a valuable role in controlling pain for many people, but they also can have serious physical side effects, and even if used appropriately, can be habit forming.

Since 2009, fatalities from painkiller overdoses have surpassed traffic accidents as a cause of death. In 2011, the U.S. Centers for Disease



Learn More

Read our [Patient Safety Blog](), which has news and practical advice from the frontlines of medicine for how to become a smarter, healthier patient.

Control and Prevention (CDC) declared the overdose situation an epidemic.

One of its victims was Nancy.

Her medical history and her emotional state left her ripe for abuse of the drugs for which her orthopedic surgeon just kept writing prescriptions without following minimal practice guidelines for doing so, given her condition. She died of an accidental overdose of oxycodone, alcohol and benzodiazepines (tranquilizers such as Valium), and only after her untimely, sad and unnecessary demise did her family learn why.

The orthopedist not only had failed to take a complete medical history that would have unearthed her addiction issues, he never contacted any of her doctors -- not the primary care physician who knew of her struggles with alcohol, not the psychiatrist she had consulted for her post-divorce depression, a well-known risk factor for substance abuse, and who had prescribed the Valium for Nancy.

And in a jaw-dropping breach of good care, the surgeon's office chart records for Nancy contained no plan of care regarding alternatives to taking narcotics for pain control or referring her to another physician with expertise in pain management. For more than a year before Nancy's death, the orthopedist didn't bother to make any notes in her chart, despite prescribing her almost 200 oxycodone tablets a month.

"It was so far below the standard of care," said her brother, Rich Ruskin, in an interview, "that it's hard to believe. She had an underlying problem, a serious medical illness, but he didn't recognize what was going on."

Takes One to Know One

Ruskin would know. He's an M.D. who is board-certified in both anesthesiology and interventional pain management. His practice in the Phoenix area is exclusively pain management.

That specialty requires holistic treatment -- physical, mental, social. All good doctors -- especially pain management specialists -- treat not only symptoms, but the whole person who presents with them.

Chronic pain, according to the National Institutes of Health, affects about 100 million Americans. That's 1 in 3 people in the U.S. About 25 million of them have moderate to severe chronic pain that limits activities and diminishes quality of life. Costs of our pain might be as high as $630 billion per year due to missed workdays and medical expenses.

But people also seek relief for shorter-term pain. And the best

practitioners address all the components of all kinds of pain they present with, including alcoholism, depression, anxiety and other life stressors.

"It's often difficult to put people in one category or another -- our goal is to get them to be more productive, more functional," Dr. Ruskin said in an interview with us.

"Unfortunately, there are a lot of so-called 'pain medicine specialists' who overprescribe medicine because they're not paying attention to the red flags. Or they fail to perform thorough histories and examinations, and don't identify the main source of the pain; they don't formulate a proper plan of care for managing the patient's pain. They fail to document clearly the patient's progress. Sometimes, they're motivated purely by financial gain, operating what we call 'pill mills.'"

Most of the patients in Dr. Ruskin's practice are referred by a primary care doctor, a specialist or a surgeon, whose records he secures and studies before he treats them. He knows some people seek him out hoping they can fool him into enabling their drug dependence for controlled substances. In those cases, he refers them to colleagues who specialize in drug addiction treatment.

"Patients don't always tell you the truth," he acknowledged.

Dr. Ruskin often refers his patients to other specialists who treat them simultaneously for complications such as depression or anxiety. The care is coordinated -- no practitioner is unaware of the other's treatment. Good care demands a complete and documented pain management plan.

Acute problems, such as a fracture, sprain or post-operative pain, usually require a shorter course of treatment. For chronic pain, Dr. Ruskin explained, usually a diagnosis has been established and part of managing it is to help the patient understand that it's quite possible that all the pain will never completely go away. He helps the patient set reasonable expectations for reducing the pain to a level that enables him or her to function.

Drugs usually play a role. Although a more liberal use of opioids is often appropriate for sufferers of acute pain, it's different for chronic problems.

"The problem with opioids," Dr. Ruskin said, "is that they can create a chemical dependence. That's not the same thing as addiction, which is extreme misuse, usually with catastrophic health, social and financial consequences.

"Dependence is a physiologic response, similar to a coffee dependence. If you drink a lot of coffee and suddenly you stop, you might suffer caffeine withdrawal. You might get headaches, and become irritable, for example."

But coffee won't kill you. Opioids can.

Treatment with Drugs

Analgesic drugs represent a wide range of availability, effectiveness

and risks. Most people have used over-the-counter (OTC) pain relievers such as aspirin, ibuprofen (Advil) or acetaminophen (Tylenol). Prescription drugs might be compounded with some of these agents to boost their effectiveness.

Topical medications are applied to the skin, such as ointment or cream, or via a patch that sticks to skin. Some patches are placed directly on the painful area where an active drug, such as lidocaine, is released. Others, such as fentanyl patches, can be placed away from the painful area. Some patches are available over the counter, and others require a prescription.

As explained by the NIH, as many as 8 million Americans use opioids for long-term pain management. Their use has increased dramatically; there were 76 million opioid prescriptions for pain in 1991, and 219 million 20 years later.

"This striking increase has paralleled increases in opioid overdoses and treatment for addiction to prescription painkillers," the NIH report said. "Yet, evidence also indicates that 40% to 70% of persons with chronic pain do not receive proper medical treatment, with concerns for both overtreatment and undertreatment. Together, the prevalence of chronic pain and the increasing use of opioids have created a 'silent epidemic' of distress, disability and danger to a large percentage of Americans.

"The overriding question is: Are we, as a nation, approaching management of chronic pain in the best possible manner that maximizes effectiveness and minimizes harm?"

According to the American Society of Regional Anesthesia and Pain Medicine (ASRA), taking opioids exactly as a good pain management doctor has prescribed is unlikely to make a patient psychologically dependent or addicted. Factors predisposing someone to opioid addiction include a history or a family history of substance abuse or of certain psychiatric illnesses.

As described by the American Pain Society:

- Addiction has a genetic and psychological aspect to the behavior. It's associated with a craving for the abused substance (such as an opioid), and continued, compulsive use of that substance despite harmful effects. Environmental factors also might affect both the development and manifestation of the addictive behavior.
- Tolerance occurs after prolonged exposure to a drug. The result is a progressive decrease in its effectiveness.
- Physical dependence usually is seen as withdrawal (nausea, sweating, abdominal pain, diarrhea, etc.) after the drug has been abruptly stopped or rapidly reduced. It's a state of adaptation. Withdrawal is not a sign of addiction.

Take opioids exactly as they have been prescribed by your doctor. If your pain continues, don't increase the dose or frequency without asking your doctor. He or she should discuss all the potential side effects, and the difference between a long-acting and short-acting opioid. If you take the first one a few times per day, you're less likely to experience the sensation of euphoria sometimes associated with some short-acting opioids.

Don't take long-acting opioids on an "as needed" basis, like aspirin; if you have a prescription, you should take them whether or not you have pain.

Some meds address underlying issues as well as pain relief, and if these are prescribed by your doctor, he or she should explain exactly what they are intended to do:

- Antidepresssants must be taken daily whether or not you are experiencing physical pain. Never take them in larger doses than prescribed.
- Anticonvulsants (anti-seizure) can treat some kinds of nerve pain (burning, shooting pain). You must take them daily as well regardless of whether you're having physical pain.

Treatment with Exercise

Usually when something hurts you want to leave it alone, but sometimes that just makes it hurt more. People with many kinds of arthritis are advised to keep moving their affected joints to the degree they can, for example, because the painful stiffness gets worse if they don't. People with back pain often are advised against lying or sitting for extended periods for similar reasons. Weak muscles are never good pain fighters.

Often, pain patients learn to exercise for relief under the direction of a physical therapist. Often, they undergo a course of treatment, then are discharged with an exercise regimen they perform at home.

Treatment with Modalities

These options are used depending on the source of the pain and the patient's situation. Apart from acupuncture, which is performed by a licensed, accredited practitioner, usually they are provided by a physical therapist.

- Acupuncture was developed in China and has been adapted in the West for pain management. It involves tiny needles so thin you often don't feel them being inserted into specified areas of the body.
- Transcutaneous Electro-Nerve Stimulator (TENS) is the placement of pads on the skin to stimulate the area of pain with a low voltage electrical current. Patients generally feel a buzziness that intensifies as the unit power is increased.
- Ultrasound uses sound waves to generate heat within a given body part via a wand and gel to enable transmission. It improves blood circulation and reduces inflammation and swelling, and can be used for nonthermal effects when warmth is not therapeutic.

Treatment with Injections

A wide variety of these invasive interventions are common for certain joint problems (for example, cortisone shots for knee arthritis) and for various spinal problems. They can be relatively superficial injections

into a painful muscle (trigger point injections), or they might involve several complicated procedures.

Most injections to treat chronic pain are performed on an outpatient basis. Some involve contrast agents to help doctors track the progress of the medicine in the body, so make sure your doctor knows if you are allergic to contrast material or if you think you might be pregnant.

Epidural injections in the back or neck for pain of the neck, arm, back or leg shoot an anti-inflammatory steroid into a space close to the inflamed area causing the pain.It's controversial about whether these work for all the conditions they're prescribed for, so do some homework before you get this treatment.

Facet joint injections facilitate movement of the neck and back, and are given while the patient lies on his or her stomach. Contrast dye might be used.

Lumbar sympathetic blocks to address the burning pain of the arms or legs due to a syndrome called Complex Regional Pain Syndrome or Reflex Sympathetic Dystrophy (CRPS) also follow this protocol, as do **celiac plexus blocks**, which generally are used to relieve the pain of cancer of the pancreas or other chronic abdominal pain.

Stellate ganglion blocks address pain in the arm or hand, or to improve blood flow to those areas for conditions that result in poor circulation. The injection is given in the neck, and can involve contrast dye.

Quality Control for Pain Relief Can Save Lives

Among the resources for patients in pain, and their loved ones, consider:

- the patient information page of the ASRA for basic information about pain management and anesthesia;
- the U.S. Pain Foundation, "created by people with pain for people with pain;"
- the National Pain Foundation, whose mission is "transform the way pain is fundamentally understood, assessed, and treated for every human being."

Unless you have a drug problem for which you're doctor-shopping, you're most likely to see a pain management doctor after a referral from your primary care doctor, surgeon or oncologist.

Check out that person's credentials to ensure that he or she is qualified to practice the current state of the pain management art. And it is an art to be the kind of caregiver who, in Dr. Ruskin's words, "can't practice in a vacuum, ... [who] sees the patient as a whole person, not just as a clinical problem."

Check with your state medical board here or here to verify that potential pain practitioners are board-certified in the field, and that they have no disciplinary actions pending or in their history. Some

state sites are better at yielding this information than others.

For a small fee, you can find out additional information about a given doctor at DocInfo, provided by the Federation of State Medical Boards.

To find a licensed acupuncturist in your area, or to verify if the one referred to you is credentialed, visit the website of the National Certification Commission for Acupuncture and Oriental Medicine.

Dr. Ruskin regularly consults his state's Prescription Drug Monitoring Program, (PDMP) which is a U.S. initiative for doctors and pharmacists to monitor controlled substances dispensed within a given state.

Unfortunately, it does not provide data about patients who received their meds from government institutions, including military hospitals and clinics and the Indian Health Service, so it won't detect drug abuse patterns by, for example, veterans, who represent a huge population of at-risk users.

Still, "It's incredibly illuminating to us," Dr. Ruskin said. He recently found one patient on the PDMP who had seen 30 different providers and patronized 15 different pharmacies in a single year, solely for the purpose of getting opioid prescriptions.

The PDMP is not open to consumers, but potential patients should ask a pain doc if he or she uses the PDMP; the answer will indicate how serious the practitioner is about true pain treatment, and not just writing prescriptions for profit.

Such professionalism is particularly important to, and poignant for, Dr. Ruskin, whose sister probably would be alive today if she had found that person. "You have to uphold the community standard of care to protect the public interest," Dr. Ruskin said. "Otherwise, people die."

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you.

- **Malpractice** and other errors happen in **military hospitals** just like civilian institutions. The big difference is the **military is immune to any lawsuit** seeking accountability for harm to an injured active duty service member. And, as a big takeout in the New York Times reported, the lack of legal accountability in military health care extends to moral and human non-accountability as well.
- Dr. Bob Wachter is a top maven of the U.S. health care system who has an interesting interview about trends we can expect in our lifetimes, as patients benefit from the "democratization" of medical information.

Past issues of this newsletter:

We're now in year SIX! Here is a quick index of past issues of our newsletter, most recent first.

Here's to a healthful 2015!

Sincerely,

Patrick Malone
Patrick Malone & Associates

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