GUEST EDITORIAL

Can we continue to do business as usual?

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In a 2006 issue of the *Journal of Medical Licensure and Discipline*, David C. Greenberg, MD, MPH, writes about "the distressed chronic pain practitioner (DCPP)" (92[2]: 5-7). He states that DCPPs are "physicians willing to sell prescriptions for controlled substances without bothering to obtain a history and work up the patient's complaint, perform a physical exam, arrive at a proper diagnosis, utilize testing or consultation, choose a rational treatment plan or properly monitor their patients . . . ." DCPPs are, in Dr. Greenberg's view, "self-declared experts in chronic pain medicine . . . with no formal training in chronic pain medicine or any history of studying under a qualified mentor in a prolonged clinical fashion . . . [and] lacking any sort of comprehensive CME participation in recognized chronic pain educational programs . . . . [They do] not [belong] to professional pain treatment organizations and . . . [do] not [read] recognized current textbooks or journals regarding chronic pain." For most DCPPs, "it appears that . . . their main source of chronic pain diagnostic and treatment information is limited to what is supplied by pharmaceutical industry representatives and their patients . . . ."

Dr. Greenberg also notes that not being properly trained in pain management, relying solely upon proprietary pharmaceutical information, and not maintaining basic currency in pain therapeutics are practices that endanger the health, safety, and welfare of people in pain. Dr. Greenberg concludes his editorial by saying that "physicians and other stakeholders need to seriously deal with prescription abuse and diversion or the government will do it. The medical profession must better train and police itself . . . to avoid being forced to take many giant steps backward into a setting where chronic pain patients were undertreated, ignored, shamed or labeled as hypochondriacs and malingerers . . . ." I refer to this past as the "bad old days."

A clear-cut example of a DCPP is Dr. X, a physician who completed only an internship after medical school and who is now operating a "pain clinic" that receives 160 or more walk-in patients daily. With the help of two "extenders," Dr. X's patients could receive prescriptions for opioids and other controlled substances with only the most cursory history taking, virtually no physical examination, no review of prior medical records, and no laboratory or imaging studies ordered, for the cash-only fee of $250 per prescription if they are willing to wait in the one- or two-city-block line—or $350 per prescription if they want "express service." No one should confuse this behavior with the practice of medicine; this is criminal activity being performed under the guise of medical care.

What about the busy primary care practitioner (PCP) trying to see 30, 40, 60, or more patients daily in a typical office setting while caring for a few hospitalized patients, responding to telephone calls, reviewing previously ordered labs and imaging studies, and refilling medication requests? Is that setting appropriate for the management of complex patients with chronic medical problems such as chronic noncancer pain? How much time is necessary to take an adequate pain-related history, perform an appropriate medical examination, determine which studies or imaging methods might clarify the underlying diagnosis, develop a plan of care, and then monitor the patient through time? Is it 10, 15, 30, 60 minutes per patient? More? Who pays for such care? How much must be done to satisfy the standards promulgated by the US Federation of State Medical Boards and adopted by the majority of state medical boards in our country?

After two decades of belt-tightening on the part of the US government and managed care organizations, most physicians are now forced to see more patients and devote less time to each patient just to stay alive in practice. "Problem-oriented medicine" means that only the presenting problem is going to be evaluated. There is no real attempt to get to the bottom of anything; all the physician can do is address the issue at hand and move on to the next patient. Can these busy practitioners adequately manage complex patients requiring years or decades of treatment? If PCPs can not care for these patients, who, exactly, will? Do these busy providers really have any understanding of the issues associated with long-term opioid therapy at anything beyond a brainstem level? Do they know about the concepts of opioid-induced hyperalgesia, immune suppression, and endocrine changes associated with opioid use? To whom will they refer patients, when the number of multidisciplinary pain programs has been steadily decreasing over the

last 10 to 15 years and interventionists now dominate the field of pain medicine? What will PCPs do with patients who are sent back to them for longitudinal care (continuing long-term opioid therapy) after referral to pain interventionists, when the interventions have all been conducted but the patients still need ongoing medication management?

These are not simple questions, but they represent the state of pain management in America, and they are exactly the type of concerns that are expressed by PCPs. These are ultimately complex societal issues, for which there are currently no good answers. Some pain specialists and many PCPs argue that only those pain sufferers with tissue-proven terminal illnesses should receive opioid therapy, or that they should only have opioids provided when interventional methods are not helpful. Others support what they feel is a more humane position: if opioids relieve pain, why not provide opioids regardless of potential long-term consequences? Today there are many published strategies for controlled-substance prescribers that will supposedly keep them out of trouble with regulators; however, none has actually been tested by the US judicial system. There are numerous screening methods and techniques that aid practitioners in making better treatment decisions about opioid therapy. Little is said about the fact that all of these strategies and techniques demand additional time, paperwork, and expense on the part of PCPs, and they hardly fit into the delivery of healthcare within our existing medical models.

Dr. Greenberg suggests that physicians themselves must monitor and police their profession. How many of us have ever taken the time to voice our concerns about colleagues to any regulatory body? How many of us have actually reported a colleague to anyone for anything at all? Weren't we trained to believe that it is improper to speak ill of another member of our profession? Those who have found themselves in trouble for their prescribing practices have usually been turned in by pharmacists, nurses, or disgruntled patients and their family members; rarely, if ever, are these doctors reported by their colleagues. In our complaint-driven system, only the most outrageous behavior or consequence (i.e., death) is ever questioned, not the day-to-day "small stuff" that involves open-ended opioid therapy that carries on for years without evidence that pain is being relieved, activity has increased, a return to work has been made possible, or even that quality of life has improved. Prescriptions are expected to be renewed, and in group practices these renewals are almost never questioned. What may have started out as an acute pain problem managed with opioid therapy soon becomes a chronic pain problem controlled with ever increasing amounts of more potent opioids.

What do good pain practitioners do that many PCPs fail to do? They take more time—enough time to understand the pain problem and the patient at a journalistic level, asking who, what, when, where, and why. They disrobe the patient, inspect the painful area, and lay their hands on it. They do their own reconnaissance, rather than assume that someone else has already done it. They question the current treatment and propose new directions for treatment based upon the presumed underlying mechanisms creating the pain, while utilizing information about the mechanisms of action for each of the therapies considered. Ultimately, they may (rightly) refuse to continue whatever is not working.

Pain management may be the only area of medicine where lack of efficacy is confused with patient rights. Many patients in pain incorrectly assume that they have a right to opioid therapy, when no such right exists. When a neurologist is faced with a patient who is continuing to experience seizures despite the current therapy, further modifications are made until the seizures abate. Uncorrected hypertension is continuously addressed until the patient's blood pressure is reduced to the desired goal. Antibiotics are modified until cultures are negative. There is no disagreement about the goal of therapy in most of routine medical care; the exception is the management of pain. For less than obvious reasons, goals of treatment are not always clear, expectations about therapy are not necessarily agreed upon from the outset, and sometimes years go by before anyone begins to consider the possibility that whatever is being done may not be working.

The remedy for the doctor who may be a DCPP but who actually wants to be a responsible pain practitioner is appropriate pain-related education. After 30 years as an area of professional interest, pain management/medicine has developed pain-related core curricula for healthcare practitioners to master. Learning opportunities are available for practitioners of all levels and backgrounds, as are several excellent professional publications and textbooks. The International Association for the Study of Pain has continued to evolve its standardized pain curriculum for healthcare professionals. The American Pain Society, American Academy of Pain Medicine, American Academy of Pain Management, and other groups offer annual conferences providing up-to-date information about pain research, pain practice, and the importance of multidisciplinary pain management. The Society for Pain Practice Management, American Society of Interventional Pain Physicians, and American Society of Regional Anesthesia and Pain Medicine provide hands-on training for physicians who want to learn specific procedures and techniques. This journal and the Opioid Management Society advance the knowledge and science of opioid therapeutics while providing necessary training for those who intend to use opioid therapy as a cornerstone in their management of people with pain. The American Society of Pain Educators offers healthcare professionals methods, techniques, and tips necessary for their successful

service as professional pain educators. Numerous publications in the form of newsletters, magazines, scientific journals, and Web sites disseminate information about pain-related diagnostics, common pain syndromes, therapeutic options, evolving regulatory challenges, risk management techniques, and more. Annually in the United States alone, there are more than a dozen major national pain conferences, dozens of smaller regional meetings, hundreds of articles published, and thousands of "one off" programs—ultimately leaving no excuse for anyone to be a DCPP.

Collectively, those who consider themselves to be frontline professional pain practitioners must challenge those who "casually" provide similar services to become more knowledgeable, to view pain practice as a serious endeavor, and to not just prescribe more medication. Pain practitioners must be willing to serve as mentors and pain educators for PCPs, other specialists, insurers, regulators, and members of the media. Pain practitioners must actively establish national standards, work with regulators, be active in the political process, and refuse to tolerate the behavior of those who intend to degrade pain management into "pill pushing." Being part of the solution requires that those who are in pain medicine for the long haul put words into action, lead by example, and, rather than just see more patients, see more patients *well*.

Developing new branches of medicine takes time, the presence of charismatic leaders, and subsequent adoption of the new ideas by others. As members of a 30-year-old profession which is recognized by the American Board of Medical Specialties as a distinct area of subspecialization, those of us who are pain practitioners must now do our part to reach out to our colleagues in other areas of medicine and help them learn more about what we do. It is our obligation to uphold the same standards of care (especially when prescribing controlled substances for the treatment of pain) and to continue the professional development of pain management/medicine. The profession on the whole is not mature enough today that we can afford to sit back and enjoy the spoils of our efforts.

The remedy for issues related to the practice of pain medicine will not be more governmental interference, the crafting of additional regulations and rules, or punitive action against the occasional "bad apple." The remedy lies in the deans of curriculum at our medical schools, the program directors for all residency programs, the directors of education for pain and primary care organizations, and a commitment to serve as pain educators made by the thousands of dedicated pain physicians and other pain practitioners who deliver care to those who suffer. Those providing appropriate pain-related therapeutics will become the best pain educators, and this will be much more than self-promotion; this will be effective self-preservation.

As most current healthcare providers were not formally trained to be healthcare educators beyond the "see one, do one, teach one" stage, those planning to serve as pain educators must now seek special training to become effective teachers. PAINWeek 2007 (September 6–9, 2007, at the Red Rock Casino, Resort and Spa in Las Vegas, Nevada) will be a "first of its kind" meeting, designed to blend teaching skills and techniques (the Pain Educators Forum) with primary care–tailored knowledge about pain and its management (the Fundamentals of Pain Medicine), along with other significant symposia to create one-stop learning for those interested in being part of the educational solution. It is expected that by the end of PAINWeek 2007, those who might be potentially "distressed" will be enlightened, and those already knowledgeable will be enthused about teaching what they know to others.

Collectively, pain professionals can seriously deal with prescription misuse, abuse, and diversion without the need for draconian governmental measures. We already know what is legal and what is illegal. The medical profession must better train its members and never allow itself to be forced into taking many giant steps backward to the bad old days, when chronic pain patients were undertreated, ignored, shamed, or labeled as hypochondriacs and malingerers. This is the promise of pain education: to improve patient care across the board and prepare a generation of leaders for the profession of pain management.

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