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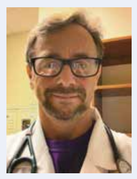
Legacy of the Plague



Written by
JD Remy, MD

"Blessings for all you do." "You Rock!" Created by local youth, the signs served as little testaments of gratitude toward our local medical community working the front lines of the COVID-19 pandemic. As an impaired physician four years into my recovery from alcohol, I felt gratitude that I would not have recognized during my active drinking years.

On November 3, 2016, I overdosed on alcohol and valium and was transported into the very emergency department (ED) where I had been practicing for 20 years. I was ultimately transferred to a drug and alcohol rehabilitation facility. After 9 months of mandated unemployment, I was approved for work in an urgent care clinic. After another year, the monitoring program granted me return to the practice of emergency medicine. After another 12 months, the ED director offered me my job back. I was interrogated by my hospital's wellness panel, scrutinized by the credentialing committees, and ultimately approved by the medical executive board. I am now 2 years back working as a full-time emergency physician.

It was only through willingness to be vulnerable and divulge my situation to the world that I was able to successfully recover and return to the profession I love. My rehabilitation was only possible with an enormous degree of outside support. Sadly, the stigma of alcoholism and addiction in the medical community is alive and well. Credentialing bodies and state licensing authorities uniquely single out alcoholism, drug addiction, and mental illness on their hospital privilege application questionnaires, making it more expedient for impaired practitioners to hide their illness at the expense of their own health, their families, and the patients they serve.

When the COVID-19 pandemic blindsided nurses and doctors, we did a gut-check and handled with poise whatever came our way. Those of us in long-term recovery, I believe, have been able to successfully cope with this event from an emotional standpoint because of, rather than in spite of, our disease. So, why does the medical community regard us with such suspicion? Until this gargantuan issue is addressed, more of our own will lose their careers and lives out of fear of "coming out" in front of the medical establishment.

When I see children's homemade signs rooting us on, I can't help but fancy that they are referring to not only the fight against some virus, but also the unspoken, ongoing secondary plague of our time: alcoholism and drug addiction secretly ravaging the medical community. To the children, I am grateful. Out of the mouths of babes.

Dr. JD Remy is a practicing emergency physician and author of the book *Ballad of a Sober Man: An ER Doctor's Journey of Recovery*, on sale at Amazon.com.

Prescription Pain Medication Use Among Adults: Estimates & Trends

Contributor
Craig M. Hales, MD, MPH
Medical Epidemiologist, National Health and Nutrition Examination Survey
National Center for Health Statistics
CDC

A national study has found that about one in 10 American adults has used one or more prescription pain medications in the past 30 days. Prescription pain medication use was higher among women than men overall and within each age category assessed.

National guidelines note that nonpharmacologic and non-opioid-containing pharmacologic therapies are preferred for managing chronic pain whenever appropriate. "Since the early 2000s, there has been a rise in opioid prescriptions and deaths resulting from these medications in the United States," explains Craig M. Hales, MD, MPH. "As a result, there has been a greater emphasis on using nonpharmacologic and nonopioid-containing pharmacologic therapies for treating chronic pain."

In an *NCHS Data Brief*, Dr. Hales and colleagues conducted a cross-sectional analysis of data from the National Health and Nutrition Examination Survey. According to Dr. Hales, these data are important in the context of the current opioid epidemic. "Data from our study are intended to provide information for policymakers, clinicians, and the public on recent trends in the use of prescription opioids and non-opioid prescription medications," he says.

Key Findings

According to the study, 10.7% of all US adults aged 20 and older used one or more prescription pain medications in the previous 30 days from 2015 to 2018 (Figure). "In addition, we found that 5.7% of US adults used prescription opioids and 5.0% used nonopioid prescription pain medications (without prescription opioids) in the previous 30 days during this timeframe," Dr. Hales says.

Overall, use of these medications increased with age, rising from 5.4% among adults aged 20-39 to 12.7% for people aged 40-59 and 15.1% for those aged 60 and older. Use of one or more prescription opioids was higher in women than men overall (12.6% vs 8.7%, respectively). Prescription pain medication use also increased with age in both women and men. "Of note, our study showed that use of one or more prescription opioids among Hispanic adults was lower than that of non-Hispanic white adults in both men and women," Dr. Hales says. Prescription pain drug use was higher in women than men for non-Hispanic white adults, non-Hispanic black adults, and Hispanic adults.

Other Important Results

"Another finding from our report was that use of one or more opioid prescription pain medications—either with or without using nonopioid prescription pain drugs—was higher for women than men and increased with age," says Dr. Hales. Regarding age, rates of using one or more prescription opioids rose from 2.8% for those aged 20-39 to 6.6% for people aged 40-59 to 8.2% for those aged 60 years and older.

"Of all races, the rate of using one or more prescription opioids and nonopioid prescription pain medications (without prescription opioids) was lowest among non-Hispanic Asian adults," Dr. Hales says. Rates were higher among non-Hispanic white than Hispanic adults, but use among both groups did not differ significantly from non-Hispanic black adults.

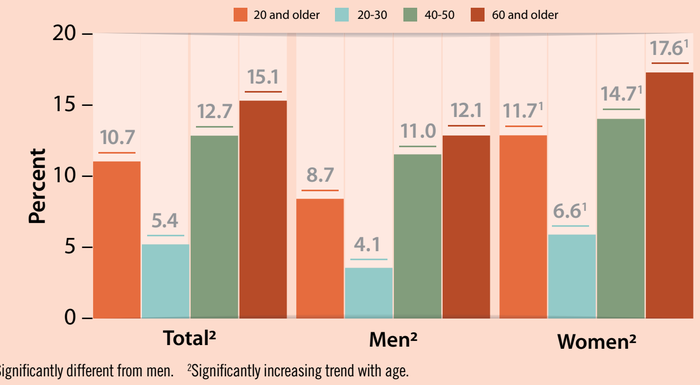
The study also showed that use of one or more nonopioid prescription pain drugs without prescription opioids was higher among women than men, and again, increased with age. In addition, use of nonopioid prescription pain medications without prescription opioids was lowest among non-Hispanic Asian adults when compared with all other race and Hispanic-origin groups. "Furthermore, our analysis revealed that between 2009–2010 and 2017–2018, there was no significant increase in the use of prescription opioids, but there was an increase in use of nonopioid prescription pain medications (without prescription opioids)," says Dr. Hales.

Critical Implications

Dr. Hales says it is important to continue monitoring use of opioid and nonopioid prescription therapies in the US population but notes that help is available to ensure appropriate prescribing of these medications in the meantime. "The CDC has published a guideline for prescribing opioids for chronic pain, which is available at www.cdc.gov/drugoverdose/prescribing/guideline," he says. "This document is available for clinicians to guide their prescribing practices when these therapies are necessary. In addition, it offers guidance on alternative treatment options to improve pain management and patient safety."

Figure Prescription Pain Medication Use in Last 30 Days

The figure below depicts the use of prescription pain medications in the past 30 days among US adults aged 20 and older by sex and age from 2015 to 2018.



[1]Significantly different from men. [2]Significantly increasing trend with age.

Source: Adapted from: Hales CM, et al. NCHS Data Brief. 2020;369:1-8.

Dealing With Non-Compliant Patients: Avoiding Liability

The first step in avoiding liability due to patient non-compliance is identifying that the patient actually is non-compliant. Then, ask about the reason for it and do what you can to counter it. Your record must reflect your attempt to determine what correctable issues underlie the non-compliance and what steps you took to counter it. If non-compliance is not solvable as a single issue and verbal reminders are not fruitful, you can consider a treatment contract, which breaks the compliance into specific acts of patient cooperation that may be easier to follow. Your last option is an "at risk" letter that states the specific non-compliant acts and their clinical consequences. This can include the warning that a failure to correct the non-compliance will result in termination from the practice. You should not create a "decline" note in which the patient signs their refusal to comply. You would be retaining the patient in your practice despite being unable to treat them as you believe is proper.

Your records need to demonstrate that the patient is being non-compliant rather than just being ill-informed. Descriptions of the patient's non-compliant conduct should state the fact of the non-compliance undeniably but without condemnatory or self-serving language. But it should not be so removed as to become meaningless in convincing a reviewer that you are not an appropriate target or in closing off patient claims that you never said something you actually did.

When the therapeutic relationship is irrevocably broken down and it is necessary for you to step away because the patient is actually preventing you from practicing medicine properly, you will have to terminate them from your practice. You will then have to consider abandonment. If you are going to take the maximum step against someone who is already in opposition to you, do so carefully. Non-compliance leading to no option but termination is a gradual process by definition and so an evaluator will want to see that it was handled that way.

You should also consider stating the reason for the termination in a letter. The general rule is to not give a specific reason, but here stating *"As we have discussed, and as outlined in the treatment contract that you agreed to, it was essential that you follow through on prescribed care. Due to your continued refusal to follow treatment guidelines, this practice will no longer be able to retain you as a patient as of (date)"* may stop a retaliatory process before it starts.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.

In Case You Missed It

Spinal Cord Stimulation May Ease Diabetic Nerve Pain

Low-frequency spinal cord stimulation (SCS) may be effective for treating painful diabetic neuropathy (DN), according to a study presented at the 19th Annual Pain Medicine Meeting. Researchers randomly assigned (1:1) 216 patients with painful DN for at least 12 months to 10 kHz SCS (Nevro Corp.) combined with conventional medical management (CMM) or CMM alone (103 patients). This is an interim analysis and follow-up will last for 24 months. The researchers found no reported study-related adverse events in the control group and 16 study-related adverse events in the SCS+CMM group. There were 2 procedure-related infections in the 10 kHz SCS+CMM group, yielding a 1.8% infection rate. There was a significant difference between the treatment groups with respect to achieving at least 50% pain relief and without worsening baseline neurological deficit. At 3-month follow-up, there were also differences noted in lower-limb pain scores, responder rates, and investigator-assessed sensory improvements. Similar improvements were seen for the treatment groups across several health-related quality-of-life and functional measures, including the impact of pain on sleep and Global Impression of Change. "These early results are encouraging for painful DN patients who are refractory to conventional care," the authors write.

Electroacupuncture Not Efficacious for Low Back Pain

Certain patient factors may affect the clinical response to electroacupuncture treatment for low back pain, according to a study published in *JAMA Network Open*. Researchers evaluated the effect of real electroacupuncture (59 patients) versus placebo (62 patients) on pain and disability among randomly assigned adults with chronic low back pain for at least 6 months. After adjusting for baseline pain scores, there was no statistically significant difference observed between groups for change in National Institutes of Health PROMIS T-scores two weeks after completion of treatment. There was a significantly greater reduction noted in Roland Morris Disability Questionnaire (RMDQ) scores in the real electroacupuncture group versus the sham electroacupuncture group after adjusting for baseline RMDQ score. Effective coping at baseline was associated with greater RMDQ score reduction, while White race was associated with worse PROMIS and RMDQ scores—both within the real electroacupuncture group. "If validated, these findings may help match people to treatment," the authors write. "For example, low scores on the coping strategies questionnaire could identify individuals who may need psychological intervention alone or as an augmentation to electroacupuncture."