Socially Deconstructing Emergency Provider Perspectives and Chronic Pain.

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Socially Deconstructing Emergency Provider Perspectives and Chronic Pain.

ABSTRACT

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Submitting to PAIN® (the official publication of the International Association for the Study of Pain®-IASP®): Socially Deconstructing Emergency Provider Perspectives and Chronic Pain.

Social consideration of provider practice and the relationship that forms with patients diagnosed with chronic pain has historically been considered within the biomedical ethics paradigm. The provider considers the principle of beneficence, recognizing the obligation to provide care that benefits the patient and promotes good. Additionally, providers are faced with treatment options that have the ability to do harm. This principle of non-maleficence is also part of the ethical practice of chronic pain management. Pair the principles of beneficence and non-maleficence with social construction and a complex equation governed by biomedical ethics and societal values (social construction) is formed. This concept is considered within the domain of emergency medicine.

Prescription drug-related Emergency Department (ED) visits are on the rise, as are morbidity and mortality injuries associated with prescription drugs. ED visits and unintentional overdoses related to prescription substance abuse are on the rise. The ED is intended for the treatment of acute conditions and, like primary care services, lacks the resources for the management of
chronic pain. In 2009, the American Academy of Pain Management provided recommendations on the treatment of pain: 1) treatment would be provided solely by a single practitioner or clinic; 2) narcotic use should be limited to circumstances where it enhances function at work and home; 3) escalating use or seeking opioids from multiple providers should prompt evaluations of the patient’s opioid use and consideration to discontinue opioid therapy (Chou et al. 2009).

Based on the above recommendations, the truth of what providers know, and what they see in clinical practice, are the socially constructed impetuses that drive the need for robust, multidisciplinary research and treatment of chronic pain. It is hypothesized that a care coordination approach to pain management in the ED is a novel program that coordinates ED care. An example is Providence Sacred Heart Medical Center (PSHMC), Consistent Care (consistentcare.com). Further research is required to enhance efforts to provide multidisciplinary chronic pain management. Perhaps Consistent Care is a model management approach that can be replicated and implemented in EDs nationwide.

Pain is more than a physiologic event. It involves social concern and the well-being of the physical, psychological and spiritual domains. It is social concern that drives an analysis of historical perspectives related to pain and pain management, prescriber attitudes, and consistent care models. The principles of beneficence and non-maleficence, social construction and the complex equation involving biomedical ethics and societal values will be considered within the setting of emergency medicine.

Key Words: opioid(s), opioid abuse(r), chronic pain, pain management, emergency department, pain guidelines, provider.
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Introduction

Pain, specifically chronic pain, is a major health problem in the United States (American Society of Anesthesiologists [ASA], 2010) and a particular problem in the Emergency Department (Rupp & Delaney, 2004). The care of patients with chronic pain is best provided through a long-term, consistent provider-patient relationship (Chou, et. al, 2009). Although the Emergency Department (ED) affords patients 24-hour-per-day access to health providers, care in an ED is often restricted to brief provider-encounters and limited access to health records and past medical history. Therefore, pain-related visits in the ED represent high risk encounters in situations where careful attention to assessment and treatment of pain should occur (Rupp & Delaney, 2004). Pain management, in an environment characterized by chaos, quick patient turnover, episodic care, and high patient volumes has led to the critical evaluation of pain management in this setting.

Prescription drug related ED visits are on the rise, as are morbidity and mortality injuries associated with the use of prescription drugs, specifically opioids. ED visits and unintentional overdoses related to opioid abuse and misuse have created an epidemiological crisis in Washington (Sabel, 2011). Of significance, opioids are prescribed more frequently in the ED when compared with other settings such as primary care offices, surgical specialty offices, medical specialty offices, or hospital outpatient departments (Burt, McCraig, & Rechtsteiner, 2007). Approximately 45% of patients who seek care in an ED report the experience of moderate to severe pain (Centers for Disease Control [CDC], 2010). Prescription drugs, including opioids and benzodiazepines, were contributing factors in nearly 60% of all ED visits and in 70% of drug related deaths in the United States (Velez, et. al, 2005). Of additional interest to Washington State prescribers is pending legislation related to opioid prescribing, the
use of opioid equivalents, and requirements for mandated referral to a pain specialist. The effect that this legislation will have on the management of chronic pain is yet to be fully understood (State House Bill [SHB] 2876).

In 2009, the American Academy of Pain Management (AAPM) made recommendations to the medical community at large on the treatment of pain. According to these guidelines, treatment should be provided solely by a single practitioner or clinic. Narcotic use should be limited to circumstances where it enhances functioning at work and home. Escalating use, or seeking opioids from multiple providers, should prompt evaluations of the patient’s opioid use and consideration to discontinue opioid therapy (Chou, et. al, 2009). Based on these recommendations, the truth of what providers know and what they see in clinical practice are the socially constructed impetuses that drive the need for robust, multi-disciplinary research and treatment of chronic pain. Identification of socially constructed bias, acknowledgement of chronic pain as a disease condition and standardized and systematic plans of care could add to the body of medical knowledge and, in turn, improve care delivery to a protected population.

In an environment that is often characterized by rapid patient turnover, episodic care, and high volumes, chronic pain treatment recommendations remain enigmatic for emergency providers and increased opioid prescribing persists. Based on AAPM recommendations and pain management issues facing EDs today, a model known as ED Care Coordination, specifically Providence Sacred Heart Medical Centers (PSHMC) Consistent Care Program has a role to play in improving the systematic and multi-disciplinary treatment of chronic pain and providers, working in urgent and emergent care settings, can play a valuable role in this process. Social construction of provider practice and the relationship that forms with patients diagnosed with chronic pain has historically been considered within the biomedical paradigm. Chronic pain
demands a new form of health care—one that is sensitive to the full range of social, psychological, and spiritual, not just the maladies of their physical bodies. This challenges not the science of medicine, but the values and ethics of the biomedical paradigm (Guinn, 2003). The principles of beneficence and non-maleficence, social construction and the complex equation governed by biomedical ethics and societal values are considered within the domain of emergency medicine. It is social concern that drives the analysis of a historical perspective of pain and pain management, prescriber attitudes, and prescription monitoring programs versus consistent care programs.

**Literature Review**

**Methods**

Acknowledging the complex nature of chronic pain patients in relation to physical health, psychological abilities, and emotional well-being, a variety of databases were searched including CINAHL, PubMed, Cochrane Central Database of Controlled Trials, Google scholar, and Google for articles from 1998 to 2010. In addition to the list obtained through database searching, articles were also obtained by comparing reference lists of reviews, studies, editorials, reports, and websites. Keywords used were opioid(s), opioid abuse(r), chronic pain, pain management, emergency department pain guidelines, provider, and variations of these words combined. In addition, multiple information sites were accessed to help clarify regional statistics, current recommendations, and definitions. PSHMCs site is referenced as an existing consistent care program.

**Definitions and Theoretical Framework**

Social construction provides a framework for understanding the perspective of members that comprise the social setting of the ED. To say something is socially constructed is to
emphasize its dependence on aspects of our social selves. It is a sociological theory of
knowledge that states that social constructs are the by-products of human choice rather than
arising from nature (Boghossian, 2006). Many observers, both in and out of the medical
community, are of the opinion that those who misuse opioids have made their choice and deserve
little sympathy or recognition of their underlying predisposition to substance abuse. This could
explain why providers are reluctant to acknowledge chronic pain and, by extension, the efforts of
others to systematically treat a chronic condition within a consistent care framework.

According to social construction theorists, the belief and preferences of an individual are
not deduced from preconceived assumptions about human nature. Instead, they are constructed
under the influence of a social environment in which the beliefs and preferences held by other
members of the community exert influence on the individual that helps the individual to
determine what is deemed to be socially valued or preferred (Cox, 2001). According to this
theory, individual beliefs and preferences can exist independently from objective realities of the
physical world. This means that beliefs about the physical world have an influence on healthcare
providers and the way they construct their understanding of chronic pain. Within this framework
however, the provider may attach values to facts and give them special meaning; in turn, this
special meaning may influence the way that actions are planned.

For something to be socially constructed, what we know, plus what we believe, equals
what we perceive to be true. Truth changes if what we believe or know changes. As it relates to
pain, and chronic pain, the evolving definitions and treatment guidelines challenge what we
believe and what we know to be true. What we assimilate through clinical practice may change
what we believe.

Pain
Pain is defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage" (International Association for the Study of Pain [IASP], 2008). This definition recognizes both the physiologic and affective nature of the pain experience. Acute pain is the "normal, predicted physiologic response to an adverse chemical, thermal, or mechanical stimulus...associated with surgery, trauma, or acute illness" (Carr & Goudas, 1999) and generally subsides within days to weeks (ASA, 2004). There is usually no way to distinguish the experience of pain due to tissue damage from pain that has a psychogenic origin. If patients regard their experience as pain and if they report it in the same ways as pain caused by tissue damage, providers are necessarily required to accept the report as accurate; the interpretation should indicate that the patient is experiencing pain. This definition avoids tying pain to the stimulus (IASP, 2008). Margo McCaffery is a registered nurse and pioneer in the field of pain management nursing. Her definition of pain as "whatever the experiencing person says it is, existing whenever and wherever the person says it does" exists as an accepted conceptualization of pain for clinicians (McCaffery & Beebe, 1989, p. 7). In contrast, chronic pain is defined as pain lasting three months or longer and hyperalgesia is defined as an exaggerated response to stimuli that are typically painful, manifested by a heightened response to pain (Polomano, Dunwoody, Krenzischek, & Rathmell, 2008).

**Healthcare Provider**

Healthcare provider is broadly defined as a licensed provider of services, a provider of medical or healthcare services, and any other individual or organization that furnishes, bills, or is paid for health care in the normal course of business (CDC, 2010). For the purpose of this paper,
the following are defined as healthcare providers: Physician, Physician Assistant, and Nurse Practitioner.

A Physician is a health professional who has earned a degree of Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) after completing an approved course of study at an approved medical school. A Physician usually enters a hospital internship or residency program for at least 2 years postgraduate education before beginning practice or further training in a specialty (Wikipedia, n.d.). Physicians have no prescriptive restriction in Washington State and out-of-state prescriptions are accepted (Washington State Department of Health [DOH], 2010). A Physician Assistant (PA) is an individual academically and clinically prepared to practice medicine under the supervision of a licensed doctor of medicine or osteopathy. Within the Physician/PA relationship, PAs exercise autonomy in medical decisions and provide a wide range of diagnostic and therapeutic services. Prescriptive authority of controlled substances is as approved by the Medical Commission and out-of-state prescriptions are not accepted (DOH, 2010). National certification is available to graduates of approved training programs including a master’s degree in most states (Wikipedia, n.d.).

A Nurse Practitioner (NP) is an Advanced Practice Nurse (APN) who has completed graduate-level nursing education (either a Master’s or a Doctoral degree). All NPs are Registered Nurses (RNs) who have completed extensive additional education, training, and have a dramatically expanded scope of practice over the traditional RN role (Wikipedia, n.d.). NPs hold national board certification in an area of specialty, and are licensed through the state nursing boards rather than medical boards. Nurse Practitioners can be trained and nationally certified in areas of Family Health (FNP), Pediatrics, including Pediatric Acute/Chronic Care, Pediatric Critical Care, Pediatric Oncology and general Pediatrics (PNP), Neonatology (NNP),
Gerontology (GNP), Women’s Health (WHNP), Psychiatry & Mental Health (PMHNP), Acute Care (ACNP), Adult Health (ANP), Oncology (ONP), Emergency (as FNP or ACNP), and Occupational Health (nurse.org). In the state of Washington, NPs have no prescribing restrictions. Out-of-state prescriptions, with the exception of controlled substances, are accepted but all drugs prescribed must be within the scope of practice (DOH, 2010). General prescribing limitations for providers in the state of Washington include the following:

• A provider may not prescribe controlled substances for self, but is permitted for a family member.

• Prescriptions written by MD and DO from out-of-state or British Columbia may be dispensed with the exception of controlled substances from British Columbia. They are not DEA registrants.

• Prescriptions must be for a legitimate medical purpose and there must be a valid provider-patient relationship

• Drugs must be within scope of practice (DOH, 2010).

*Opioid Misuse, Abuse and Diversion*

Substance misuse is defined as the use of any drug in a manner other than how it is indicated or prescribed (Jamison, et. al, 2010). Substance (drug) misuse is a term commonly used for prescription medications with clinical efficacy but abuse potential and known adverse effects linked to improper use, such as psychiatric medications with sedative, anxiolytic, analgesic, or stimulant properties. Prescription misuse has been variably and inconsistently defined based on drug prescription status, the uses that occur without a prescription, intentional use to achieve intoxicating effects, route of administration, co-ingestion with alcohol, and the presence or absence of abuse or dependence symptoms (Barrett, Meisner, & Stewart, 2008).
Substance abuse is defined as the use of any substance when such use is unlawful, or detrimental to the user or others (Arnstein, 2010). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines substance abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress. This is manifested by one (or more) of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- Substance use in situation in which it is physically hazardous.
- Recurrent substance-related legal problems and the continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (American Psychiatric Association [DSM-IV], 2000)

A prescription opioid is considered diverted when it is given, sold, or traded to someone other than the patient for whom it was intended (CDC, 2008). In the terminology of the United States Drug Enforcement Administration, diversion is the use of prescription drugs for recreational purposes. The term comes from the "diverting" of the drugs from their original purposes. Opioids, such as hydrocodone and OxyContin, pseudoephedrine, Dextromethorphan, Depressants such as diazepam, temazepam, clonazepam, and alprazolam, and stimulants such as amphetamine and methylphenidate, are common drugs that are diverted, in an approximate order of popularity (Drug Enforcement Administration [DEA], 2011).

**Beneficence and Non-maleficence**

Beneficence is a principle of medical ethics according to which a person should do good to others, especially when one has a professional duty to do so (Stedman’s Medical online
As it relates to the management of chronic pain, the concept of beneficence relates to the adequate treatment of pain.

Non-maleficence is the ethical principle of doing no harm and is based on the Hippocratic maxim, primum non nocere; meaning “first do no harm” (Stedman’s Medical online dictionary, n.d.). This principle offers little guidance to providers since many beneficial therapies have serious risks. The treatment issue is whether the benefits (beneficence) outweigh the burdens (non-maleficence). Traditionally, by providing informed consent, providers give patients the information necessary to understand the potential risks and benefits of a proposed treatment and the patient assigned weight to the risks and benefits. Beliefs related to pain and practices related to pain management have evolved historically and this postulate is no longer presumably true.

“It is the imperative of science to seek truth and the ethical obligation of the medical community to apply such truths justly with respect for each patient so as to do no harm and facilitate overarching good” (Giordano, 2004, p. 409).

A Historical Perspective of Pain.

Historically, pain was generally a short-term problem because people died from pain causing illness. Major advances in healthcare enable people to live for decades with chronic illnesses that are often associated with pain. The definition of pain introduced in 1968 by a pioneer of nursing care of patients in pain, Margo McCaffery, is “Pain is what the person says it is and exists whenever he or she says it does” (McCaffery & Beebe, 1989, p. 7). Prior definitions of pain provided only the physiologic perspectives of pain. In the 1970’s the under-treatment of pain was related to the lack of education of healthcare professionals (Marks & Sachar, 1973). Numerous efforts were made to educate medical professionals. This culminated
in the development of clinical practice guidelines and the significant dissemination of standardized pain management guidelines.

In 1997, expert panels in the United States introduced clinical guidelines for management of chronic pain (ASA, 1997). The initial guidelines encouraged the expanded use of opioid pain medications when other treatments were inadequate and following careful patient evaluation and counseling. Between 1997 and 2007, during the decade following the publication of these guidelines, per capita retail purchases of methadone, hydrocodone, and oxycodone in the United States increased 13 times, 4 times, and 9 times, respectively (Automation of Reports and Consolidated Orders System [ARCOS], 2010).

In 2001, the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) introduced recommended pain standards (Phillips, 2000). These performance standards centered on patient rights, assessing and documenting pain, education of acute pain management to healthcare professionals, and the promotion of this education for patients and families. Pain assessment became known as the fifth vital sign. The resultant practice changes were increased pain assessment, opioid dosing, and reassessment of pain. Studies following the Joint Commission’s pain initiative indicated an increase in opioid requirements in the PACU without associated opioid-induced morbidity in the immediate postoperative period (Frasco, Sprung, & Trentman, 2005). Other studies reflect a greater incidence of opioid-related adverse effects with the Joint Commission’s mandate for pain control based only on numerical rating (Vila et al, 2005). Both studies effectively demonstrate an increase in patient satisfaction with pain control. The potential for adverse drug reactions and the importance of vigilant clinical assessment were well documented.
The role of professional medical organizations and their mandates necessitates a review of historical contributions to opioid management in the ED. Pain has been identified as a compelling reason for individuals to seek care in the ED (Eder, Sloan, & Todd, 2003). In Emergency care, pain is commonly and necessarily viewed as a symptom that guides the diagnosis of an underlying pathology. The Code of Ethics of the American College of Emergency Physicians formally recognizes an obligation to relieve pain as part of ED treatment (American College of Emergency Physicians [ACEP], 2008). In addition, ED providers are obligated to provide a medical screening evaluation for any patient presenting to the department as mandated by the Emergency Medical Treatment and Labor Act or EMTALA (42 U.S.C. § 1395dd).

Is pain an emergency medical condition that requires stabilization? Is avoidable or treatable pain a material deterioration of the patient’s condition? These two questions remain unanswered regarding pain and emergency medicine (Furrow, 2001). EMTALA provides for a private cause of action for violation of the statute and any individual suffering harm as a “direct result” of a hospital’s violation of the statute has a cause of action against the hospital (42 U.S.C. § 1395dd). It is the combination of the Joint Commission’s statement of Pain Assessment and Management (Phillips, 2000), evolving clinical practice guidelines, and tort liability that contribute to the historical perspective of pain management in the ED.

Patients who make multiple visits to EDs have been called “heavy users” (Malone, 1996), “repeaters” (Jacoby & Jones, 1982), and “frequent fliers” (Murphy, et al., 1999). If social construction applies, have chronic opioid users/misusers made a conscious decision or is the nature of pain and pain management to blame? What is the historical responsibility of providers caring for patients identified as “frequent fliers” who may or may not be abusers of the system
and chronically dependent on opioids for daily functioning? Referral sources have been identified in the research as scarce. Perhaps the answer does not lie in available referral sources, but in appropriate referral sources (Peikes, Chen, Schore, & Brown, 2010). Is a multi-modal plan of care, and a systematic, standardized approach to a chronic medical condition (i.e. pain), the answer to managing chronic pain?

**Physiology of Pain**

Pain originates when the perception and transmission of painful or injurious stimuli are stimulated by mechanical, chemical, or thermal injuries (acute pain). After this initial damage, tissues and inflammatory cells release a variety of mediators including histamine, serotonin, prostaglandins, and bradykinin (Besson, 1999). Substance P is released from the peripheral neurons in response to the injury and stimulates mast cells to release their contents. This causes a cascade of vasodilatation, increased vascular permeability, and activation of local inflammatory cells. The release of these mediators promotes local inflammatory action, sensitizes activated pain receptors and activates dormant ones. Amplification and further sensitization of pain receptors occurs and results in peripheral sensitization, a process whereby stimuli, not previously perceived as noxious, can evoke pain. Nerve growth factor is an additional insult to the up-regulation of pain receptors and further facilitates this process (Fields & Martin, 2008).

Once generated, the noxious stimuli travel through two distinct afferent pathways. An example of the transmission of pain via two pathways is the sudden, acutely sharp pain experienced by hitting a finger with a hammer, followed by a dull, throbbing sensation (Polomano, et. al, 2008). Excitatory neurotransmitters are released from the afferent neurons and play an important role in the transmission of pain signal centrally, as well as central sensitization
and hyperalgesia. Once noxious stimuli reach the sub-cortex and cortex, they create subjective and cognitive responses that determine an individual’s reaction to pain. This individualized response is further complicated by the fact that the peripheral and central pain pathways are not static. They change rapidly in response to environmental influences. This response to environmental influences is termed neuroplasticity, a process that describes the progression of inadequately treated acute pain to chronic pain (Carr & Goudas, 1999).

Since the late 1990’s, prescribers have been encouraged to address acute pain more aggressively from a perspective of beneficence. These same treatment options have the ability to do harm (non-maleficence). Patients have been advised to subjectively rate their pain and receive medication that would nearly alleviate their pain without the understanding that opiates have addictive properties and that due to up-regulation, they may not remain effective. The truth of what providers know and what they see in clinical practice are the socially constructed impetuses that drive the need for robust, multi-disciplinary research and treatment of chronic pain.

**Prescription Drug Monitoring Programs (PDMPs)**

In 1982, Texas began collecting data for Schedule II prescriptions. This program has since been expanded to cover Schedules III, IV, and V (Texas Prescription Drug Monitoring Program [PDMP], 2006). Pennsylvania passed legislation in 1972 but the program was not operational until 2002 (Pennsylvania PDMP, 2006). In 2009, a total of 40 states had laws allowing for prescription drug monitoring programs (PDMPs) but only 33 states have them in place, six have legislation enacted but are not operational and Washington’s program has been suspended due to lack of funding (United States Department of Justice [USDOJ], 2011).
PDMPs were created to help states address prescription drug abuse, addiction and diversion by gathering some or all of the following: patient name, date of birth, address, drug name, strength, and quantity, provider name and DEA, date written, refills and day supply (Foxhall, 2010). Prescription drug abuse/misuse has been identified as a key health issue by Healthy People, 2020 (U.S. Department of Health and Human Services [DSHS], 2010) and recommendations have been made to promote monitoring, educational, and community-based programs for the management of prescription drugs abuse. PDMPs were created with laudable goals but the lack of standardization is a critical element in examining the shortcomings.

Some states will notify prescribers and/or dispensers regarding patients receiving multiple prescriptions from multiple prescribers. The information gathered in the PDMPs is accessible to prescribers and dispensers but there is little guidance regarding what the provider should do with the information available. Some states do not require providers to even utilize this information. These states include: Alabama, Alaska, Arizona, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Minnesota, North Dakota, Ohio, Oklahoma, Oregon, South Carolina and Wyoming (Simeone & Holland, 2006). Additionally, Alabama and Wyoming do not provide civil immunity if the information isn’t used and Idaho and Illinois provide protection when information is accessed and used negligently but do not provide immunity for failing to access the program.

The goals established by the PDMPs are to support access to legitimate, medically necessary controlled substances, help identify, deter, or prevent drug abuse/diversion, and facilitate and encourage the identification of abuse/diversion. Additional aims include intervention and treatment of persons addicted to prescription drugs, outlining use and abuse trends of controlled prescription drugs, education of individuals about PDMPs, and the use,
abuse, diversion of, and addiction to controlled prescription drugs (DEA, 2011). The objectives of PDMPs are excellent but in a recent review article, (Baehren, et. al, 2010) the PDMPs fall short by not allowing interstate sharing of prescription history information. PDMPs are not National All Schedules Prescription Electronic Reporting Act (NASPER) qualified and do not allow interstate information exchange. NASPER is a federal grant for the establishment of PDMPs with interstate sharing that remains unfunded (NASPER, 2010). PDMPs do not have the ability to provide consistent alerts to regulatory boards, Medicaid, and law enforcement regarding potential “doctor shopping” or illegal and/or unprofessional conduct by health care professionals. Finally, PDMPs are not that “magic answer” that will independently and significantly reduce diversion and abuse of prescription medication.

PDMPs can be useful tools for clinical decision making and the prescribing of controlled substances. This is particularly true in the ED. In managing pain complaints, emergency providers are responsible for both beneficence and non-maleficence. Pain and suffering are to be treated while minimizing the enabling of substance abuse by both ED patients and, in extension, the general public. The medical community has acknowledged that opioid misusers need to be identified but little has been done to identify underlying predisposition to substance abuse or the clinical solution for treatment of a chronic condition. To date, little research has examined the efficacy and safety of PDMPs in clinical practice and none have been completed in emergency medicine (Todd, 2010).

**Current Prescriber Attitudes**

Chronic opioid therapy is now a common strategy for the treatment of nonmalignant, chronic pain. There has been an increase in chronic opioid therapy and a resultant increase in reported opioid abuse and deaths from prescription opioid overdose in the United States.
(Manchikanti, 2007). In Washington, an increase in overdose deaths among individuals receiving workers’ compensation benefits was observed between 1996 and 2002 (Franklin, et. al, 2005). This statistic occurred concurrently with a shift toward more potent Schedule II opioids and a 50% increase in average daily morphine equivalent dosing (Franklin, et. al, 2005). The Centers for Disease Control estimates that the number of ED visits for nonmedical use of opioid analgesics increased 111% from 2004 to 2008 (CDC, 2010).

Nationwide, there has been an increase in overdose deaths and ED visits involving use of prescription opioids (Hall, 2008). It is unclear whether specific aspects of chronic opioid therapy prescribing were related to adverse events. Deaths related to prescription opioid use might be attributed to abuse and diversion of opioids, or they might be accidental (Hall, et. al, 2008). A recent study by Braden, et. al (2010) concluded that the use of schedule II opioids, headache, back pain, and substance use disorders were associated with an increase in ED visits and alcohol- or drug-related encounters among adults prescribed opioids for 90 days or more.

An unmet need for education in acute and chronic pain management has been identified by current research (Chou et. al, 2009; Ferrell, & Juarez, 2002; Rupp & Delaney, 2004). Many providers are not knowledgeable about the consequences of pain management and are ill prepared to assess pain and monitor the physiological consequences of suboptimal or excessive analgesia (Arnstein, 2010). This may be correlated with a socially constructed resistance to acknowledge pain, and in extension, the efforts of others to systematically intervene and identify shortcomings in pain management education.

Pain is one of the most common reasons that patients seek help from health care providers and yet published information on Nurse Practitioners’ (NP) role in pain management are virtually non-existent. A large number of journal articles focus primarily on patients with
chronic pain who are receiving care in in-patient settings. In 2004, a study looking at the role of the NP in managing patients with pain identified two key features: pain consciousness and practice climate (Droes, 2004). Pain consciousness was defined as the NPs awareness and sensitivity to pain as a chronic health problem that a patient brought to the clinical setting. Practice climate was the regulatory atmosphere or environmental tone in which the NP functions (Droes, 2004). This study is an example of pioneering research. It revealed that NPs with high levels of pain consciousness, regardless of practice climate, related strategies in managing pain in accordance with recommended guidelines. The take away message from the preliminary research is the need for continued attention given to pain management. Professional associations, educational institutions, and legal agencies have an obligation to respond to this need and work to ensure that patients receive evidence-based, quality care related to pain management (Ferrel & Juarez, 2002).

In a poignant portrayal of a person in pain, Elaine Scarry explores the vulnerability of the human body in pain and the relationship between the sufferer and the caregiver. She describes the “model of certainty” in which the person in pain is absolute in her awareness and experience of pain while external observers (caregiver, provider) live in a “model of doubt,” always questioning the person’s pain. She concludes that “To have pain is to have certainty; to hear about pain is to have doubt” (Scarry, 1985, p. 13). The social deconstruction of provider perspectives and chronic pain may be validated by the preceding statement. The only thing certain in chronic pain management is the subjective reporting given by the patient. The appropriate treatment and the concepts of beneficence and non-maleficence may only contribute to the doubt. Provider perspective, training, and clinical experience in addition to patient perspective contribute to the balance of beneficence/non-maleficence.
Consistent Care Guidelines

Practice guidelines are assembled from a systematic review of the literature, evaluation and grading of levels of scientific evidence, related literature, and consensus among national experts (ASA, 2010). Once compiled, the guidelines provide a useful framework for rational decision-making and evidence-based practice. When well-designed guidelines are followed, variations in practice are minimized, processes of care improve, adverse events are decreased, and health care costs may be reduced (Polomano, et. al, 2008).

Care coordination is the purposeful organization of patient care to facilitate the appropriate delivery of health care services. According to the National Coalition on Care Coordination, this is a client centered, assessment based, interdisciplinary approach to healthcare integration (Brown, 2009). Components of care coordination generally include: 1) promoting patient-centered care and improving provider-patient communication; 2) increasing patients' adherence to recommended medications and self-care regimens; 3) facilitating greater communication between healthcare providers; 4) making medical care more evidence-based (Peikes, et. al, 2009).

Does this work? Controversy exists regarding the appropriate treatment of acute exacerbation of chronic or subjective pain in the ED. Opioid treatment for subjective pain complaints in the ED may seem compassionate by providing pain relief (beneficence), yet may also be harmful to the patient in the long term (non-maleficence) due to the lack of monitoring that is recommended by chronic pain guidelines. In 2009, the American Academy of Pain Management provided its recommendation on the treatment of pain that include single practitioner or clinic prescribing, evaluation of escalating use or high risk behaviors, and only dosing opioids to enhance function. Escalating use or seeking opioids from multiple providers
should prompt evaluation of the patient’s opioid use and consideration to discontinue opioid therapy (Chou, et. al, 2009).

A paradox exists with chronic pain and the ED. In 1996, a study by Zechnich and Hedges measured community-wide use of ED services by patients with drug-seeking behaviors. Chart reviews identified 17 patients who were told they “would receive no further narcotics” at a given facility. These patients subsequently received controlled substances from another hospital in 93% of cases and from the same facility in 71% of cases. If the problem is socially constructed, the resistance to acknowledge systematic pain management could be correlated to the concept what is known (pain management education) plus what is believed (clinical experience). Education on current chronic pain guidelines and an evaluation of provider beliefs may identify components required for a paradigm shift.

Early work has been done by pioneers in this field. In 2000, a study completed by Pope, Fernandes, Bouthillette, and Etherington demonstrated that a blanket approach to frequent users of ED services has little effect. However, a dramatic reduction in the number of visits to the ED by patients enrolled in a case management program was attributed to an individualized plan of care (Hall, 2008). Complex care plans were developed through a multi-disciplinary committee and provided close follow-up for each visit. Community resources, supportive counseling, and referral to a single primary care provider were utilized. The Consistent Care program at Providence Sacred Heart Medical Center mirrors many of the listed approaches. Further research is required to enhance efforts to provide multi-disciplinary chronic pain management. Perhaps Consistent Care is a model management approach that can be replicated and implemented in EDs nationwide as a starting point in addressing the management of chronic pain by limiting the number of narcotics that are dispensed by non-primary care providers.
Discussion

The EDs have reached a point in time where ignoring the problem of chronic opioid misuse is no longer a feasible option. Yet, despite well documented facts, little has been done to address the problem of substance abuse and the effect it has on the prescriber. Some of the biggest obstacles identified in the research were lack of clinical pain specialists, lack of money, lack of referral sources and training, reluctance of those misusing opioids to be treated by current guideline recommendations, and the differential attitudes of the staff and the public.

The lack of clinical pain specialists was easily the biggest barrier. Adequate funding follows as a close second and may be a contributing factor to the lack of clinical specialists. Budget constraints in private and public sectors and limited resources have forced those providing care on the front line to be overworked, emotionally depleted, and left feeling like they represent a fragmented service line. Simultaneously, a coordinated effort by federal agencies to crack down on prescription drug abuse is occurring (Wilsey, Fisherman, & Ogden, 2005). There is pending legislation in Washington State related to opioid prescribing, opioid equivalents, and mandated referral to a pain specialist. The impact this will have on the chronic pain management community is yet to be fully understood (SHB 2876). The combination of factors has produced reactions that complicate care. Skepticism toward patients reporting chronic pain can promote stigmatization, opiophobia, and under treatment of legitimate problems (Rapp & Delaney, 2004) and may create a counterproductive adversarial tone in provider-patient communications.

Education regarding the treatment of malignant pain management has been well documented. In 1997, the Institute of Medicine study, *Approaching Death: Improving Care at the End of Life* (Field & Cassel, 1998) recommended changes in undergraduate, graduate, and continuing medical education to improve the attitudes, knowledge and skills of practitioners.
caring for dying patients. Subsequently, advanced practice programs have added training in these areas to their curricula. Education regarding the treatment of acute pain has also been well documented but barriers exist. Personal bias, lack of knowledge regarding current pain treatment guidelines and fear of addiction have been identified (Weinstein, et al., 2000). It is intuitive to suggest that the lack of training in acute and malignant pain management correlates directly with the current problem of chronic pain management based on the principle of neuroplasticity. Education and training will play a major role in the establishment of programs developed to manage the chronic condition of pain associated with chronic opioid use.

Issues related to lack of referral sources are multifactorial and include lack of reimbursement, lack of training, and an inability to accept new patients based on the lack of health care providers. The patients tend to have complex problems including chronic illness, substance abuse, mental illness, and psychosocial deficits (i.e., homelessness, lack of resources). A multidisciplinary approach is required to manage these patients and typical family practice and/or internal medicine practices are not designed to deliver the following services: case management, mental health, drug and alcohol counseling and other public services (Hall, 2008). In fact, the answer may not lie in available referral sources but in appropriate referral sources. Merely billing for continued dysfunctional utilization would be a hollow achievement.

Indifferent attitudes emanate from the staff and the non-opioid misusing public who question how much money should be spent on substance abuse and misuse, and if this population deserves increased services. Despite the on-going criticism that “frequent fliers”, “heavy users”, and “repeaters” receive better care and more privileges than the majority of the general public, the reality is that this vulnerable population must rely on the system to provide their care. The
ED setting is neither equipped, nor trained to deal with ongoing and chronic pain management (Cordell, et. al, 2002).

The high prevalence of pain requires ED clinicians to become experts in pain management. Recognizing the high prevalence of pain in emergency medicine is the first step. The second step is acknowledging that the familiarity of pain complaints may create a culture of indifference in an environment that is often the last line of access for this group. Gallagher wrote “I wonder whether the ubiquity of pain renders it too familiar to merit concern... Is it trivialized by familiarity” (Gallagher, 1998, p. 278). Pain is more than physiological. Social concern has been explored utilizing Social Construction.

It is hypothesized that a care coordination approach to pain management in the ED is a novel program that coordinates ED care. An example is PSHMCs Consistent Care program (consistentcare.com). This program coordinates, organizes and facilitates communication between hospitals in this metropolitan area and the surrounding rural region. Facilitated communication between provider and patient, patient-centered care, improved patient adherence, and evidence-based medical care are the hallmarks of the Consistent Care program. The implication for patients and providers is a systematic approach to a chronic medical condition (Peikes, et. al, 2010). This standardized plan of care exists within a chaotic environment and offers excellent, evidence-based, chronic pain management.

Barriers such as reluctance of those misusing opioids to be treated by current guidelines and differential attitudes of the staff and public are removed as issues are addressed through a case-management approach with clear, concise, and transparent treatment standards. In theory, adapting this type of treatment plan in EDs will result in patients receiving a consistent message from ED providers. The future benefit to the prescriber, the system, and ultimately, the patient is
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