COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety Data Study

July 2019

A Look into Pain Management

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Few things grab our attention more than pain. On the positive side, it teaches us to avoid possible painful events, like playing with fire. Its nature can be anything from an irritant to debilitating, from temporary to permanent, and sometimes have detrimental effects on the quality of life. As Marcia Meldrum PhD[1] put it "Pain is a constant companion for humanity".

Narcotic Use and the Opioid Crisis

One cannot discuss pain management as a specialty without first addressing the role the opioid crisis has played in the issues raised in this study. In the 1980s there was a push for increased use of drugs to treat long term non-cancer related pain citing a "low incidence of addictive behavior" with narcotics[3]. Drug makers jumped on the bandwagon promoting narcotic prescriptions by physicians. In 2001 the Joint Commission, addressing the undertreatment/underassessment of pain, introduced the "5th vital sign"[4] and pain scales. Physicians were criticized for inadequately dealing with pain, and failing to do so got the attention of Medical Boards. Now, the pendulum has swung to the other side and we have an opioid "epidemic", which is causing the Medical Boards to investigate physicians for over-prescribing opiates. There is much debate over the cause of the new opioid epidemic, but what's not up for debate is that narcotics are addictive and need careful coordinated management.

Pain Management as a Specialty

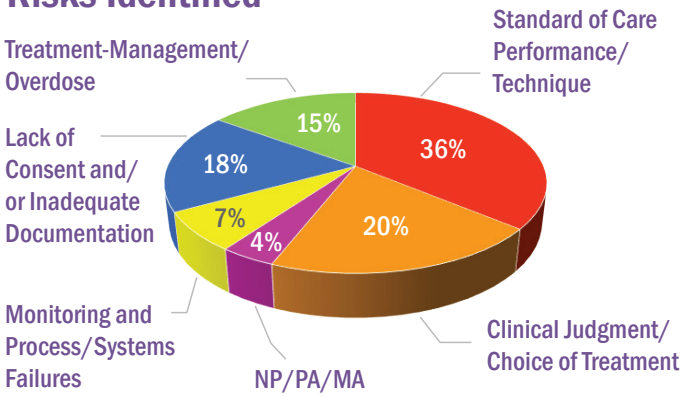
The field of pain management was first proposed as an anesthesia-based service in 1988[2] in the pre, peri and postoperative arenas. Our data study delves into the realm of CAP's experience in both the prescribing of analgesics and the use of epidurals in all the above areas.

What Our Experience Shows

Using a data range from 2005 to 2017, we analyzed 42 cases involving pain management through prescribing and/or epidural methods.

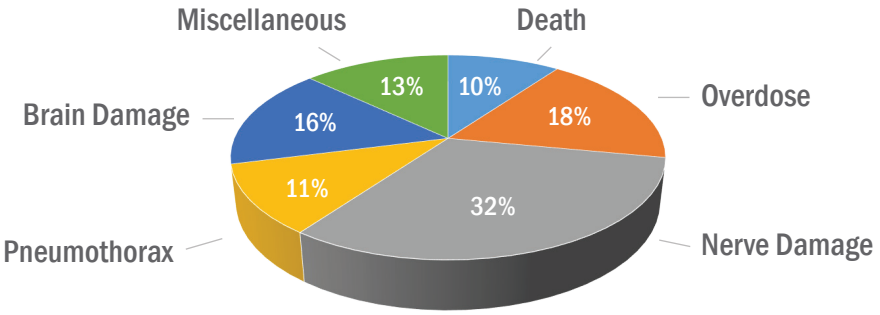
TOTAL INDEMNITY	$12.488M
TOTAL COSTS	$1.968M

Risks Identified



Study Caveats: By its nature, this study has a commingling of elements of risk with actual patient injury. It is difficult to correlate a single risk factor as the cause of a specific adverse event. For example, issues *with clinical judgment regarding the choice of treatment* occurred in 20% of the claims resulting in a range of injuries shown in the injury graph, including nerve damage, brain damage and death. The extrapolation with precision of those cases of clinical judgment resulting only in nerve damage (for example) is beyond the scope of this review. The same is true with claims resulting from shared issues of clinical judgment and standard of care/technique.

Injuries Related to Risks



Claims Reviewed by Injury

Nerve Damage

32%

Nerve damage, including paresthesia and paraplegias, represented the largest single event category, occurring in 32% of the cases reviewed. Slightly more than one third of these cases involved issues with the performance of epidural or other injections. As could be expected, small variations in technique, placement and/or manipulation resulted in outcomes as varied as complete pain relief to long-term nerve related complications. In those cases with unanticipated long-term nerve complications, a failure to preserve fluoroscopy images confirming appropriate needle placement severely compromised the defensibility of the involved care when litigation ensued. Even more problematic were those cases in which the medical record indicated fluoroscopy had been used during the procedure, but the images were no longer available. This situation can give rise to an implication the images were intentionally not preserved; after all, who wouldn't preserve images that demonstrated proper needle placement where the patient suffered an unanticipated nerve injury as a result of the injection?

Moral of the story – It's not enough to document fluoroscopy was used; the actual images should be preserved in the medical record.

Overdose

18%

Overdose was the cause of injury in 18% of the cases reviewed. The injuries seen in these claims involved brain damage and death, usually resulting from apnea/respiratory depression. The issues raised in the majority of these claims fell into two categories: failing to adequately monitor the patient, and failing to appreciate the compounding effect of other medications. In some cases, allied healthcare provider involvement added another layer of complication.

Case illustration: Patient presented for a refill of her pain pump medication. Both the refill and pump programming were done by a medical assistant (MA). The patient left the office in "good condition." However, the MA failed to document how long the patient was monitored prior to her departure. The patient drove home and was later found unconscious in her car parked in her driveway. Fortunately, the patient made it home before passing out. If she had lost consciousness while driving and injured herself and/or another driver, the physician and his MA would have had to defend their care with a less than adequate medical record. (Yes, you can be held liable to a third party injured under such circumstances.)

Moral of the story - The mandatory use of CURES (Controlled Substance Utilization Review and Evaluation System), effective 2018, may help limit/prevent the number of overdose cases by identifying multiple prescribers and drug seeking behaviors. Monitoring CURES for drug combinations and interactions is important. However, the CURES database will not affect those cases where clinical judgment is involved. Patients need adequate post procedure monitoring and advisements never to drive or participate in other hazardous activities after procedures involving medications known to induce cognitive impairment (with documentation thereof). **And medical assistants are never ever qualified to administer scheduled drugs without adequate training and supervision—period. It is important to develop systems and protocols for post-procedure monitoring, supervision, and follow-up as well as specific discharge instructions for each patient.**