



Pain Management in the Crosshairs: A CAP Roundtable, Part 1

Guests: Dr. T. John Hsieh, Dr. Medhat Mikhael, Dr. Charles Steinmann, and Dr. Jae Townsend

Moderator: Carole A. Lambert, MPA, RN

CAP: We recently had the opportunity to sit down with four CAP members who care for and protect patients as well as clinicians by their expertise and their experience. They are all anesthesiologists who are also interventional pain management physicians. Joining us were Dr. T. John Hsieh from Irvine, Dr. Medhat Mikhael from Fountain Valley, Dr. Charles Steinmann from Newport Beach, and Dr. Jae Townsend from Pasadena. What follows is Part 1 of the edited version of the roundtable. Dr. Steinmann got the ball rolling by sharing a brief historical perspective on the challenges of pain management while he's been in practice.

CS: The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain protects us from injury and disease. Fact is, we always will have to deal with pain. The trick is once the injury or disease is recognized, how do we shut off that response?

In one of the earliest recorded pain treatments, the ancient Egyptians used beer for surgical procedures. For the last few centuries, the gold standard for controlling

pain has been morphine. By the time of the Civil War, general anesthesia – ether or chloroform – was used in over 85 percent of all amputations on the battlefield. During the mid-20th century, other mechanisms began to be used, such as local anesthesia, pain blocks, acupuncture, antidepressants, pain pathway inhibitors like gabapentin, and anti-inflammatories.

By the late 1990s, it was still easier for prescriptions for pain medications – such as Vicodin or codeine – to be written that way. At the same time, multiple pressures were put on the physician to prescribe more. Because of the problem of addiction, now we are under pressure to prescribe less.

TJH: I've watched the pendulum swing throughout my career. In 1980, a letter to the editor was sent to the *New England Journal of Medicine*, stating that treating pain patients with narcotics would not cause them to become addicted to narcotics. This was a revolutionary statement, and that letter – with its observations and conclusions – became the most cited publication for the treatment of pain and influenced how physicians prescribed opioids for the following 25 to 30 years.

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Dr. T. John Hsieh



Dr. Medhat Mikhael



Dr. Charles Steinmann



Dr. Jae Townsend

But, pinpointing where and when the use and abuse of addictive substances really took off is difficult because our society has historically been a society of using pills. In the years I was going through high school and college, the use of cocaine and ready access to prescription drugs was obvious. It's very hard to say that physicians promote pill popping when it is such a part of American society. And there is the economic reality that prescription medications are big business, which has to be part of any attempt to deal with substance use and abuse.

At the end of the day, pain is very difficult to measure. It is ultimately subjective and unlike any other vital sign in that there is no real measuring device you can use. When you're treating pain, it is based on the patient's perspective and sometimes a lot more complicated than it first appears.

JT: My experience in collecting historical information for a patient going into anesthesia and then receiving post-op care just underscores the fact that every human being is wired differently. So, the wiring of a female is different from a male. A person who has had experience with pain throughout their whole life, or just even early in childhood, has different wiring than an adult who has no experience. As a society, as a culture, I encounter people daily who are about to undergo surgical procedures and have an unrealistic expectation that they're going to have zero out of 10 pain post-operatively. So as a society, we've set ourselves up to have an unrealistic societal expectation that you're never going to have any pain or suffering. We are a culture of pill poppers.

People have pills for every single thing from slight anxiety or slight depression to minor discomfort. Granted, there are plenty of times that this is warranted and appropriate, and I'm not undervaluing that at all. But we have to undergo nothing short of a cultural revolution in which we, as physicians, educate people that it's unrealistic to expect no pain. I typically tell my patients that we're going to have controlled or managed pain after surgery.

Over-prescribing originated due in large part to instances in which physicians were held accountable for patients with uncontrolled pain. Specifically, end

of life, death, and dying. There was liability, there was accountability, there were physicians who were sued. In consequence, I think clinicians overreacted and began over-prescribing because they were afraid of having patients complain about their being under-prescribers.

Let me just add that opioid use in the United States has consistently been the same. We just had opioid use that was prescription opioid use. Whenever there wasn't a lot of prescription opioid, there was a lot of heroin. Now that there's less prescription opioid, there's more heroin. People in this culture, in this society, are addicted to opioids and we have to have a societal change. So, back to your question. What do I do as an anesthesiologist to prepare patients? I do a lot of education about realistic expectations. I tend to refer to opioids as the poison. I'll give you some of the poison, but we'd like to get you off the poison as soon as possible. Sometimes, you need a little bit of the poison, but we're going to try to minimize it and create a situation where we use all sorts of alternatives, so you need as little as possible.

MM: You know, there is a huge unrecognized role of other medications in the increasing death rates from overdoses. The common factor among all these patients is how polypharmacy has contributed to a lot of the accidental deaths that have happened.

For patients with chronic pain, we may start by adding anti-seizure medications. Then we might add antidepressants. Some clinicians like to use anti-anxiety agents that they believe affect muscle relaxation. These medications contribute to depressing the central nervous system and, as a result, they can depress respiration and can lead to an overdose and death. This point has been addressed in the CDC guidelines, particularly with benzodiazepines and of the synergistic effects of drug combinations. Our patients ask why we want to review and maybe modify their medications when they have been on, say, Ativan and Norco for years without any problems. We tell them that if the patient is at a weak point – on any given day they were dehydrated, they had a flu, they were malnourished, they were sick for any reason – the combination of these medications was too much for them to handle and they ended up with an overdose or dying.

So, Dr. Hsieh and Dr. Townsend talked about the pendulum that has swung from one extreme to the other because the designation of pain as the fifth vital sign puts pressure not only on clinicians, but also on hospitals. If the HCAHPS score showed that patients rated you as controlling their pain well, your reimbursement was impacted positively. But if the pain score was down and the patient was below extremely well controlled, the reimbursement rate was negatively impacted. Now the government is recognizing this wide variation and its impact, so the 2018 changes to HCAHPS moderate the measure.

That shows you how the pendulum has swung. But we clinicians are challenged to care for our patients, to respond to their concerns, to prescribe and refer appropriately, all in an atmosphere of intense scrutiny and potential liability. We all need to continue to educate ourselves and then educate our patients.

CAP: Dr. Steinmann, you have a very active pain practice and you do injectables as well. Tell us about the patient education efforts in your practice and the staged interventions that you use, even in the face of patients' demands for ultimate treatment.

CS: Well, we try to answer the questions of how to protect the physician and the patients. My approach is, first of all, when you first meet a new patient, you have to document. Having worked with CAP on many cases, the biggest thing is communication closely followed by documentation. Dr. Mikhael has noted a real problem: We're given a pain patient and a situation where we may not have the time to be able to give him the full education. But it is our duty to communicate with the patient. I think communication is half the battle of a treating a pain problem.

There are things that are helpful for us as physicians. The CURES system is excellent to follow up to find out if patients are having other doctors write prescriptions. An agreement, whether oral or written, between the physician and patient is a good topic for us to talk about as well. But my basic plan is that the last thing I'm going to do is give a narcotic. So, I tend to start with anti-inflammatories.

I tend to use obviously injectables, like pain blocks and even oral steroids, before I would opt to going

to any narcotic, even Vicodin. And I've been relatively successful in doing that, but then again you have to look at the patient match. I tend to get patients that might be less pill-driven than other physician practices.

CAP: Dr. Townsend, you are a pediatric anesthesiologist. There's always been a concern about children being under treated for pain. How do you approach achieving an assessment and a treatment plan for a child in pain?

JT: I do acute pediatric pain management as well as anesthesia. Children are really different from adults, and the younger the child, the more so. For example, a premature neonate has different physiology than a full-term neonate. We know because there have been very eloquent studies done that have proven that children exposed to early painful experiences become adults who have poor mechanisms to control pain later in life. I also am involved with fetal surgery and we're not really sure exactly when a fetus starts to develop their top-down regulatory mechanisms, but we know they're certainly not there when we're operating on one at 16 and 17 and 22 weeks of gestation. So, we're providing analgesia that crosses the placenta to prevent a painful experience.

Studies have been done comparing children who had immunizations. All kids in the U.S. get immunizations at two, six, and 10 months and it hurts, but who cries the most? Other studies compare boys to girls. Boys who were circumcised with anesthesia were compared to boys who were circumcised without. Boys who undergo circumcision without anesthesia cry longer and harder and score inordinately higher on pain skills consistently through their childhoods. So, we changed our medical practice based on studies like this from the 80s. We started providing anesthesia for little, little children undergoing circumcision. Hopefully, you prevent a lifetime of enhanced pain perception that way. Interestingly, the kids who felt the least amount of pain were girls, and you would think girls and uncircumcised boys would be the same but they're not. That's because little girls, when they are born, have high levels of estrogen, and estrogen is very analgesic. Yay, girls! ➦

Part 2 of "Pain Management in the Crosshairs: A CAP Roundtable" will follow in the June issue of CAPsules.

Risk Management — and — Patient Safety News



The Synergistic Relationship Between Patients and Physician: What You Need to Know in Preparation for Healthcare Risk Management Week

by Steven Blackburn, MBA

Healthcare Risk Management (HRM) week starts June 18, 2018. In preparation for the week, it is important to understand the role risk management plays in creating a safe and protected physician-patient relationship. Healthcare is constantly evolving, keeping risk management personnel on their toes, researching old and new trends, and adapting methods and strategies that can be used as resources and tools for physicians, practitioners, and their staff.

At the Cooperative of American Physicians, our goal is to prevent issues by utilizing these risk strategies across the industry, reducing adverse events and claims. We want you to be your patient's superhero— without risk and stress — and CAP's Risk Management and Patient Safety Department can help. This includes increasing our member's awareness of proactive-related regulations and providing practice surveys to members on a consistent basis to ensure the practices are equipped with the most up-to-date arsenal of protection. We also staff a 24/7 emergency hotline to encourage early intervention as a means to help prevent an adverse event from becoming a claim, and even walk members through the safest ways to respond to events.

Risk management strategies can not only protect all stakeholders involved in your practice but can save substantial amounts of money by putting safeguards in place. These safeguards can create a less disorganized practice. Below is a list of current problems that continue to occur, and ways to practice implementing safeguards that can protect your practice from a malpractice claim:

1 Informed Consents and Informed Refusals

Informed consents and refusals are in place for a variety of reasons. They help the patient fully understand the procedure that is being done, they detail how and what was said by the physician, and they show proof that a patient accepted all the risks of that procedure or did not accept the risks of the procedure after receiving an in-depth education of the procedure.

- a) Informed consents and refusals should name the physician educating the patient. It is recommended that the physician who completes the consent or refusal sign the form to ensure their confidence in the inform consent or refusal that took place. Although not required, the physician's signature, along with a witness' signature, can be the key in determining that the patient understood and signed the consent or refusal on his or her own accord. Documentation in the patient's chart could reflect a phrase similar to "Informed consent (or refusal) performed on *date* at *time*" and the copy of the informed consent/refusal given to the patient and scanned into the chart.
- b) It should be completed in the practice before hospital pre-op and maintained in the patient's office record.
- c) The form should list common terminology and medical terminology, specific and general risks for the procedure, alternatives to treatment, and risks of not getting any treatment.

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2 Supervision of Physician Assistants and Nurse Practitioners

Supervising physicians receive claims against them when their supervised advanced healthcare professionals have an adverse event or a claim. The common response to a majority of these cases is, "I didn't do anything wrong, my PA or NP didn't keep me in the loop." As the supervising physician, having open communication with your delegated staff is very important. Be an active component in the physician/PA or NP team and make sure the supervised practitioner is aware of the policies and procedures in your practice. Those who work together in synchronicity are the safest teams in preventing patient injury and malpractice claims.

- a) When hiring a PA or NP, complete a Delegation of Services Agreement or Nursing Standardized Procedure for each practitioner.

- b) Board requirements for supervising a PA or NP differ slightly. Get familiar with the requirements for any practitioner that is brought on board.
- c) Remember, there are limits to the amount of advanced practitioners that may be supervised by one physician. Keep the ratio 1:4 in mind, one physician per four advanced practitioners. Any more than that, and it really wouldn't be supervising.

It all comes down to this: At CAP, we are here for you. Contact the Risk Management Department to schedule a practice survey to get the tools your practice may need or call the CAP Hotline at 800-252-0555 to address immediate needs of your practice. As a member, you are not, and will never be, alone! ↩

Steven Blackburn is a Senior Risk Management and Patient Safety Specialist for the Cooperative of American Physicians. Questions or comments related to this article should be directed to sblackburn@CAPphysicians.com.



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Implementation of CURES has Arrived

by Gabriela Villanueva


The federal Comprehensive Addiction and Recovery Act (CARA) to address the opioid crisis was passed and signed in 2016 with bipartisan support. The passage of CARA included federal grants to help boost state databases that flag patients who may be overusing prescription drugs.

In California, checking a database before prescribing opioids became mandatory with the passage of SB 482 in 2016 by Senator Ricardo Lara (D-Bell Gardens). The law requires physicians to check the state's Controlled Substance Utilization Review and Evaluations System (CURES) when prescribing Schedule II, Schedule III, or Schedule IV drugs for the first time and at least once every four months thereafter if the substance remains part of the patient's treatment.

A provision in SB 482 states that the requirement will not go into effect until six months after the state's Department of Justice certifies that the CURES database is ready for statewide use. At the time the bill was signed into law in October 2016, certification was expected to occur soon after but eventually experienced delays in its process out of the Attorney General's office.

Until recently, CURES was scheduled for a certification date in July 2018, meaning that implementation of mandatory use was speculated to begin in January of 2019. What's happened now is that the Attorney General's office has announced that as of April 2, 2018, the CURES database is ready for statewide use, having secured adequate staff, user support, and education for its use. With this announcement, it is now confirmed that mandatory CURES consultation becomes effective on **October 2, 2018.**

In order to be in full compliance, all California licensed prescribers must be registered to access the CURES 2.0 system. Prescribers will also be required to obtain and use tamper-resistant prescription forms ordered only from state-approved security printers. ➦

 CURES User Registration: <https://cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml>

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Are You Taking Advantage of Your CAP Member Benefits? Benefits You Can Take Home with You

Did you know that many of the benefits you're entitled to as a CAP member extend beyond helping you run a safer, more successful medical practice? Physician members and their entire staff can take home a host of high-quality programs and services designed to save money and/or make everyday life a bit easier. Below are descriptions of each and how to easily access them:



Car Rentals

CAP has established relationships with both Avis Rent a Car and Budget Rent a Car that can save you, your family members, and staff up to 25 percent off car rental base rates — plus enjoy additional offers like dollars off, a complimentary upgrade, or a free weekend day.

→ To reserve your vehicle through Avis, visit www.Avis.com/CAP or call 800-331-1212, referencing code **S131700**. To reserve your vehicle through Budget, visit www.Budget.com/CAP or call 800-527-0700, referencing code **D871000**.



Pet Insurance

We love our four-legged family members, but don't always love the expenses they incur. Securing pet insurance is one of the smartest things you can do to help keep your pet (and wallet) healthy. To make the decision easier, CAP members can take advantage of 10 percent off regular coverage rates from Pet Plan, the world's #1 pet insurance provider.

→ For a free quote, call 866-467-3875 or visit www.GoPetplan.com, using code **EBP2307**.



Financial Planning for Physicians

Hippocratic Financial Advisors is an independent wealth management firm specializing almost exclusively in the needs of physicians. Its advisors are deeply familiar with

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→ For more information, contact principal Ravi Davis at 323-238-3045 or ravi@hipadvisors.com. Or visit their website at <http://hipadvisors.com>.



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→ For more information, contact BofA's statewide Doctor Loan program specialist, Kristin Bati, at 949-300-0012 or Kristin.bati@bankofamerica.com



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Case of the Month

by Gordon Ownby



The Risks of Deviating from Your Usual Practices

When communicating with patients, a physician's "custom and practice" as to what he or she advises is often an acceptable substitute for granular detail in a chart entry. But when the physician departs from his or her custom and practice, it's easy for things to go wrong.

A 34-year-old woman visited Dr. GS, a general surgeon, for grade III infiltrating ductal carcinoma in her left breast. A hormone receptor analysis was mostly negative from a prognostic standpoint. Dr. GS encouraged the patient to get genetic testing to assist her in deciding whether to pursue radiation therapy or surgery. The patient opted for a lumpectomy and afterward underwent aggressive chemotherapy.

In an office some two months after surgery, Dr. GS and the patient again discussed genetic testing, with the patient deciding to undergo BRCA analysis, for which blood was drawn the next day.

A report prepared two weeks later showed the patient had a deleterious mutation in the BRCA1 sequencing. The report noted that "although the exact risk of breast and ovarian cancer conferred by this specific mutation has not been determined, studies in high-risk families indicate that deleterious mutations in BRCA 1 may confer as much as an 87 percent risk of breast cancer and a 44 percent risk of ovarian cancer by age 70 in women." The report continued that after a first breast cancer, there was a 20 percent risk of a second breast cancer within five years and a ten-fold increased risk of ovarian cancer.

Though Dr. GS initialed the report showing that she

received it, the record bears no indication the patient was advised of or received the results. Dr. GS's later belief was that she spoke to the patient by telephone but that she did not alert the patient to a concern regarding the results. The patient saw Dr. GS twice again that year to remove her Mediport and for a breast check. Two visits the next year included a normal mammogram and no new complaints with regard to the patient's breasts.

Six years later, Dr. GS learned that her patient had been diagnosed with Stage III ovarian cancer and carcinoma of her right breast. Dr. GS received a report by fax from a genetic testing clinic showing that the patient reported to the clinic that she had an earlier BRCA test performed, which was reported to her as negative.

The patient sued Dr. GS for negligence and claimed that the surgeon failed to properly inform her of the results of her BRCA analysis. Had she learned of the true results, she claimed, she would have had a bilateral mastectomy and bilateral salpingo-oophorectomy. Dr. GS and the patient resolved the litigation informally.

Physicians typically develop their own custom and practice with regard to advising their patients of significant test results. The legal value of a physician testifying on custom and practice is that if the physician has no reason to believe that he or she diverted from a usual practice with a particular patient, the physician can testify in great detail on the medical advice given to the patient, even if all such details do not appear in the record. But in varying from one's custom and practice by, for example, reporting important test

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results over the telephone instead of in a face-to-face meeting, a physician can lose such testimony — while also jeopardizing the delivery of information that an in-person meeting might better afford. ↩

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

Unbeatable Rates for Personal Umbrella Coverage

Whether it's wishful thinking or just poor planning, most of us don't give much thought to preparing for a possible calamity. But life happens and an incident such as an automobile accident or slip and fall by a visitor in your home can leave you vulnerable to a substantial liability claim to your personal lines policy — especially when an opportunist sees a doctor as a source of "deep pockets."

That's when personal umbrella coverage becomes an essential part of your collective insurance protection. This must-have coverage will provide you and your family members with additional liability protection should you be faced with a lawsuit that exceeds the coverage provided under your automobile, tenants, homeowners, recreational vehicle, or watercraft insurance policies.

Take, for example, a CAP member who was involved in a head-on car collision with a gentleman who sustained severe head injuries and could no longer work in his high-paying job. Without sufficient personal umbrella coverage, our member would have been responsible for over \$3.5 million in lost wages, medical bills, and other related costs, putting his personal assets at risk. Are you prepared for that kind of loss? Probably not.

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