

ROADBLOCKS TO EFFECTIVE PAIN TREATMENT IN THE UNITED STATES

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INTRODUCTION

There is evidence that all types of pain are inadequately managed in the United States and that this was true long before the advent of managed care.^{37, 39, 42} This situation is likely due to a number of social factors, including the following:

1. Inadequate training of medical, nursing, and related health care providers in techniques of pain management, including the appropriate use of opioids.
2. Inadequate public and professional knowledge about the pathophysiology and psychosocial aspects of pain and inadequate resources available for appropriate management.
3. Fear of punitive action against practitioners who use opioids.
4. Charlatanism in the area of pain treatment.
5. Paucity of treatment guidelines and *best practice standards* which, in part, is secondary to the difficulty in collecting and analyzing uniform treatment outcome measures in this large and heterogeneous patient population.
6. Roadblocks to access of care by experienced pain medicine practitioners for a variety of reasons.

Public interest in the problem of pain is mounting. Several states have developed Pain Commissions or investigative and advisory task forces to study the issues^{1, 31} and recommend legislation. Intractable pain treatment laws or regulations have emerged.^{2, 23} Despite efforts such as these, the plight of many chronic pain patients remains quite real. Patients are, for the most part, often poorly understood; seriously undertreated or overtreated; and sometimes seen as social outcasts by friends, family, and other support systems. Underscoring these kinds of issues is the undeniable fact that Americans have been unwilling to pay for some basic level of health care for all of its citizens. The elderly and chronically ill, who are more likely to suffer with problems of pain, are therefore likely to be among those who are disenfranchised by the system. Without a national health plan, Americans are left with an unregulated health care delivery system driven by multiple and often, conflicting interests.

ROADBLOCKS TO MEDICAL CARE

Conceptually, barriers to health care in general can be classified as extrinsic and intrinsic to the health care system. Extrinsic barriers include administrative, regulatory, and socioeconomic roadblocks. Intrinsic barriers include issues of competence and availability of care. Pain Medicine, an emerging medical specialty with a well-defined body of knowledge and circumscribed scope of medical practice, has its own set of roadblock issues. This article

discusses both the general roadblocks and those that in addition, are specific to Pain Medicine, and to the special population of patients that it serves.

Many physicians, beleaguered by loss of autonomy, decreasing revenue, and threats of professional liability, focus on extrinsic barriers. Patients confronted with denial of access to specific practitioners or treatment modalities by managed care organizations, understandably also focus on such extrinsic roadblocks. This perception gives rise to the increasingly loud chorus denouncing managed care and its associated administrative and regulatory tools of enforcement. It is equally important, however, to recognize that there are several intrinsic barriers to effective health care, roadblocks that are inherent to the medical profession. Among the general extrinsic barriers are; (1) inadequate financial resources (millions of Americans remain uninsured or underinsured, and the numbers grow daily); (2) professional liability threats that create tension between the overutilization associated with practicing defensive medicine and the utilization management that ratchets down access to care; (3) regulatory barriers associated with government-sponsored programs; (4) managed care techniques, and; (5) chaos within the business community as the financing of health care continues its rollercoaster ride. Intrinsic barriers include; (1) medical workforce issues, such as maldistribution of medical specialists; (2) clustering of high competency specialists and high technologic resources within a few regional and academic institutions; (3) decreasing financial resources for adequate medical training, research and maintenance of existing health care facilities; and (4) lack of quality of care at the physician-patient encounter level characterized by underuse, overuse or misuse of services.⁶

Roadblocks to effective pain treatment are encompassed by the extrinsic and intrinsic barriers to general medical care previously discussed. Pain Medicine is a unique specialty that experiences some additional discrete barriers to effective pain treatment. Inadequate financial resources create a major barrier. Prolonged management of complex persistent pain problems is expensive. In the event that health care insurance is nonexistent or pain treatment is not a covered benefit, patients generally have inadequate financial resources to assume personal responsibility for their care. Health care insurance, even when providing coverage, is often inadequate or depleted. Some of this relates to diagnostic and therapeutic coding problems. There are no distinct ICD-9 codes, which clearly identify persistent pain problems, particularly those that do not have a recognizable disease entity defined by histopathologic considerations.³⁰ The CPT codes used to identify medical services and surgical procedures tend to be inappropriate for the specialty of pain medicine. Evaluation and management codes particularly do not encompass the work, as defined by time and complexity, necessary to evaluate properly a patient with complex pain problems.⁴⁰ Many of the medical services and diagnostic and surgical procedures relevant to pain medicine are not adequately valued to recognize the work involved.

Many of the extrinsic barriers to effective pain management are the result of an identity problem. Although Pain Medicine is a distinct specialty and is recognized as such by the American Medical Association and many other specialty organizations, it still lacks credibility and true identity from the viewpoint of many administrative and regulatory agencies and third-party payers. Often the specialty of Pain Medicine is confused with subspecialties in pain management, representing components of other primary specialties. Even more devastating is the confusion of Pain Medicine with unorthodox modalities of treatment that are elements of the health care community. Understandably, in the face of such rank confusion, third-party payers,

managed care organizations, regulatory agencies, and even other medical specialists are reluctant to acknowledge the legitimacy of pain medicine or to provide benefit coverage for pain problems. To remedy this situation, it is imperative for the specialty of Pain Medicine to achieve a clear identity as a legitimate and credible specialty.

Restrictions imposed on prescribing controlled substances, particularly opioids, represent a unique barrier to effective pain management. Oversight of controlled substances is within the purview of the Federal Drug Enforcement Agency (DEA) and state medical licensing boards. There is a widespread perception that these agencies have exercised surveillance and control over physicians with excessive and misdirected zeal. Many of the existing statutes and regulations are antiquated. Pain organizations (American Academy of Pain Medicine and American Pain Society) have done an excellent job of educating regulators at the federal and state levels and achieving more enlightened regulations and policies.^{2, 43}

Expectations of patients suffering from persistent pain problems are often unrealistic, albeit for understandable reasons. Many patients with persistent pain problems have had prolonged, ineffective and unpleasant relationships with physicians and other health care providers. Such patients are confused, angry, conflicted, depressed, impoverished and alienated. They expect complete and immediate relief of pain and suffering at minimal expense. Not only are such expectations unrealistic, but also the effective management of complex pain disorders is at best prolonged, expensive and incomplete.

Perhaps the single greatest intrinsic barrier to effective pain management is the lack of a clear identity for the specialty of Pain Medicine. This transcends the lack of recognition and credibility by outside providers and organizations. It includes physicians who are dedicated to treating pain disorders, many of whom fail to recognize or acknowledge the difference between a subspecialty of pain management and a specialty of Pain Medicine. Even physicians who classify themselves as specialists in the field of Pain Medicine may not appreciate the body of knowledge and scope of practice of this particular field.^{17, 35, 36}

Research in the treatment of pain disorders lags behind other fields of medicine. There is a paucity of evidence-based methodology in Pain Medicine. There is a dearth of data concerning pain management based on sound scientific studies using outcome criteria. The cost-effectiveness of much of pain management today cannot be adequately supported. In the face of such deficiencies, coverage and reimbursement for the management of pain disorders is often difficult to obtain.

Education in pain management is virtually nonexistent at the graduate and postgraduate levels. A survey of medical schools in several states indicates that few hours beyond the basic courses in pharmacology are devoted to the recognition, evaluation and management of pain disorders. Residency training programs, particularly those in primary care, frequently do not provide adequate education in the area of pain management. There is some indication that certain specialty fields do require training in pain management as part of the special requirements imposed by the American College of Graduate Medical Education.²¹ More education is necessary at all levels, however, including medical school, residency training, fellowship training, and continuing medical education. It is imperative that the specialty of Pain Medicine

work with educators in these areas to achieve a broader, more comprehensive educational opportunity for physicians.

It is widely recognized within and outside the medical profession that physicians in general have not performed credibly in the alleviation and management of pain disorders.^{7, 8, 39} Patients still suffer needless pain postoperatively. Pain associated with malignant disease is not effectively managed in many instances. Persistent benign pain problems, including those falling into the diagnosis of *Pain Disorder* (as listed in the Diagnostic and Statistical Manual of Mental Disorders [DSM IV]), are subjects of confusion and mismanagement. The focus of Pain Medicine is *pain*, not so much as a symptomatic manifestation of a nociceptive stimulus but rather as a distinct multifactorial illness with biopsychosocial components.³⁶ To appreciate the specialty of Pain Medicine, it is necessary to differentiate between category I pain, frequently referred to as *acute* or *subacute pain*, and category II pain, frequently but erroneously referred to as *chronic pain*. For the sake of clarity, category I pain has been designated as *endynia* and category II pain as *maldynia*. Although these concepts have been articulated and have been accepted by the leadership of organized Pain Medicine, much work needs to be done to educate the medical profession and the public. It is particularly imperative that orthodox palliative medicine recognizes the validity of maldynia as an entity consistent with the biomedical model on the basis of cellular and molecular pathology. The problems in clinical practice are those of underuse, overuse and misuse of services, and frequently misguided efforts to relieve the suffering of these patients.³⁹ Many of these problems relate to the poor education of physicians with respect to recognition and management of a wide spectrum of pain disorders. The alleviation of this particular barrier is multifactorial. Clearly, education of the medical profession is in the forefront. Education of the public, third-party payers, managed care organizations and regulatory agencies is also necessary to remove the extrinsic barriers. Efforts must be mounted to correct the present undersupply of physicians who are adequately trained in Pain Medicine and are committed to the evaluation of care of patients with pain disorders. Quality assurance and peer review mechanisms must be established to detect and eliminate marginal practices that prey on an unsuspecting public.

MANAGED CARE INDUSTRY

To achieve optimal medical care outcomes, a balance must be reached among various competing needs and values. These include individual and societal health care needs and expectations; the availability of care to those who cannot afford it; costs to individuals, payers and society; and expectations of medical practitioners for rewards commensurate with the value of their services. For years, it was broadly presumed that physicians had a commitment and responsibility to their patients, themselves and society in achieving this balance. Physicians, however, are not well equipped to meet that degree of responsibility in today's world and have fallen short of that expectation.³⁸ Managed care, at least in its idealized form, is aimed at filling the gap left by medicine and bringing together sufficient resources and expertise to provide *rational agency* for the various stakeholders in the health care system.⁵ Whether the turmoil that surrounds managed care today bears greater witness to its success or failure in reaching that target remains to be seen. In the meantime, it would be helpful to medical providers to understand some of the issues facing organizations that lead to the creation of roadblocks for them and their patients. This approach, instead of unbridled *managed care bashing*, would be a positive step toward the

development of more integrated, effective and efficient health care delivery systems of the future. The shift of authority from patients and physicians to a wide variety of private and, more recently, public managed care organizations has raised important questions about the fairness and legitimacy of decisions that limit medical care.⁶ These questions are at the heart of the so-called *managed care backlash* occurring today. Perhaps the most glaring shortcomings of managed care organizations pertinent to this discussion are the general absence of outcome data, clinical algorithms or *best* practice information, that enable managed care organizations to (1) select and deselect panel members most intelligently; (2) establish reasonable health plan limits; (3) employ utilization management or utilization review standards fairly; (4) employ other potential utilization or cost reduction processes, such as demand management, quality management, disease management, and wellness programs; and (5) establish criteria by which to include *last chance* or investigational therapies.^{10,11} This last issue is of particular concern to many pain practitioners, who sometimes serve dying patients requiring heroic and expensive treatments or who employ new technologies in an effort to serve complex pain patients better. A general absence of clear-cut statements detailing the reasons for coverage restrictions by many managed care organizations has led some to call for definitive public policy over this issue.⁹

The behavior of managed care organizations has been affected by (1) federal and state regulatory changes; (2) voluntary accreditation by outside agencies, such as the National Council on Quality Assurance (NCQA) and the American Accreditation Healthcare Commission/URAC; and (3) the response to public demand for more accountability. The fact remains that the ability of managed care organizations to serve as society's *rational agents* in the evolution of a just and equitable health care delivery system in the United States remains severely compromised. The *trend* toward value added services in place of, or as an adjunct to, cost containment can only be lip service until appropriate outcome data are available. Without this, according to Eddy,¹⁵ "The necessary connection between value and cost has been largely severed." It is tragic that the health care industry has lagged so far behind other sectors of American business in the use of technology and resources to develop these kinds of information. Who should take the responsibility for developing it, and how can it be coordinated and standardized to be generally useful and publicly available?

FEDERAL AND STATE GOVERNMENT

Despite the failure of the Clinton Administration to develop a national health plan in 1993, which would have significantly altered the American health care delivery system, the federal and state governments still underwrite 40% of the health care in the United States. Similar to the private sector of the healthcare industry, there are enormous problems faced by government, some of which are shared by other sectors of the industry and others that are unique. For example, the cost to the Social Security Administration for people in pain is a major issue, which was reviewed by Turk et al in 1988.⁴⁴ The regulatory barriers to treatment for the unique population of pain-disabled patients remain unchanged in the Social Security System since that report. After the failed Clinton proposal, many of the health care issues were relegated to state government and private industry.

Regulatory agencies at the federal and state levels have imposed increasingly burdensome statutes, regulations and policies on the medical profession. An aging population, with increasing

enrollment in Medicare programs, has made the Health Care Financing Agency an increasingly greater presence. Frequently changing convoluted and arcane rules and regulations, progressively decreasing reimbursements, and increasing threats of investigation and conviction for perceived *fraud and abuse* in the Medicare system have become challenges for participating physicians. At the state level, increasing rolls within Medicaid programs mirror the threats of the national Medicare program. The increased *hassle* factor, threat of litigation, and low rates of remuneration have taken many physicians and other health care providers out of the field, thus limiting access to needy patients.

PHYSICIANS AND ORGANIZED MEDICINE

It is time for individual physicians and organized medicine to take more accountability for their role in the perpetuation of the chaotic, disorganized American health care delivery system. Pain practitioners, similar to other medical specialists, and the professional organizations that represent them (such as the American Academy of Pain Medicine and the American Society of Anesthesiologists) need to stop finger pointing at other sectors of the health care industry. In an eloquent discussion of the reality of current American medical practice, Millenson³⁸ calls on the medical profession to take an intelligent look at the delivery system and to take a meaningful role in the changes ahead. This involvement requires a hard look at current truth. That truth is that the old structure failed to contain runaway health care costs and failed to protect patients from ineffective, inappropriate, or even dangerous care. It also failed to guarantee that most medical practice was truly anchored in sound medical science. In today's age of medical accountability, the presence still of unsound medical practice should no longer be tolerated by the medical profession.

Physicians are to blame for the absence of outcome-based clinical guidelines and algorithms for the evaluation and treatment of patients in pain. Thus, some of the roadblocks that practitioners perceive to have been imposed on them by government or private business are, in fact, their own creation. Enough information has now been gathered about the basic science aspects of pain and about both effective and ineffective treatment of a whole variety of patients in pain. Organized Pain Medicine has failed to exert effective leadership, either in the education of health care professionals or in the development of pain treatment guidelines. Pain specialists, similar to many other medical practitioners, have allowed their individual needs to prevail over a more worthy public cause—that of exerting unified leadership in the cause of people in pain. Berwick, President of the Institute for Healthcare Improvement, has called on physicians to understand that, “The solo doctor who embodies (by himself) every process needed to ensure highest quality care is now nearly a myth.”³ Rather, a new paradigm of medicine calls for continuous quality improvement within an ever-changing health care delivery system. This improvement requires the highest degree of teamwork and deference to both the individual skills of the outstanding physician and the kinds of information that technology within the new delivery system can provide. Reputation-based medicine alone can no longer carry the day. As Berwick puts it, “How good you are doesn't say how good you can be.”

IMPLICATIONS FOR PAIN MEDICINE SPECIALISTS

In addition to the considerations above, it is important that Pain Medicine specialists realize that in many situations, they may be called upon to play multiple medical roles in the life of their chronic pain patient: primary care physician, specialist, medical and/or spiritual advisor, educator, medical case manager and liaison among the multiple other parties who may be involved with the case, including other health care providers, managed care professionals, attorneys and family members. Much is asked of us in these roles, which often require our non-billable time. I personally believe that this needs to be considered to be the cost of doing business in this specialized area of medicine. There are other compensations and rewards for our service.

Pain Medicine specialists can turn to other resources for help in assuming these important multiple roles. For example, there are sources of educational material for patients and other health care professionals on the Internet. A good source of general pain information can be found at http://dir.yahoo.com/Health/Medicine/Pain_Management/. The American Academy of Pain Medicine offers its newsletter, along with position papers and information about educational meetings at <http://www.painmed.org>. The National Foundation for the Treatment of Pain is at <http://\paincare.org/default.htm>. The Website for the National Pain Foundation is www.telsoftcorp.com/npf1.

Whenever possible, early referral to a recognized pain specialist should be encouraged, as it may help to prevent the vortex of events that often leads to permanent disability. Recognize, however, the difference between specialists who offer palliative care (pain management), such as Anesthesiologists who specialize in nerve blocks, from those who are trained to evaluate and treat all of the medical and social issues associated with chronic pain (Pain Medicine). While there is compelling evidence⁴⁵ that referral to Pain Medicine clinics improves the quality of life of chronic pain sufferers, the risk of caring for this population has been gradually shifting unfairly from payers to healthcare professionals. PCPs who accept global capitation contracts, for example, may have to assume the responsibility of directly caring for or triaging these patients to specialists who may accept none of the risk. This creates enormous ethical pressures on the PCP to “do the right thing.” Before succumbing to these pressures by either denying care, pretending that such patients do not exist or are “crocks,” or throwing up one’s hands in despair at the unacceptable aversive behavior of the payers, we would urge a more proactive stance. This might include: (1) learning who the local and regional pain specialists are; (2) engaging them in risk-sharing healthcare delivery models for the sake of the health of the community (this requires dedication, personal sacrifice and creativity, as well as administrative skill and support); and (3) learning what community resources are available to help patients, such as pain support groups and hospice. Patients in pain deserve our best efforts and our mercy, whether that be in the arena of end-of-life care, those dying with painful conditions such as cancer or AIDS, or those disabled by a large number of other medical, psychological and social problems.

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