Response to Dr. Oliver’s Letter

Dear Editor,

I thank Dr. Oliver for his interest in my report on “Breaches of Standards of Medical Care in Chronic Opioid Analgesic Therapy” [1] where Controlled Substance Model Guidelines were applied to the case review by the “experts” to determine if there was a “standard” breach [1]. This case was presented (as a number of others [2–4]) from the standpoint of the “experts”—the plaintiff’s expert’s allegations as to where the defendant fell below the “standard” and the defendant’s expert’s responses to those allegations. This format was [2–4] and is chosen in order to alert the pain community on how “experts” currently interpret the “standard.” So, if the plaintiff’s expert did not view an issue in the case as falling below the “standard,” it was not identified or discussed as such an approach would bring in the opinion of the writer, which may not necessarily be the “standard.” For this reason, only information available to the experts reviewing the case was presented and nothing else. Finally, because the experts chose the Model Guidelines for the “standard,” these were discussed with emphasis on where the plaintiff’s expert alleged a breach. Unfortunately, the information mentioned earlier may not have been transmitted in the way the case was described, as some of Dr. Oliver’s comments indicate that this format was not understood.

Dr. Oliver points out that the first element of the model guidelines (diagnosis) was glossed over and not discussed. He states rightly that chronic right-shoulder pain is a symptom and not a diagnosis and therefore implies that there was a breach here. In response, I would call attention to the fact that the plaintiff’s expert did not identify this as a breach and this is the reason why this was glossed over. In addition, in the vast majority of patients with chronic pain, no firm diagnosis can be reached (about 80% of chronic low back pain patients have nonspecific low back pain (LBP) [5]). Should all these chronic LBP patients be denied chronic opioid analgesic therapy (COAT) because there is no diagnosis to explain their pain? Some clinicians now consider chronic pain and chronic benign intractable pain as genuine diagnoses. Perhaps this is the reason why the plaintiff’s expert did not identify lack of diagnosis as a breach. Note here also that the Model Guidelines do not specify the type of diagnosis required.

Dr. Oliver implies that because of the history of substance abuse disorder (SAD) that this patient should not have been placed on COAT (also plaintiff’s expert’s Allegation # 3). However, as pointed out in the discussion [1] the Model Guidelines do not preclude a chronic pain patient (CPP) with a present or past SAD history to be placed on COAT. In addition, the American Pain Society and American Academy of Pain Medicine have stated that such patients should not be deprived COAT if required [1]. Because of this, there was no official breach here. However, she should have been placed on “compliance monitoring” [1] from the beginning of COAT treatment as discussed [1]. This was actually the plaintiff’s expert’s Allegation # 6 [1].

Dr. Oliver echoes the allegation of the plaintiff’s expert in that old medical records should have been obtained in a CPP with SAD (Allegation #2). As noted in the Discussion, this is one of the recommendations of the Model Guidelines applying to all patients considered for COAT.

Dr. Oliver suggests that the defendant fell below the “standard” because he did not: 1) coordinate care with other physicians treating her; 2) send her to an SAD counselor; 3) check with the methadone clinic and; 4) check with surrounding pharmacies. As pointed out in the discussion [1], the defendant could not coordinate a treatment plan (plaintiff’s expert’s Allegation #4) because to his knowledge there were no other physicians treating her. However, the defendant could have and should have sent the patient for an SAD consultation before beginning COAT treatment. Not checking with the methadone clinic was identified as a breach by the plaintiff’s expert under the rubric of failure to get records (discussion [1]). Failure to contact surrounding pharmacies was not identified as a breach probably because a prescription monitoring program was not available. In addition, it is currently unclear whether this step should be considered a “standard” under the Model Guidelines (the guidelines are not specific on the types of medical records that should be obtained). In my opinion, this step may eventually become a standard before COAT.

Dr. Oliver implies that because of no diagnosis, suspicious non-healing, significant opioid requirements (four 10-mg tablets of hydrocodone and 10 mg methadone), high pain ratings, history of SAD, no improvement in function and no improvement in pain levels that a diagnosis of factitious disorder/psychogenic pain should have been considered and that a reasonable physician should have terminated COAT. Failure to remove the patient from treatment for these reasons was not one of the allegations of the plaintiff’s expert. In addition, some clinicians would disagree that any or any combination of these reasons are indications for COAT termination. However, these reasons could be an indication for compliance monitoring and urine toxicologies as discussed [1]. There is also significant controversy over the whole concept of psychogenic pain and this diagnosis no longer exists as such. There have been only two cases of factitious disorder reported in the pain literature (both by myself). This diagnosis can only be made by the patient admitting that he/she is fabricating his/her pain to get drugs and/or catching the patient in the act of fabricating his/her illness (e.g., injecting insulin in
order to fabricate hypoglycemia). The difficulty in getting this type of evidence for this diagnosis is the reason why there are so few cases in the pain literature. In my opinion, this patient was abusing her medications and others, which could have been identified with compliance monitoring (urine toxicologies) and under these circumstances, the patient could have been offered alternate treatment [2].

Dr. Oliver asserts that "Dr. Fishbain claims that the patient had no aberrant behaviors, etc." There are lists of aberrant drug related behaviors (ADRBs) in the pain literature [1]. According to the chart review, the patient did not demonstrate any ADRBs (on the list) during the treatment period. If she would have, it is likely that the plaintiff’s expert would have identified the defendant’s non-response to the ADRBs as a breach if the defendant did not respond to the identified ADRB with a treatment plan. The "red flags" listed by Dr. Oliver in item # 5 (listed earlier) are not ADRBs. Dr. Oliver implies that he would have looked for ADRBs in this case, I agree and this is the reason why this patient should have been considered for compliance monitoring from the start of treatment. Such an approach could have identified ADRBs via urine toxicology before the tragic outcome.

Finally, I take significant issue with Dr. Oliver’s final paragraph. Here, he states that the article seems to maintain “that anyone . . . stating they hurt somewhere . . . can get COAT treatment solely based on the patient’s testimony.” This is a gross misunderstanding and misinterpretation of the article. As noted earlier, this article only presents the opinions of the experts and discusses these according to the Model Guidelines and current literature. This article makes no recommendations but only tries to transmit the thinking of the "experts" on the current COAT treatment "standard."

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References


