Fear and Loathing in the Pain Clinic

The piece by Jung and Reidenberg presents updated information on U.S. Drug Enforcement Administration (DEA) activities against physicians that we have heard reported on multiple occasions over years as pain professionals, both attending and speaking at conferences. Often presented by active or retired members of law enforcement, such data were nearly believable enough to be taken at face value during the Hutchinson years at the DEA, when balance and collaboration were the stated goals of the agency in its interactions with pain professionals. “The DEA is not after you; the DEA does not want to tell you how to practice medicine” was often the theme. Never mind the fact that at every advisory board or meeting there was always at least one physician in attendance who had been the subject of an investigation, their life, reputation, and practice disrupted or ruined, pointing out the platitudes inherent in such comments. Always there appeared to be an undertow of fear related to the suggested disconnect between the preaching in Washington at the top of the agency and what was “really happening in the field,” where agents and prosecutors often see things differently. In recent years, reassurances related to data suggesting a miniscule number of investigations, arrests, and sanctions ring hollow. These numbers seem particularly tiny when the “denominator” utilized is the total number of physician-registrants in the United States, all 936,385 of them. It makes any fear of DEA action appear to be nothing more than a collective neurosis shared by physicians who treat pain and/or prescribe controlled substances. However, the presentation of these data begs the question: what is the denominator? Also, why are so many physicians and organizations involved in the treatment of pain worried when they have been specifically told that they will not be sanctioned for prescribing opioids [1,2]? The denominator is the key to a better understanding of the fear.

Fear

The only thing we have to fear is fear itself—nameless, unreasoning, unjustified, terror which paralyzes needed efforts to convert retreat into advance.

Franklin Delano Roosevelt—First Inaugural Address (1933)

Are pain physicians running scared? Are they afraid of their own shadows? Is the fear of regulatory oversight in pain practice regarding the prescribing of controlled substances a figment of their collective imaginations? If the data presented by Jung and Reidenberg are an accurate representation of DEA action against doctors, then it is time for a serious re-evaluation of our field and its members. The numbers, as presented now and similarly in the past, suggest that the likelihood of punitive action, arrest, and/or conviction for issues related to opioid prescribing are as likely as winning the lottery or being hit by lightning. But this is simply not the case.

Let’s deal with the numerator. Tables 1 and 2 in the article present “Arrests of Physicians” (N = 47) and “DEA Revocations” (N = 56) for the year 2003. Miniscule numbers, certainly; but are these numbers representative of the true impact of the DEA on pain practice? We think not. Investigations of a physician’s practice are time-consuming, embarrassing, sullying of reputations, costly, and distracting, to use just a few of the commonly heard (and printable) adjectives. Even if vindicated in the end, the damage is often done with regard to lost time, reputation, referrals, revenue, and the physician’s resolve (to treat pain aggressively, advocate for patients, etc.) by the time the proceedings are completed.

One of us (S.D.P.) was once talking with Mary Baluss, a well-known attorney who advocates for pain physicians and patients, and was bemoaning the fact that physicians are so fearful in treating pain and advocating and sacrificing for their patients. S.D.P. pointed out that this was from members of a profession that historically had laid down their lives to care for sick people with infectious diseases, only to succumb themselves at times. Ms. Baluss pointed out, though, that sacrificing one’s life is heroic and final. Having one’s (and one’s family’s) livelihood threatened; and having to face living after one’s good name and reputation have been dragged in the mud; having been portrayed as a drug dealer and pariah in the community is on some level harder and even more to ask of a physician. And physicians are often perceived as guilty simply because they are being investigated, which influences prescribing in their community. As Rebecca J. Patchin, who serves on the board of the American Medical Association, told the media, “Doctors hear what’s happening to other physicians, and that makes them very reluctant to prescribe opioids that patients might well need” [3]. Further, as Jung and Reidenberg point out, this does not even take account of investiga-
tions stemming from local authorities and state medical boards.

Therefore, we believe the most important “numerator” in the article is the number of investigations begun in the first three quarters of 2003 (N = 557). Prorated out to 12 months, there would be approximately 742 investigations expected for the full year of 2003. Investigations of only 742 physicians in a year still suggests that a very small percentage (0.07%) of physicians will be affected—

if that number is juxtaposed against the total number of physician registrants (N = 936,385). But is the total number of physicians the true denominator? We tend to not think so, as it does not reflect the reality of the government’s impact on pain management, as demonstrated below.

What if the denominator is the number of self-identified pain experts in the United States? These physicians are probably the most likely to be targeted because of the volume of their prescribing of controlled substances. It is well known that a very small subset of physicians prescribe a disproportionate percentage of opioids for pain. For example, 30,000 physicians in this country prescribe 85% of all of the modified release opioids used for chronic pain. So only a handful of doctors (approximately 3%) are likely to practice state-of-the-art pain medicine and therefore make sense as targets for investigations. Ronald Libby, MD, writing for the Cato Institute, used such an approach when he commented on the situation surrounding data for 2001 [4]. He concluded that 17% of pain specialists were investigated by the DEA in 2001 (when there were 861 investigations of the roughly 5000 doctors considered pain experts). Applying such a formula now, the numbers are very similar, with 742 investigations representing 15% of the 5000 pain experts. Fifteen percent of physicians is a far cry from less than a 1/10th of a percent of physicians when chilling effects and negative impacts are being discussed.

Loathing

One of the things which danger does to you after a time is, well, to kill emotion. I don’t think I shall ever feel anything again except fear. None of us can hate anymore—or love.

Graham Greene—The Confidential Agent (1939)

Needless to say, fear is not good for patient care and empathy is commonly an early victim [5,6]. As physicians respond to their fear by “identifying with the aggressor” and taking on more and more of the law enforcement role in their practice, concern for patients takes a back seat. Survival of the practice and protection of oneself naturally become “job one.” Doctors and patients in pain become adversaries.

We must begin the process of reducing fear if pain management is to get back on track. One approach would be to limit investigations of physicians. Perhaps only when the medical board has concluded that something medically inappropriate has occurred should the possibility of law enforcement involvement be considered. Recent revelations about the magnitude of nonphysician sources of opioid diversion [7] cast doubt on the legitimacy of targeting physicians in the first place. It seems that law enforcement investigations can and should be targeted elsewhere in the supply chain in the search for criminal activity. Certainly, fewer than 10–15% of physicians who aggressively treat pain deserve to be investigated. Until a new accord is reached or some policy changes are effected, physicians who treat pain will have more to fear than fear itself.

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References