July | 2014

SPS NEWS

The Official Publication of The Southern Pain Society

INSIDE

Summer Edition

Mission Statement

The Southern Pain Society is a regional section of the American Pain Society (APS) and endorses and supports the mission and goals of the APS. The Southern Pain Society's missions are to service people with pain by advancing research and treatment, and to increase the knowledge and skill of the regional professional community.

Notice Something New?

Lori Postal, RN, MHA

The Southern Pain Society was incorporated in 1988. During the past 26 years, the organization has grown and prospered through the work, commitment and tenacity of our members, leadership team, committee chairs, supporters and districts. During this past year, we felt the need to critically evaluate and refresh the look and feel of the organization to better reflect our current vision, goals and style. As a progressive organization, SPS continues to refine the way in which we reach out to the professional community to provide information, education, support and advocacy efforts.

Today we debut our new logo, color scheme and fonts. This collaborative effort was spearheaded by our current president, Leanne Cianfrini, PhD along with our board of directors and e–communications committee. We are delighted to share the work on our redesign with you, in this printed format.

Additionally, we're developing a new website that will be ready for presentation at our annual meeting in September. We hope that the additional functionality and "members only" section will enhance the utility of the website for you, for our partners, other pain professionals and the public. You should have received a personalized letter asking you to verify your demographic information so we can prepare the database for the password-protected section of the website.

We hope you're as excited as we are about the future of our organization. Your participation, engagement, ideas and suggestions are important to our continued success.

SPS
SOUTHERN PAIN SOCIETY

WE'LL SEE YOU IN NASHVILLE!

2014 Annual Meeting

Pain Management:
The Good, The Bad, The Ugly

September 12-14, 2014

The Omni Hotel—Nashville, TN

SHIFTING THE PARADIGM:

Ann Quinlan-Cowell, PhD, RN and Susan O'Conner-Von, PhD, RN

Several years ago, as people dispersed after a funeral, the sister of the woman who died spoke with me. She shared her frustrations about her sister's agonizing death. Her sister had been sick for some time and in severe pain for several days but resisted going to the Emergency Department. The reason she resisted was that she was using opioids for chronic pain and didn't want people to think that she was "just drug-seeking." Her sister had significant chronic pain and never took more medicine than was prescribed. It seems that at a previous ED visit, she overheard health care professionals talking about a patient "really liking the narcotics" and "drug-seeking." Whether they were talking about her or not, she took it personally because she was taking daily opioids to treat her pain. By the time she finally went to the ED, she was actively dying to the point that the process could not be reversed. Her sister believed that if she had sought care sooner, she would have recovered. Unfortunately, the concern about the "drug-seeking" stigma prevented her from going sooner.

Shortly after this experience, I had the fortune to visit with Dr. Susan O'Conner-Von in Minneapolis. Dr. O'Conner-Von teaches her nursing students that patients are not "drug-seeking" but rather are "*comfort*-seeking." This sounded like a nice way of viewing these patients, but after thinking about it for a while, it became about much more than being a nice nurse.

Describing a person as "drug seeking" is a judgment that may or may not have any degree of credence. This is compounded because the person is then viewed with a negative label that is often conveyed to others.

Adjectives and labels can have a powerful effect on how we view, interact and care for others. The term "drug-seeking" conveys that there is not a legitimate medical issue but rather the person just wants "drugs". From that perspective, the person may be considered less than a legitimate patient, and not deserving of care. Attention, assessment, interaction and treatment may be compromised, even though the judgment may be inaccurate. Even if the person does misuse or abuse substances, appropriate and non-judgmental assessment and health care should be provided respecting the inherent dignity, worth and uniqueness of every individual (ANA, 2001). We know that we cannot feel the pain of another person, but we know that people who are in pain want to alleviate the pain and be comfortable. We also know that the majority of people who misuse or abuse substances do so because they are trying to self-treat physical, emotional or spiritual pain.

Last year, I began challenging providers at our health care facility to replace the term "drug-seeking" with "comfort-seeking." The paradigm shift has been subtle and it continues. First, I began receiving consults to "see this patient who is comfort-seeking." Now some consults are aimed "to help this patient be comfortable." I rarely hear anyone use the negative label of drug-seeking. In the last few months, no patient has complained to me that they were judged or labeled. Moreover, a few weeks ago, a nurse manager who had been very frustrated with all of the "narcotics that these patients use" told me that he doesn't even think that anymore. He just thinks about what we need to do to get the pain under control. Certainly, we have room for improvement, but the paradigm has started to take hold and I will continue to gently nudge it.

I encourage you to convey this challenge to those with whom you work to replace the pejorative term with the more accurate term of "comfort-seeking."

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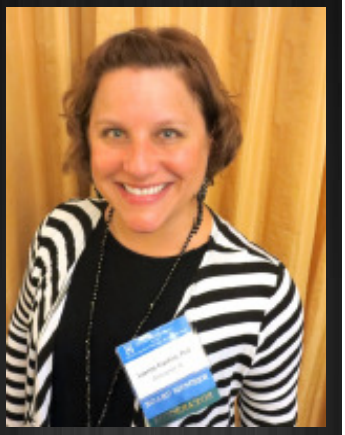
PRESIDENT'S COLUMN

Leanne Cianfrini, PhD

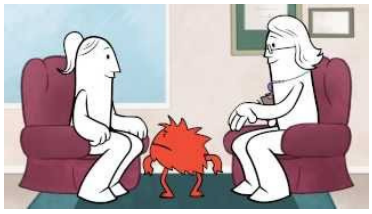


I look forward to seeing you in Nashville the weekend of September 10-12th for our annual meeting. I'm getting more and more excited about our speaker lineup and the new hotel venue. Please come up and introduce yourself. See you there!

In the midst of an unusually busy summer, both professionally and personally, I decided to take a moment to practice gratitude and appreciation. We so often "glorify the busy," and although Type A's like myself seem to thrive on the stress of a full plate, that level of go-go-go can become personally draining as well as tiresome to others. So, here's a list of six things I just think are pretty cool and wanted to share. These were selected for some relevance to the field of pain management.

- Alabama has an extensive system of wheelchair accessible hunting and fishing trails for physically disabled outdoorsmen. https://www.outdooralabama.com/hunting/land/physically-disabled/ We've even learned of a local organization that transports patients to designated trails, provides equipment, and accompanies them on hunting outings. What a fantastic way for our patients to continue engaging in their outdoor hobbies — Check to see if there's a similar service in your state!

- This link is for a short video about the effects of stress on health -- and how health psychologists can help. https://www.youtube.com/watch?v=bOmJ5FHr0a8. The animation is amusing, and it's about time there was a "commercial" for cognitive-behavioral therapy!



- While we're online checking that one out, take a peek at this brief TED-Ed lesson on the Brain in Pain. Again, GREAT animations in the service of health education. http://ed.ted.com/lessons/how-does-your-brain-respond-to-pain-karen-d-davis

- If you didn't get a chance to read it, The New York Times published an excellent article on May 10, 2014 — "A Soldier's War on Pain" by Barry Meier. A worthwhile read. http://www.nytimes.com/2014/05/11/business/a-soldiers-war-on-pain.html?_r=0

- For any of your patients looking for online support, there are some reasonably good Facebook "communities" you can recommend. These moderated groups try to stay positive and also post about non-pharmacological options. Have them search through Facebook for the pages: /chronicbodypain, /chronicpaininfo, and /SurvivingChronicPain.

- Finally, I'm so thrilled with our new logo and our upcoming website re-design. Many thanks to Geralyn Datz and Lori Postal for helping to coordinate the revision process, and the board for their opinions and support. Believe me, there were fervent discussions over an "icon" that represents our multidisciplinary nature or our Southern region. In the end, we decided against an icon-based logo, and chose a modern font and clean color scheme. Interpret the "swish" as you will (Is it a spine? A North/South divide? A hint that pain is not what it seems on the surface?). This graphic "rebranding" is not just style over substance — we needed to let our new web developers shine with a solid foundation. Hopefully, the logo update signifies SPS's flexibility and desire to bring us all up to speed with the technologies of our time. With better online functionality and an emphasis on e-communications, we'll be able to quickly respond to the rapidly changing issues of our field, to communicate more effectively and efficiently with our members, and maybe save some trees in the process.

That's it – back to the grind. I hope you're making time in your own busy schedules for a family vacation, some exercise, and some mini-breaks for gratitude and humor. Have a lovely summer!

NEWS FROM A STATE HEROIN SUMMIT

Daniel M. Doleys, PhD

In the last year or so, some 50 heroin overdose deaths were recorded in a one Alabama county, a 10-fold increase over a span of less than 10 years. The majority of deaths involved 17- to 24-year-olds from middle class communities. In response to this alarming statistic, U.S. Attorney for the Northern District of Alabama, Joyce White Vance, organized "Pills to Needles: The Pathway to Rising Heroin Deaths. A Community Alert and Call to Action" in Birmingham on June 10, 2014. This community-based open forum was expected to draw an audience of about 125; the final number exceeded 300. Members from law enforcement, first responders, the judicial system, the medical community, and parents of two teenage victims of heroin overdose presented. The keynote speaker was The Honorable James E. Cole, Deputy Attorney General, U.S. Department of Justice. Similar meetings had been held in New York and Cleveland, Ohio.

Although concern was expressed over the non-medical use of prescription opioid pills by adolescents and young adults, the emphasis was on the growing availability, low cost, and lethalness of heroin. Deputy Attorney General Cole suggested that oxycodone products may be 'gateway drugs' to heroin. The data suggests that non-medical users of prescription pain relievers were 19 times more likely to have initiated heroin use recently, and 4 out of 5 people who recently began using heroin had previously abused prescription pain relievers (www.samhsa.gov). Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings reported that over 80% of nonmedical users of prescriptions drugs 12 years and older obtained the pills from a parent, relative, friend, or by prescription (www.samhsa.gov, cited in Manchikanti et al., 2012).

Education in the schools and community, use of naloxone by first-responders, destigmatizing addiction, and providing more extensive treatment and aftercare were highlighted. It was very clear that "…we cannot arrest our way out of this problem".

The assessment of the 'drug security risk' should include the degree of responsibility shown by the patient, the age and history of others in the home as it relates to use of drugs and alcohol, the cognitive functioning of the patient, and co-morbid psychiatry and/or personality disorder(s). The pain management community was *not* vilified at this meeting. But, we need to be at the forefront of the issue. There is much we have to offer and should consider it a moral and ethical obligation to do so.

I presented a list of 'action items' with the intent to minimize unauthorized acquisition and non-medical use of prescription opioids. We, as pain practitioners, ideally should:

1. Adequately assess for 'drug security' as well as abuse risk;
2. Base treatment plans upon initial and ongoing risk stratification;
3. Consider and recommend use of non-drug therapies;
4. Consider and recommend non-opioid analgesic drugs;
5. Control monetary motivation on the part on the part of the prescriber,;
6. Adequately monitor compliance with prescribed regimens through the use of pill counts, locked dispensers, urine drug screens, significant other reports, and access to state prescription drug monitoring program databases;
7. Focus on improved quality of life/function vs. pain relief;
8. Avoid being co-dependent/unassertive with the patient when boundaries and limits need to be set;
9. Demand security of controlled substances;
10. Emphasize use of the most tamper-resistant and least abuse-able medicines; and
11. Avoid treating according to insurance guidelines and/or patients' desires/wishes vs. executing established protocols, guidelines, and professional experience.

PAIN PRACTICE CORNER

SPS Member:
Thomas Kraus, DO

Pain Management Services, PC in Birmingham, Alabama

How long have you been associated with the Southern Pain Society?

Since moving to Alabama in 1994.

What does your practice consist of?

Pain Management Services, P.C. (PMSs), consists of three full-time physicians and one part-time physician. We practice both interventional and primary care pain medicine in Birmingham, Alabama.

(continued on Page 5)

(continued from page 4)

How long have you been doing this?

The most senior part-time pain physician has been in practice for 40 years while the three other partners have been in practice for about 25 years.

Tell us a little bit about your typical work day?

Our typical work day begins at 7 am and ends about 6 pm. Mornings consist of interventional procedures while afternoons consist of both new and established patient clinic visits. Weekends are relatively free.

Has your practice changed over time? How?

Having trained at one of the true multidisciplinary pain programs in the country – The Cleveland Clinic Foundation – we understand that patients desire to have one pain physician who 'does it all'. This requires a physician who not only can perform interventional procedures, but who is also willing to care for or direct the majority of their patient's needs; this care may be through medication management, physical rehabilitation, or emotional and family support. Patients who are cared for in this approach will achieve superior results when compared to the one-dimensional pain physician or clinic. Therefore, even though medications and interventions have changed, the necessity for complete care of the pain patient has stayed straight and true.

Tell us a few things about your practice.

PMSs staff members feel that they have a calling to take care of pain patients. The biggest enjoyment we have is for patients to not only feel comfortable with their physician, but also their interactions with other clinic caregivers. The emotional burden is dispersed among the entire clinic, allowing one of us to have a "bad day" with our colleagues filling the void. Likewise, a patient can feel comfortable having a "bad day" in front of us, knowing that we understand.

PMSs is a true group practice with enviable working relationships. Even though each one of us has our own unique style, we respect each other's talents. Our success has been built around hard work and the notion that if we all are successful individually, then the group will be successful.

What are the other things that you feel matter in life, and how to you find the time for them?

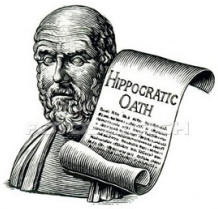
My father said, "If you try to do more than two things in life, you will be mediocre in numbers 3, 4, 5…". Thus my family and caring for pain patients are the #1 and #2 things that matter to me. My grades for the rest? #3) Eating habits and exercising (C), #4) Watching TV (F), 5) Golf (handicap rising rapidly).

What do you think is the biggest problem in pain/medical care today?

The rationing of care has already commenced in the private sector culture, so why do we waste our time rankling over the Affordable Care Act? En vogue terminology of "experimental"/ "investigational" has taken off like metastatic disease waiting for the ultimate consequence—death. Procedures performed on patients for years are now trashed under the "investigational" terminology. Why the demagoguery? "We will not pay."

Evidence-based medicine depends upon human experimentation, straddling the intersection between science and ethics (values), and concomitantly asking about the spirituality of self. We have been through many unethical human experiments from those of Nazi Germany to the infamous Tuskegee syphilis study. Numerous studies have been conducted where patients have been put at risk for serious disease, or in which healthy people have been intentionally made ill to study disease. The "gold standard" test of the efficacy of a new drug/procedure is the randomized, placebo-controlled, double-blinded study. Because IRBs deem sham procedures unethical, few have ever been performed. The estimated cost for one "gold standard" study is a few million dollars. Who will pay?

Various economic models including classical, Keynesian, supply-demand, moral hazard, and rational choice have theoretically been tested to control the cost of health care. However, the dilemma of cost containment remains prominent. Clinical relevance and academic economic theory have failed to heal the problem. The patient is still sick: how will we pay?



The classic Hippocratic Oath states, "I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion." Contrarily, the New Hippocratic Oath of 1964 states, "But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God." But, we are playing God: medical care rationing has commenced. Now, you will pay.

According to the Apostolic Letter Salvifici Doloris of the Supreme Pontiff John Paul II, the words "suffering" and "pain" can be synonyms, for physical suffering is present when "the body is hurting" in some way, and moral suffering is "pain of the soul." The medical profession's governing body started aging with the inception of third party intervention, and decaying with the conceptual thought of a "living Hippocratic Oath" and presently, with so many outside forces driving a stake into the heart of physician-patient relationships, the medical profession's soul may be resting in peace.

Solutions?

VOLUNTEER OPPORTUNITIES

Each year, SPS has a number of opportunities to serve on various standing committees. Service on a committee enables you to use your expertise and experience to help SPS develop our marketing reach, enhance benefits for our members, and improve our educational programs. Working on projects with current board members is an excellent networking opportunity and gets your foot in the door for future leadership positions.

EXPECTATIONS FOR COMMITTEE VOLUNTEERS

You should simply:

- be a current SPS member
- be willing to actively participate in email communication and periodic phone calls
- have some experience or expertise (as well as passion/creativity) to contribute to the committee

We also have some positions coming open on our **Board of Directors**. Elections will be held this year. Board members are involved with conference calls about twice a year, and the in-person board meeting held the day before our annual meeting. E-mail discussions may also be involved, but are usually minimal. We are seeking to fill three positions:

- President-Elect
- Two at-large directors

HOW TO APPLY

Nominate yourself or another member by emailing the position you're interested in to Lori Postal at **SOUTHERNPAIN2@GMAIL.COM.**

THANK YOU FOR YOUR INTEREST IN CONTRIBUTING TO YOUR PROFESSIONAL ORGANIZATION!!

CURRENT COMMITTEE OPENINGS

E-Communications

Work to improve all forms of electronic communication with members, including our re-branding and website development, social media, email communications, web surveys, etc. Some experience with these formats would be helpful.

Newsletter

Participate in writing and soliciting content for the quarterly newsletter.

Membership

Work to increase membership and assess/meet the needs of existing members.

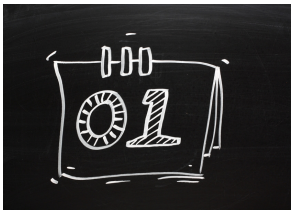
2015 Annual Meeting Program

Participate in planning the speaker agenda, poster session, and other aspects of the 2015 annual meeting, which will be help in Orlando, Florida. *Note: This committee does require a commitment to short monthly calls.

SPS News is the official publication of the SPS, provided quarterly to its members. SPS may publish material dealing with controversial issues. The views expressed are those of the authors and may not reflect those of the SPS. No endorsement of those views should be inferred unless specifically identified as the official policy of the SPS.

Submissions are welcomed. Publication is based on editorial judgment as to quality of material, timeliness, and potential interest to members. Submission deadlines:

January 1 **April 1** **July 1** **October 1**



DRUG-SPECIFIC OR CLASS-WIDE REMS?

Leanne Cianfrini, PhD

In Alabama, we've been following an interesting series of events surrounding Zohydro ER. On May 22nd, the Alabama Board of Medical Examiners (ALBME)established an emergency rule limiting the prescribing of Zohydro ER, the nature of which was that "the medication poses a risk to the public health and safety and is at great risk of misuse and diversion due to its pure hydrocodone formulation."

This rule apparently went into effect on May 23. In fact, this happened so quietly that our prescribing clinic physicians did not hear about it until we read an email alert from the Director of Policy and Advocacy from the American Academy of Pain Management (AAPM) on June 3rd. The most intriguing part of the rule prohibited prescribing of Zohydro ER in the state of Alabama unless the physician completed a "REMS course specific to Zohydro ER offered by the Alabama Board of Medical Examiners". The course was "currently in development", and there was no timeline as to when it would be available. We were told that a notice would be mailed to licensed physicians (still not received).

Zogenix and their public relations team requested that the Board rescind the emergency status of the rule. The ALBME Chairman noted that there would be no action before the next full board meeting to prohibit the prescribing of Zohydro or to discipline a physician who prescribed it. In the meeting on June 18th, the emergency rule was repealed. The BME will now proceed with the non-emergency route of publication for public comment. There is a public hearing scheduled for July 17th in Montgomery, and the vote will be in August. Zogenix has called upon physicians to submit a letter of support to the board. **If you'd like a copy of the draft letter, please email me (lcianfrini@doleysclinic.com) and I'll pass that along.**

Obviously, this extended-release hydrocodone formulation has its critics and defenders. Consumer groups, addiction treatment providers, and over 20 state attorneys general have all expressed concern. Massachusetts Governor Deval Patrick made headlines by imposing sweeping restrictions on its use through an executive order declaring it a Schedule I drug, and other states have introduced legislation to ban Zohydro in their jurisdictions. On the other side, some national pain organizations like the AAPM have issued statements that the FDA-approved Zohydro ER "has a place in the pain management armamentarium."

So, I'm not that interested at this very moment in a debate about whether Zohydro is a "good" or "bad" medication in its current formulation. Obviously, we're all concerned about the prescription drug abuse problem in our state and across the nation. Each licensed prescriber already has a duty to examine the evidence on individual drug efficacy, balance with risks and side effects, engage in appropriate opioid monitoring behaviors, and make their own determination on whether to prescribe.

I'm very curious, however, about the request for providers to complete a drug-specific REMS course for Zohydro — especially one that is not yet created or accessible. There are other non-abuse-deterrent opioids out there already. I understand the point that Zogenix made to the ALBME: "This drug has been on the market for just a few short months. It is not the cause of the current opioid abuse problem in our country." As you will read in Dan Doleys' article elsewhere in this edition summarizing the recent Alabama Heroin Summit, oxycodone is being heralded as the gateway drug to heroin use. As we know, Methadone has unique actions and a unique profile of adverse events, but is still part of the "class-wide" REMS.

What are your thoughts on this? Regardless of whether you're personally comfortable prescribing it, **should Zohydro ER be singled out as subject to a specific REMS course**? What are your thoughts on this emergency rule and quick repeal? What's the status in your own state? What would you do if you had started a patient on Zohydro, only to find that suddenly you could be disciplined because you hadn't taken a REMS course that hasn't been designed yet? Just curious, and I'd like to start a dialogue— it's been an interesting month here in Alabama.

SPEAKING OF REMS…

*At our Nashville meeting in September, we'll be offering ER/LA Opioid Analgesic REMS education that is fully compliant with REMS education requirements issued by the FDA. This activity reviews content provided by CO*RE.*

CO*RE

Join us at the Saturday, 9/13/14 lunch event to get credit for REMS: Balancing Safe Use and Risk to Improve Patient Care, presented by Mordecai Potash, MD.

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