2010 PAINWEEK® news
Red Rock Casino, Resort, and Spa
Las Vegas, NV

PREVIEW

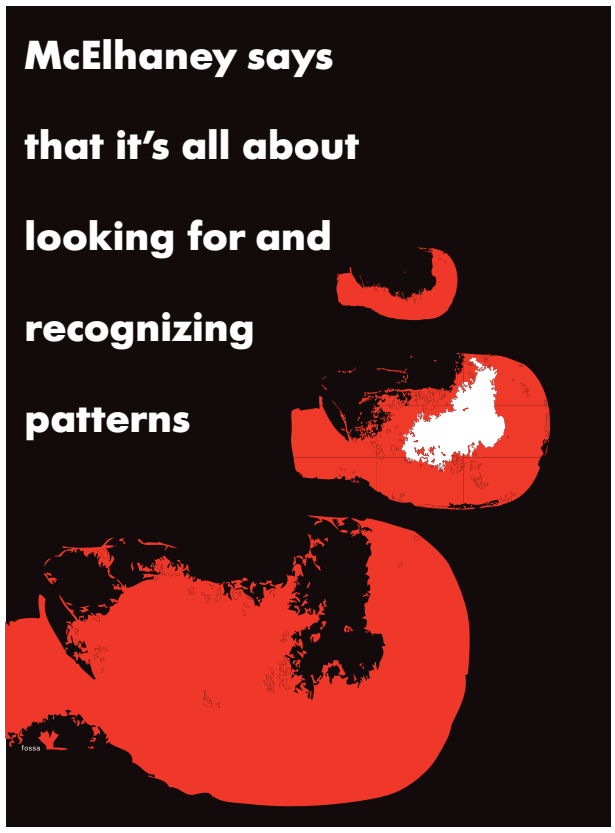
Could You Spot a Doctor Shopper or Drug Diverter?

Patients seeking to obtain pain medications and other controlled substances for illicit purposes will employ a variety of sophisticated tactics and approaches, many of which are designed to play on the sympathy and empathy of the physician.

Lisa McElhaney, National Vice President, National Association of Drug Diversion Investigators, says that her presentation today at PAINWeek 2010, "Is going to bring a law enforcement perspective to the topic of pharmaceutical drug diversion." McElhaneyis session will explain "why law enforcement is involved, paralleling the practice of medicine, and in most recent years, why law enforcement has become more of a focal point in what's transpiring in our medical community."

Scheduled for 2:30pm today in Veranda DE, "Rx Fraud, Doctor Shoppers, and Pill Mills" is intended to help attendees understand the current criminal trends in the field of medicine, learn how physicians can become targets and victims of drug seekers, and identify the telltale signals of a drug shopper or diverter so that physicians can defend their practice and prevent themselves and their employees from becoming victims.

"Communication is a huge part of combating pharmaceutical diversion," McElhaney says. "Many physicians are afraid to call law enforcement or don't know who to call." Although she says that "not every law enforcement officer is going to eagerly respond to such calls," creating and developing an open line of communication is a vital part of preventing misuse, abuse, and diversion. There's more to it than just reporting the crime, says McElhaney. Providers must also "invite law enforcement in to take a look at their practice to see what obvious signs and targets exist for a drug seeker." For example, drug seekers will often look for prescription pads, so McElhaney suggests that medical practices keep the pads under lock and key. Physicians should also review the authority and access privileges granted to some employees—even employees that may have worked for a physician for many years can be a part of the problem, says McElhaney. "You need to put a checks and balances system into your practice to make sure that diversion does not readily happen."



Because many physicians don't understand the world of pharmaceutical drug diversion unless they actually have first-hand experience with it, many practitioners are left in the dark when it comes to drug seekers. "They've heard about prescription fraud," she says. "They've heard about doctor shoppers. But, again, they're not familiar with the patterns and the signs and indicators of activity, and once they allow that element into their practice, many times unwittingly, all of sudden they become inundated with the problem. And that's something they need to recognize. They need to know who to call and how to handle it."

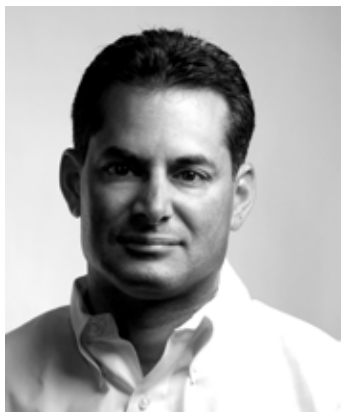
What are the signs to look for in a drug diverter or drug seeker? McElhaney says that it's all about looking for and recognizing patterns. For example, she asks physicians to consider the case of an individual who supposedly is "allergic" to everything but one specific drug. "They have all of the right answers and their pain is over the threshold, especially if they're taking large quantities of pain medication, and yet their pain seems to be at such a high level that they need excessive quantities." Other potential red flags include patients who are cash payers, says McElhaney, or patients who "are out of their general travel area," whose residence is more than 50 miles from the office (many times in another state). She says that these drug seekers will "try to play upon the sympathy and empathy of physicians, and once they find someone who believes that they're actually doing the best for that patient, they'll play them for all it's worth."

Drug diversion is also a pressing issue that will affect more providers

(continued on page 8)

RECAP

Pain Basics: Sorting out the Good Pain from the Bad



So much for the storied Las Vegas nightlife. PAINWeek 2010 attendees apparently retired early Tuesday evening, judging by the standing-room only attendance at "Pain Mechanisms," one of the five concurrent sessions to open PAINWeek 2010 Wednesday morning. The speaker, David M. Glick, DC, DAAPM, CPE, set the stage for the show through an overview session that he called "pain management-lite."

"You have to lay the groundwork to set the stage for what happens later," said Glick. "If we have the fundamental story, we can follow everything else. I'm going to lay the foundation. Even if you know the material, it might help you find an area you have greater interest in as you look at the other sessions."

Glick then proceeded to give a 30,000-foot overview presentation that was ideal for the primary care

(continued on page 11

IMPORTANT COURSE CHANGES

Schedule Change: *Addition*
(NAD-05) Teen Abuse of Prescription Drugs: A Cause for Concern
Presenter: John J. Burke
Day: Thursday, September 9, 2010
Time: 11:50am – 12:50pm
Location: Veranda DE

Schedule Change: *New Presenter*
The following course will now be presented by James J. Giordano, PhD:

(NAR-02) Caught in the Crossfire: Narcoterrorism's Impact on Patient Care
Day: Saturday, September 11, 2010
Time: 9:20am - 10:20am
Location: Summerlin A

Schedule Change: *Revised learning objectives*
(NAR-01) Defining the Problem, Process, and Needs for Policy
Presenter: James J. Giordano, PhD
Day: Saturday, September 11, 2010
Time: 8:10am – 9:10am
Location: Summerlin A
Learning Objectives:
- Describe the variables affecting pain as an illness
- Review the foundational duties of physicians who manage pain
- Identify the foundations of effective policy for physician pain management

PREVIEW

When Teaching Adult Learners, Keep it Real

Continuing medical education expert Marcia J. Jackson, PhD, FACME, will offer advice and share strategies and approaches designed to engage adult learners and provide meaningful educational experiences.

When it comes to pain education, not only must a physician be able to effectively introduce and describe the physiological process behind the conditions, but often he or she must "uneducate" or re-educate patients, according to Marcia J. Jackson, PhD, FACME. Jackson owns CME by Design, a consulting group that provides instructional design services in the continuing medical education field, and she is also a board member of the American Society of Pain Educators.

"I think one of the difficulties in educating about pain is that you're not starting with a clean slate," Jackson said. "And so, there may have to be some 'uneducating' that would have to take place before re-education could take place. People may have come to the session with preconceived biases that you have to recognize and address in some way and remove or at least diminish so that you can begin to introduce the new ideas."

Jackson's presentation, "Principles of Adult Learning," is scheduled for today from 11:50am - 12:50pm. During the presentation, Jackson will discuss how these concepts can be applied in the pain management setting as she delves into the distinct thought processes of adult learning.

Audience participation will be encouraged during the presentation. Jackson will ask those present to think of their own experiences as adult learners and identify the specific features that made those experiences memorable. She will poll the audience on real-life situations in which participants successfully implemented educational programs (ie, created materials) for their adult learners.

Jackson first became interested in medical education in the mid-1970s when she served as a project manager funded by the National Institute of Cancer at the University of Iowa's Department of Continuing Education. In the early 1990s, she was hired by The American College of Cardiology as division vice president and senior advisor of the national education programs.

Adult education is tricky, Jackson says, which is partly why she finds it so fascinating. "It's interesting to me because as an instructional designer, I know that adults represent a great opportunity as well as a great challenge," she says. "By that I mean that I think the opportunity for educators is that usually adults are very willing to learn, but the challenge for educators is that they have to make the experience meaningful for adult learners."

Children usually take in material without any hesitation, because they do not question its relevance, Jackson says. "Adults are much more practical. They'll ask 'What's in it for me?' 'Is this something I can use?' 'Is this something I will use?' If it isn't, they either don't participate or they tune out," Jackson says. "So you have to capture their interest and make education realistic and that has always intrigued me."

Jackson's presentation is part of the pain educators' track, and she says that providing realistic strategies and an opportunity to think about how to present meaningful education and facilitate learning should be useful for the pain management professionals in the audience.

Education may also be the key to dealing with a topic that causes a great deal of frustration among many pain physicians and health professionals: the prescribing of opioids. Despite all of the information available and educational initiatives that provide guidelines on effective opioid prescribing, many physicians are still reluctant to prescribe opiates because they think it could lead to potential dependence and addiction in patients, Jackson says.

"So, if you're interacting in an educational setting with a physician who may not admit it to you but who is thinking 'Well there's no way I'm going to prescribe an opiate, because not only might the patient become dependent but I may be subject to some litigation as a result of this,' you've got to somehow tease that out. You have to be aware of the issues that are in play and begin to address them. You have to say 'Ok, let's talk about that—let's hear your concerns and not pretend they're not there," she says. "I think with pain especially, and the management of pain, you're going to run into that more than you would in other medical fields."

Jackson hopes that her presentation will help physicians and health professionals to think about patients and colleagues as adult learners and implement successful strategies to engage these learners and educate them about pain and other topics in the future.

Pain Basics: Sorting out the Good Pain from the Bad

(continued from page 1)

physician who treats patients in pain and most likely prescribes many medications that they don't fully understand. "Pain mechanisms can be very complicated," Glick said. "We could have a meeting called Pain Mechanisms Week, and we wouldn't even scratch the surface. That's daunting."

The picture Glick painted of the pathways and receptors of pain revealed exactly why pain management is such a difficult and complicated field. In short, it's because of the nature of good and bad pain. "Some pain is good; it's purposeful—it's a warning sign," Glick said. "If I have a heart attack, I want pain to let me know there's a problem. Pain can be good."

Nociceptive pain is pain with a purpose, pain of perception. If you touch something hot, you have to remove yourself from it. "I'm always looking for the pain generator. I'm proverbially looking for the spear in the foot. I'm going to have trouble managing that pain if the spear is there. If you can remove the cause, alleviating the pain becomes a lot easier."

Bad pain is pain that doesn't have a purpose—often, pain linked to disorder, illness, or damage. "It's like a car that's out of tune," said Glick. "There's an error somewhere in the system."

Within the category of "bad pain," Glick further identified two types: Neuropathic pain, and functional pain. The latter, according to Glick, is the most recent area of discovery and includes pain conditions that don't fall into the inflammatory category, such as fibromyalgia and irritable bowel syndrome. "The majority of the advances and change in pain management is going to come in these last two categories," he said.

Glick then went into some detail on the transduction, conduction, transmission, and perception of pain. Transduction is simply the conversion of one signal to another, like a pain stimulus. Conduction takes the signal to the spine, like a conductor taking a passenger from one place to another. Transmission takes the signal from the nerves to the brain. Once in the brain, perception occurs.

"People perceive pain different ways," Glick remarked. "There's an emotional component involved in it. You can have a patient with a paper cut and ask him to rate his pain on a scale from 1 to 10, and they'll tell you it's a 15. Another patient with a knife to the abdomen might describe his pain as a 2, because it could be a lot worse."

Perhaps the most interesting aspect of Glick's talk was the role that evolution (or intelligent design, Glick was careful to mention) plays in the difficulty of treating pain. For example, he walked through the number of different ways that nociceptors transmit signals to the spine. This intentional redundancy has a powerful purpose in sustaining human life—responding to good pain, if you will. But it creates many challenges to treating pain at its source, because the signals a medication would need to block are so numerous and varied. "Nociceptors are mediated by many things," Glick said. "There is a lot going on under the skin."

I'm always looking for the pain generator. I'm proverbially looking for the spear in the foot.

Glick said that the difficulty associated with blocking pain from all of those mediators means a multimodal approach is needed—what he calls "rational polypharmacy."

Why is pain management so complicated? "There are lots of overlapping things happening at the same time, each of which react in their own way," he said. "Many of the current treatments focus on modulation. We've decided we can control this pain better than the body can. If that was true, would we be here [at PAINWeek]? No, because we'd have the solution. We're just making a dent in it."