

How to Tell if Someone is Faking it.

Pain that is.

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Pain, its something we all have to deal with. It is a condition that men and creatures have battled with since they have been on this planet. Throughout history witch doctors, midwives, medical doctors, etc, have all struggled with the responsibility of relieving pain. We have struggled through treatments such as bloodletting, leaches, electric shock, and drugs, all in an effort to relieve the discomfort of pain.

Within in the last five years, the topic of pain and pain management has surfaced again in today's medical profession. This time the concern is not how to treat pain but when. Criticism has been flowing from all different directions at the medical profession with allegations of doctors significantly under treating pain, which has left millions of people struggling for comfort. Jim Guest, Executive Director of the American Pain Foundation, claims "Over 50 million Americans live with chronic pain. The crime is that treatments and therapies to manage most pain are available, yet most pain goes untreated, under treated, or improperly treated." (APF, 2000)

There has been an enormous push from the general population to be treated properly for pain. Lawsuits have been filed, pain campaigns have been run, and even doctor shopping has

begun as a common practice for patients who feel their physicians do not adequately treat their pain. But within this rush to receive adequate pain relief there is a danger of overcompensation.

The basic fact is there is no definite way for a doctor to tell that a patient is in pain. In reality, it is all about what the doctor knows should be painful and the patient's description of the pain. So, if there is enormous pressure on doctors to aggressively treat the discomfort that the patient is claiming to have, then what is to stop someone from pretending be in pain in order to take advantage of this fear of under treating pain? Nothing. Drug-seekers, as they are affectionately known, actively try to fool medical professionals in order to receive opiates and narcotics for their own personal use.

Why Doctors Fear Under Treating Pain

With 50 million people in pain in this country, the question of why doctors are hesitant to alleviate the problem is in the forefront of everyone's mind. It is certainly not a lack of knowledge about the pain relief benefits of drugs. According to Ben Rich, the reasons that doctors under treat pain range from insufficient knowledge about the assessment and management of pain, failure to make pain relief a priority, lack of accountability for when pain is not adequately treated, and the persistence of myths concerning addiction. (Rich, 2001) Doctors generally feared that if they treated their patients with opiates, then their patient would become addicted which would just add to the problems. However, science has proven that that is not the case. "Physical dependence occurs in almost everyone who takes narcotic medication regularly for at least two weeks. Addiction- a craving for the drug and its compulsive use to regulate ones mood- does not. With dependence, the body adapts physiologically to the drug, and if it's stopped abruptly, withdrawal symptoms occur." (Satel, 2004)

There has become little tolerance from patients who are not receiving the adequate care they need, whether the fear is addiction or not. Recently, there have been two cases where doctors have been sued for failing to provide the necessary pain relief to their patients. “In 1991, a North Carolina jury awarded \$15 million in compensatory and punitive damages to the family of Henry James, a nursing home patient who died a painful death from terminal metastatic prostate cancer. The jury found that a nurse’s refusal to administer the opioid analgesics necessary to relieve Mr. James’s pain, on the rationale that he would become addicted, constituted a gross departure from acceptable care.” (Rich, 2001) And on June 13, 2001 a California jury awarded \$1.5 million to the family of William Bergman after they filed suit against Dr. Wing Chin, claiming that Chin had failed to adequately treat the pain of Bergman’s apparent lung cancer (no definitive diagnosis was made). (Rich, 2001)

Both of these cases sent shock waves through the medical profession. Now, not only can doctors be sued for clear malpractice but also they could now be sued for failing to provide pain relief. Clearly, there is a responsibility the doctor accepts when becoming licensed, that he/she will seek to relieve the suffering of a patient. But, these lawsuits certainly shook the profession up and doctors started to actively pay attention.

One of the primary forces in making sure that the medical profession knows about the danger of under treating pain is the American Pain Foundation (APF). In 2001 the APF launched its first ever national campaign, “Stop Pain Now!” to end the inappropriate treatment of pain, whether that be under treating, mistreating, etc. According to Jim Guest, “The problem is that, in general, healthcare professionals, policymakers, and the public don’t consider pain a critical health issue.” (APF, 2000) In an effort to make pain a national healthcare priority, they

called for grassroots initiatives, pain management standards for HMO's, federal pain management legislation, and for pain to be described as the fifth vital sign.

The idea that pain should be considered the fifth vital sign was pioneered in Missoula, Montana and now "the country's 18,000 hospitals nursing homes and other care facilities can no longer be accredited unless they measure pain as "the fifth vital sign" boasted Russ Massaro, an executive vice president of the Joint Commission on Accreditation of Healthcare Organizations. (Fischman, 2002)

In Missoula the strategy was not to just place responsibility with the doctors in treating pain, but to also include the patient in that responsibility. They adopted a standard pain scale, 1-10 and took that information out to the community. Educating people about how to accurately describe pain was a clear and definite priority. "The goal was to get people to understand how to report pain before they actually needed to. When people started walking into the ER saying, 'I have pain between 8 and 10', we knew that we'd succeeded" claimed Ira Byock, cofounder of the pain project in Missoula. (Fischman, 2002) But there are clearly some dangers in presenting that information to the public. Making sure that everyone knows how to claim pain, while inherently a good idea, can have the side effect of providing critical information to certain drug-seekers in order to make it extremely easy for them to fake the pain. Although one would like to think that people would only use this particular information when they were in pain, it is a system that could be easily abused. The question now becomes, how can you truly diagnose pain, even if someone is providing the appropriate scale information?

What is Real Pain and How Can a Doctor Spot it?

“Pain is widely regarded as a subjective phenomenon or the perception of ‘an unpleasant sensory or emotional experience associated with an actual or potential tissue damage’”.

(Churchill, 1997) Although pain, as it is accepted, can only be truly confirmed by the patient it is clearly important for doctors to know the physiology of pain. If a patient comes into the office complaining of pain, and the symptoms and description do not match the physiology of what occurs when the body is responding to an injury, then the doctor is able to identify that the patient is not in the pain they are claiming.

Basically, what happens is that pain impulses are transmitted from the periphery to the central nervous system. Neurotransmitters then transmit the impulses to the brain's higher structures. When the reticular formation gets the message, that's when initial attention is paid to the injury. The hypothalamus then controls the body's response to the pain and the thalamus interprets the intensity of the pain. From there the messages get sent to the limbic system where the emotional reaction to the pain occurs. Finally the pain impulses are sent through the somatosensory cortex where the person can make sense of the pain within the context of the situation and higher thinking. (Daly, 1999)

However, these processes all occur internally, for the most part. In order to assess the pain the doctor, according to Dr. Patrick Murphy, relies on two systems; the Waddell signs and pain scales. As explained in a personal interview, Dr. Murphy claimed that one of the most effective tools a physician has to tell whether the patient is faking it or not are the Waddell signs. (See Appendix A) This is a list of 5 indications (tenderness, simulation tests, distraction tests, regional disturbances, and overreaction) that a doctor can use in order to identify real pain in a patient. Originally, Dr. Waddell designed these criteria to discern pain in the lower back that had

no apparent cause. However, over the years, Dr. Murphy said, these signs have been used to diagnose all different types of injuries.

The other system of diagnosing pain are the pain scales. These scales have been developed in order to allow the patient to accurately describe their pain. According to Rhonda Graham, there are generally three accepted scales of pain: the Wong-Baker Faces Pain Rating Scale, verbal scales, and numerical scales.

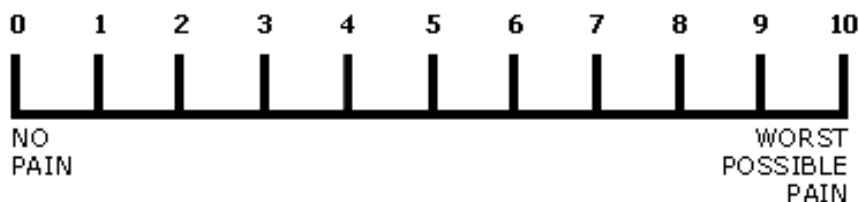
The Wong-Baker scale is particularly helpful when dealing with either young children or the elderly. It provides an opportunity to describe pain when they are not otherwise able to communicate their symptoms. All the patient has to do is identify with one of the faces and the doctor generally knows how much pain that person is suffering from.



A verbal scale is generally helpful in determining post surgical pain. The patient just describes the amount of pain that they are suffering from: mild, moderate, severe.



The final scale, which is used most often with the general public, is the numeric pain scale. A patient describes intensity of their pain on a scale, generally, from 1-10. 1 is usually considered no pain whereas 10 is the worst pain you can imagine. (2004)



How a Doctor Can Identify a Drug Seeker and How They Protect Themselves

As cited in a Drug Enforcement Administration (DEA) publication (2001) (See Appendix C) a Drug Abuse Warning Network (DAWN) study in 1993 claimed that “narcotic analgesic abuse has been increasing in the U.S. since the mid-1990’s, and more than doubled between 1994 and 2001. DAWN bases its statistics on what are called “drug mentions”. A drug mention is recorded when a person comes into the emergency room and mentions that they had been taking a drug. Obviously there are problems with this type of data collection. Just because a drug was present in the body or was mentioned does not necessarily mean that it is the reason the patient is in the emergency room. However, this data can indicate trends in drug use and abuse.

According to DAWN, in the year 2002, abuse of hydrocodone (Vicodin) mentions increased 160%, methadone mentions increased 176%, morphine mentions increased 116%, and oxycodone mentions increased 560%. (2003) Prescription drug use was on the rise and possibly contributing to people’s trips to the emergency room. Another indication that prescription drug abuse is on the rise is the finding in 1999 of the National Household Survey on Drug Abuse, when it claimed “in 1998, an estimated 1.6 million Americans used prescription pain relievers non-medically for the first time.” (Hampton, 2004)

But the question is, if these drugs were being prescribed by legitimate doctors for pain management, would they be then visiting the hospital? The logical conclusion that a person can draw from this data, while also considering the limitations of the statistics, is that these people

who were visiting the emergency room due to prescription drugs were either not taking the medication properly or were abusing it. Enter the drug seeker.

The American Society of Addiction Medicine came out in 1998 with a Public Policy Statement on the Rights and Responsibilities of Physicians in the Use of Opioids for the Treatment of Pain and claimed

Despite appropriate medical practice, physicians who prescribe opioids for pain may occasionally be misled by skillful patients who wish to obtain medications for purposes other than pain treatment, such as diversion for profit, recreational abuse, or maintenance of an addicted state. The physician who is never duped by such patients may be denying appropriate relief to patients with significant pain all too often...Physicians who are practicing medicine in good faith and who use reasonable medical judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non medical purposes. (p. 129-133)

According to Dr. Patrick Murphy, "Doctors get burned about 8% of the time, and that's if they do everything right." Although it is acknowledged that you can't catch everyone, he points out that there are tricks of the trade that allow skilled medical professionals to determine who is trying to pull the wool over their eyes. The first trick is to just observe. "People show what we call pain behaviors. When a person is experiencing real pain they will act a certain way. However, if a drug seeker is looking to get some medication they will certainly do their best to act as if they're in pain. However, more than likely they will trip over their own lie." (Murphy, 2004)

“Another indication that a person is just looking to “get a fix” is when they call you at 4:30 pm on a Friday and claim that their dog swallowed their prescription. They try to catch you, or your partner, at the end of the day when they think you’re not paying attention.” He claimed that lies such as “my dog ate it, it was stolen, my pills accidentally got flushed down the toilet” are not at all uncommon. (Murphy, 2004) When asked, what do you do when that happens, he replied, “You can not abandon the patient”. Remedies such as limiting prescriptions are all that a doctor can do if they would like to ethically do their job. Murphy explained that he “can not tell you you’re not having pain.” and because of that doctors are usually treat the patient.

Murphy then answered the most obvious question, what can doctors do to protect themselves and their patients? “In order to protect ourselves and our patients we require that an agreement be signed between both parties, where ground rules of the use of the prescription are laid out. If the agreement is violated, then the treatment is terminated” (Murphy, 2004)

In these agreements, there are terms such as: (Consent for Chronic Opioid Therapy, 2004)

1. All prescriptions must come from the physician who signs the contract
2. The pharmacy where the patient will be filling out the prescription is listed, prohibition of sharing prescription with another person,
3. Unannounced urine or serum tests may be requested
4. Original containers must be brought in for every visit

(See Appendix D)

However it is a possibility that if the patient is indeed faking the pain, and is prescribed the medication, they can fulfill all requirements of the contract and never get caught. “If you’re a good enough liar, you can get away with anything” (Murphy, 2004)

Last Thoughts

With greater attention being paid to the under-treatment of pain, the public has become armed with information that will enable them to achieve greater relief. More information into the public's hands on the topic of pain management is generally considered a good thing.

Unfortunately, as usual, there will be people who will abuse the system. Using the information that has been made public as a sign of good faith, drug-seekers are able to accurately fake pain in order to acquire prescriptions that they don't need. Whether they "fake it" in order to abuse or sell the drugs, they are inherently putting a stress on the entire system. The DEA has stepped up and attempted to arm physicians with the information they need to detect drug seekers while also giving them a guideline for how to deal with the situation.

The partnership between the government, medical profession, and the public interest groups is critical in addressing this problem. No one wants to see an elderly person left agonizing in pain from terminal cancer or have a person who has a back injury be unable to function in their daily life. However, in trying to protect the needs of the pained, policy must address those who will be abusing the good will of others. Illegal prescription drug sales and abuse puts a strain on the entire system and needs to be dealt with appropriately. It may take some time for the policy makers to understand the situation and come to an appropriate solution; however, this is a direction we must strive to go in. Only when every patient who suffers is adequately treated and people who are not in pain are denied medication will the job be complete.

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