The Challenges of Treating Pain in the Emergency Department

Elizabeth Nestor, MD, FACEP

"Hi Mrs.S____, my name is Elizabeth Nestor and I'm the Emergency doctor. Tell me what's going on."

"I was sent down from the Clinic. My doctor isn't there and I needed some more pain medicine for my leg; I have lots of screws and rods in there."
or
"My doctor is away and the covering doctor said to go to the ER because he couldn't re-write the prescription for percocet. I have Fibromyalgia. I need to have the 10mg pills"
or
"The pain from my tooth is killing me and I can't get in to see a dentist: they want the money up front."
or
"My son-in-law stole my pain pills."
or
"Here's my MRI. I have really bad disc problems, and my doctor can't do another operation until I get insurance."
or – or – or –

Every day in every Emergency Department (ED) of this state, and I imagine, in most states, these stories are repeated. Just because they are familiar doesn't mean that they aren't true. There is (no question) a lack of availability of clinic appointments, and it is true that covering physicians don't want to prescribe narcotic pain medication for patients they don't know. Dental coverage is only common among well-insured people and tobacco use along with little dental care means there are many patients waiting for the dental clinic appointments which are available; three months is typical. Prescription narcotics are among the most abused/misused medications, and not just sons-in-law, but sons and daughters and neighbors have been known to take mom's meds. And disc disease is an endemic finding, which probably would be present on your MRI as well as mine.

But just because these are plausible histories doesn't mean that we in the ED feel entirely comfortable in simply complying with patient requests. Currently it takes about five minutes, I would say, to search our RI Hospital ED records and see if the patient has been here before with similar requests, and to see what prescriptions have been given. It might take another 5 to search the hospital's medical records for clinic notes which could signal a potential problem with narcotics. It might take 15-30 minutes to reach a **Primary Care Provider (PCP)** if they are available (since covering physicians likely wouldn't know) to enquire if the patient has a problematic history with narcotic use. At RI Hospital (as is the case in all the EDs of the state), we are seeing increasing numbers of patients: we are up 20% over the last six years and continue to be among the ten highest volume EDs in the country. With over 100,000 patient visits per year in our adult ED, we annually see by gross numbers about 10% of the states' population. Some individuals are very high utilizers of our ED. In 2009, 319 patients visited the Anderson Emergency Center 12 or more times, accounting for more than 7000 separate visits. Many of our mid-level providers, residents and Attending physicians feel that an extra 30 minutes spent on a patient who might otherwise be dispositioned in five minutes with a prescription, is an untoward amount of time and threatens patient safety for more critically ill patients. There is a point there. But as a group, the physician and mid-levels of the RI Hospital Anderson Emergency Center have undertaken to make that investigation.

The Joint Commission says that there is "an **epidemic** of critical proportion for persons suffering with **pain" and I agree, but referral to Pain Management centers, from which many patients would benefit is largely for insured patients with PCPs.** Many patients, however, have no doctors or dentists of their own; the clinic systems are overburdened so that referrals to local dental clinics or to our own hospital-based medical clinics may take three months (if one is persistent) to produce a follow-up appointment. Many groups of primary care physicians in the state are either no longer taking new patients or can't provide the space to see their own patients urgently. Patients are left to visit 'emergency rooms' for amelioration of conditions which others might not judge to be emergent. These, among others, are by default our patients.

We have general guidelines (non-binding) at the Anderson Emergency Center of Rhode Island Hospital to limit the number of visits in which we give parenteral narcotics for chronic intermittent non-hemotologic or non-oncologic pain to once monthly, and to limit the number of narcotic prescriptions we dispense these patients to once quarterly. We have a group (the **Patient Centered Approach to Pain, or P-CAP,** including representatives from the provider group and from nursing as well as from the Department of Social Work; two members are also on the hospital Ethics committee) which meets bi-monthly to discuss the situation, and representatives from that group meet regularly with the committee from the RI Hospital clinics which discusses patients with aberrant narcotic use patterns. Other hospital EDs (Miriam and Newport for example) are also involved in similar formal efforts, and these are tied to our continuing efforts to communicate with PCPs about their patients' use of the state EDs, which ranks fourteen among the fifty states plus the District of Columbia, in frequency of ED visits by population (431 per thousand people per year, in 2003).

Emergency physicians have advocated for establishing that a patient's emergency is self-defined. We stand by that position so it is up to us to take responsibility for the appropriate treat-

ment of patients, for coordination of care with the PCPs for the patient, and for trying to arrange adequate (and, one hopes) timely follow-up. It is a mountain of work if done right, and sometimes we slip up, I will be the first to admit.

So—what is the right response to Mrs. S. and to her colleagues-in-pain, quoted at the start of this reflection?

> *"I'm sorry. We have the position that only one person should write narcotics on a patient with chronic pain problems. Go and see your PCP next week/month."*
>
> *or*
>
> *"Here is a prescription for vicodin." or percocet.*
>
> *or*
>
> *"Here is a prescription for Ibuprofen. We don't think treating chronic pain with narcotics is a good idea, and we've spoken to your PCP who will see you tomorrow."*
>
> *or*
>
> *"I've put you in the clinic system as a referral so you can be seen in follow-up. Here is a prescription, but I need to let you know that you may not be seen in the clinic for some months, that they may not re-write this prescription, and that we won't write you another for 3 months. By that time you may actually have an appointment to be seen by a doctor."*
>
> *or – what?*

My guess is that the possible appropriate (and inappropriate) answers are as diverse as are our shared patients. We very much want to be of help in caring for them, and we welcome your deeper insight into their treatment.

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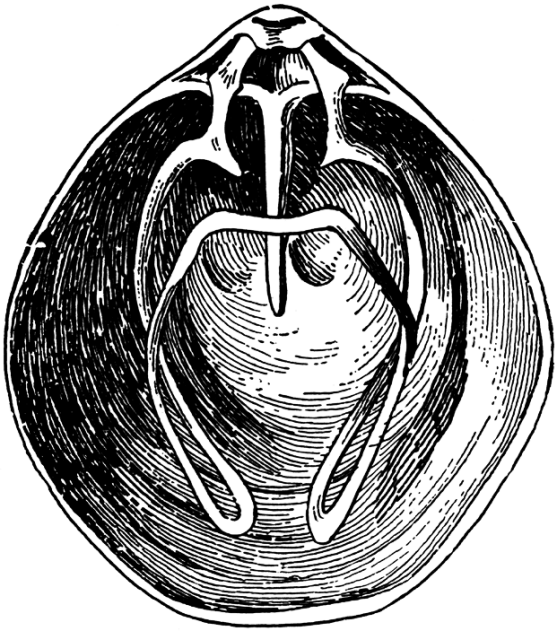
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