
Chronic Pain and Aberrant Drug-Related Behavior in the Emergency Department

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Pain is the single most common reason patients seek care in the emergency department.¹ Given the prevalence of pain as a presenting complaint, one might expect emergency physicians to assign its treatment a high priority; however, pain is often seemingly invisible to the emergency physician. Multiple research studies have documented that the undertreatment of pain, or oligoanalgesia, is a frequent occurrence.² Pain that is not acknowledged and managed appropriately causes dissatisfaction with medical care, hostility toward the physician, unscheduled returns to the emergency department, delayed return to full function, and potentially, an increased risk of litigation. Failure to recognize and treat pain may result in anxiety, depression, sleep disturbances, increased oxygen demands with the potential for end organ ischemia, and decreased movement with an increased risk of venous thrombosis.

Given this state affairs, we should examine the barriers that serve to block the adequate recognition and treatment of pain in emergency departments, as well as other healthcare delivery settings. One of these barriers is the physician's fear of being "duped" by patients who fabricate pain symptoms in order to obtain controlled substances for recreational use or diversion. This article will focus on the problem of substance abuse, and the perceptions of healthcare providers regarding substance abuse, as they relate to patients who present to the emergency department with complaints of pain.

The Prevalence of Pain

Pain is a near universal human experience. Acute pain can be defined in terms of duration: characteristically it is of recent onset and lasts no more than a few days to several weeks. It usually occurs in response to tissue injury and disappears when the injury heals. Acute pain serves an adaptive purpose in that it is associated with protective reflexes, such as withdrawal responses to remove a limb from danger, or muscle spasms that serve to immobilize an extremity; however, some responses associated with acute pain may be maladaptive, leading to impaired immune responses, elevated myocardial oxygen demands, hypercoagulation, and atelectasis.

While less common, chronic pain affects approximately one third of the U.S. population annually.³ Domestic and international survey studies have reported chronic pain prevalence rates as high as forty percent.⁴ Traditionally, chronic pain has been defined as pain

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that lasts for more than three to six months; however, it is better considered as pain lasting longer than the usual time period expected for tissue healing, however long this might be. Given our present understanding of pain-related pathology, chronic pain syndromes are often associated with low levels of identified pathology, particularly when only standard diagnostic techniques are employed; however, as we better understand the biological mechanisms underpinning chronic pain, or use more sophisticated diagnostic technologies (e.g., functional magnetic resonance imaging) this may change. Chronic pain serves no adaptive purpose.

Recurrent pain is best considered a subset of chronic pain. Most patients with chronic pain experience recurrent, acute exacerbations of their pain syndrome

of both groups continued to experience pain of moderate to severe intensity. In fact, eleven percent of children and adults in this study actually reported clinically important increases in pain intensity during the emergency department stay.

A second prospective study, conducted by Tanabe and Buschmann, found that among adults treated at one Chicago emergency department, fully seventy-eight percent presented with a chief complaint related to pain.⁶ Of these patients, only fifty-eight percent received analgesics or nonpharmacologic interventions to treat pain. For patients receiving analgesics, an average of seventy-four minutes elapsed from the time of arrival to the time of treatment. Only fifteen percent of patients were treated with opioids, despite high levels of pain intensity.

Interestingly, sixteen percent of patients with pain in this study indicated that they would have refused analgesics had they been offered. The principal reported reason for their refusal was the fear of addiction resulting from opioid exposure, even when opioids were indicated for the treatment of pain.

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(e.g., low back pain, most patients with sickle cell disease), while patients with migraine headaches, or inflammatory bowel disease may experience few symptoms between painful episodes.

Of particular importance to the emergency physician's assessment of pain, and as one potential explanation for the phenomenon of oligoanalgesia, acute and chronic pain can be associated with markedly different pain-related behaviors. While acute pain is usually associated with objective signs of sympathetic nervous system activation and overt signs of physical suffering, patients with chronic pain may not exhibit such typical behaviors and signs of autonomic nervous system overactivity. This disparity between observed patient behaviors and physician expectations of such behaviors in the setting of chronic pain may lead to inaccurate determinations of pain intensity and ultimately, the undertreatment of pain.

Several studies have attempted to define the prevalence of pain in emergency department settings. Johnston, et al., conducted a prospective study to determine the incidence and severity of pain among patients presenting to non-critical treatment area within the emergency departments of two urban hospitals in Canada.⁵ Fifty-eight percent of adults and forty-seven percent of children reported pain on emergency department arrival. For approximately one-half of both groups reporting pain, the intensity of this pain was considered moderate to severe. At the time of discharge, one-third

In 2002, Cordell, et al., reported an analysis of secondary data from an urban, tertiary-care emergency department using explicit data abstraction rules to determine the prevalence of pain and to assign painful conditions into standard categories.⁷ With inclusion of all age groups, they found evidence of pain in sixty-one percent of patients. Pain was the chief complaint for fifty-two percent of patient visits. After excluding patients less than five years of age for whom chart reviews are obviously less reliable, almost seventy percent of patient encounters were determined to involve pain complaints.

While the high prevalence of pain among emergency department patients is well documented, the underlying conditions responsible for pain in this population are less well characterized. In Cordell's retrospective study, eleven percent of patients presenting to the emergency department were judged to be suffering from pain that was chronic in nature. In a recent prospective multicenter study conducted in the U. S. and Canada, forty-four percent of ultimately discharged patients presenting to the emergency department with pain reported underlying chronic pain syndromes.⁸ In one-half of these cases, the emergency department visit was prompted by an exacerbation of this chronic pain condition. Importantly, patients with chronic pain reported three to four times the number of annual physician visits when compared to those without chronic pain. Median and mean durations of symptoms for those re-

porting chronic pain syndromes were twenty-four and fifty-two months, respectively. For physicians who view themselves as experts in the management of acute medical and surgical emergencies, chronic pain may represent a less familiar condition with which to contend.

The Prevalence of Substance Abuse

Definitions

In discussing issues of chemical dependency and aberrant behaviors related to opioid use, a valid system of nomenclature is necessary for clear communication and measurement. Historically, the meaning of different terms has changed, particularly in light of the increased use of chronic opioid therapy for malignant and non-malignant chronic pain conditions. In treating pain in this population of patients with chronic opioids, confusion over the concepts of physical dependence, tolerance, addiction, and pseudoaddiction may constitute a barrier to understanding and to appropriate treatment. These phenomena are discrete and standard definitions may be helpful in caring for such patients. Currently accepted definitions of these terms are as follows:⁹

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and may otherwise seem inappropriately "drug seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

The term, "substance abuse" is particularly problematic and resistant to precise definition. The American Psychiatric Association has defined substance abuse as a maladaptive pattern of drug use associated with some manifest harm to the user or others.¹⁰ Other groups using consensus methodology have defined abuse as any use considered to be outside of socially accepted norms.¹¹ Determining the bounds of "socially accepted norms" within the broad range of social strata treated within any emergency department is a difficult task. Physicians may believe that they "know abuse when they see it" and its identification may be influenced by subjective judgments that may, or may not, correspond to socially accepted norms for the index patient's particular social group. Often the term, "substance misuse" is applied to behaviors that are not perceived as particularly extreme, e.g., taking opioid analgesics to relieve symptoms other than pain such as anxiety or boredom.

The difficulty in determining whether a given set of behaviors fall within accepted definitions of substance use, misuse, or abuse has important implications outside the clinical realm. Physicians may prescribe controlled substances for the treatment of pain while patients may use these drugs to treat a broad range of symptoms with varying degrees of relatedness to underlying pain syndromes and may, in fact, use drugs in a manner totally unrelated to the physicians' intent, i.e., to obtain euphoric, rather than analgesic, effects. Given the unclear distinctions between use, misuse, and abuse, and a regulatory climate in which practitioners prescribing patterns are increasingly scrutinized, emergency physicians are understandably reluctant to prescribe controlled substances to patients with whom they expect to have only a transitory relationship.

Using any definition, substance abuse is a highly prevalent problem. The National Survey on Drug Use and Health (formerly the National Household Survey on Drug Abuse) reports that in 2003, an estimated 19.5 million Americans, or 8.2 percent of the population aged twelve or older, used an illicit drug during the month prior to the survey interview. Illicit drugs included marijuana, cocaine, heroin, hallucinogens, inhalants, and nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.¹² Importantly, the survey documents an increase in the lifetime reported nonmedical use of pain relievers between 2002 and 2003, from 29.6 million to 31.2 million persons. To be considered "nonmedical" use, the respondent had to take drugs not prescribed for them or take them only for the "experience or feeling" they caused. Specific analgesics showing statistically significant increases in lifetime use were (in order by magnitude): Vicodin, Lortab, or Lorcet; Percocet, Percodan, or Tylox; Hydrocodone; OxyContin; Methadone; and Tramadol.

In contrast to the prominence of emergency department-based data collection systems in efforts to monitor deleterious outcomes associated with substance abuse, relatively few studies have systematically assessed substance abuse prevalence and treatment needs in the emergency department population. As an example, the Drug Abuse Warning Network (DAWN) is a federally financed, public health surveillance system that monitors drug-related emergency department visits and drug-related deaths investigated by medical examiners and coroners. This reporting system involves hundreds of hospital emergency departments throughout the U.S. and provides valuable data with which to monitor drug abuse trends. In contrast to this large monitoring research enterprise, relatively little focus has been given to use of the emergency department as a setting in which to intervene in substance abuse problems.

In 1997, Soderstrom, et al., assessed the prevalence of psychoactive substance use disorders in a large, unselected group of seriously injured patients treated at a Level I trauma center in Baltimore, using standardized diagnostic interviews and explicit criteria.¹³ Psychoactive substance use disorders were diagnosed using the Structured Clinical Interview (SCID), an instrument based on the Diagnostic And Statistical Manual of Mental Disorders, Revised Third Edition (DSM-III-R).¹⁴ Of 1118 patients consenting to the study, more than half had one or more lifetime abuse or dependence psychoactive substance use disorders, and eighteen percent were currently considered dependent on drugs other than alcohol.

In 1996, Rockett, et al., used direct interviews to ascertain unmet substance abuse treatment needs in a statewide probability sample survey of adults presenting to seven Tennessee emergency departments.¹⁵ While only one percent of emergency department medical records indicated a diagnosis of alcohol or drug-related problems, as many as twenty-seven percent of patients were determined by the researchers to need substance abuse treatment on the basis of explicitly defined case definitions. Less than ten percent of patients that were ultimately determined to need substance abuse treatment in this study were actually receiving such care. Thirty-two percent of all patients in this study had a positive saliva or urine assay for psychoactive drugs and nine percent screened positive for opioid use. Unmet substance abuse treatment needs varied directly with the frequency of emergency department visits and inversely with patient age.

A subsequent study by Rockett, et al., examined the association between unmet substance abuse treatment needs in the emergency department and excess utilization of health services in order to estimate the health

care costs savings that might result from effective emergency department-based substance abuse treatment interventions.¹⁶ The researchers estimated that patients with unmet substance abuse treatment needs accounted for an estimated 777 million dollars in extra hospital charges for Tennessee, or 1,568 dollars per emergency department patient when compared to those without substance abuse treatment needs. They suggested that the costs of emergency department-based screening and intervention efforts targeted to substance abuse disorders would be more than offset by savings from decreased health care utilization and that these programs were likely to be highly cost-effective if implemented.

The Problem of “Drug-Seeking Behavior”

The preceding review makes clear the high prevalence of both pain and substance abuse disorders in the emergency department. Although acute and chronic pain is far more common than substance abuse disorders, it is inevitable that emergency physicians will frequently encounter patients presenting with both pain and substance abuse disorders. Professional discussions of pain treatment in the emergency department frequently center on concerns of being duped by such patients who fabricate painful symptoms in order to obtain opioids, so-called “drug-seeking behavior.”¹⁷ “Drug-seeking behaviors” may represent an entirely appropriate response by those with chronic pain who are routinely undertreated by the medical profession and for whom comprehensive pain treatment centers are in short supply. Although the term, “drug seeking behavior,” is poorly defined, it is used in the emergency medicine literature and will be used in this article, with acknowledgement of its imprecision.

Only a limited amount of emergency medicine research has addressed this problematic issue. In 1990, Zechin and Hedges attempted to measure community-wide use of emergency department services by patients at high risk for drug seeking behavior.¹⁸ In this retrospective, observational study patients were categorized as exhibiting drug seeking behavior if they sought care at a university hospital in Portland, Oregon for a specific pain-related diagnosis (i.e., ureteral colic, toothache, back pain, abdominal pain or headache) and were either independently identified on at least one other local hospital’s “patient alert” list or suffered a drug-related death during the year in question. After identifying thirty-three such patients, they determined the frequency of their emergency department visits at each of seven local hospitals and conducted detailed chart reviews of their visits at three of these hospitals. The patients identified as drug seeking were generally young and one-half of drug seekers were female. The

latter is a surprising finding; given that substance abuse disorders are more than twice as common among males.¹⁹ This suggests that drug seeking behaviors are exhibited (or identified) more commonly among female emergency department patients with substance abuse problems than among males.

The thirty-three patients visited emergency departments, urgent care clinics, or were hospitalized a total of 379 times over the study period, for an average of 12.6 visits per person annually. Interestingly, although chart reviews identified seventeen patients who were told

mentation of individualized chronic care plans that included social work interventions at the time of the visits, emergency department use by this group of super-utilizers dropped to a median of 6.5 visits per person per year.

In 2003, a publication by Geiderman discussed ethical, legal, and regulatory considerations surrounding the use of what were termed “habitual patient files.”²² The article acknowledged the common and informal use of such files, and set forth standards intended to promote the development of formal policies and pro-

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that he or she “would receive no further narcotics” at a given facility, these patients subsequently received controlled substances from another hospital in ninety-three percent of cases and from even the same facility in seventy-one percent. The authors suggested that information sharing between hospitals could help to identify drug seeking patients and promote more consistent community-wide care and appropriate substance abuse interventions.

The maintenance of lists that include the names and medical information for patients frequently seen in the emergency department is thought to be a common practice. In a mail survey conducted in 1995, Graber, et al., described the use of what were referred to as “problem patient files” in the state of Iowa. Fifty-eight percent of emergency department medical directors acknowledged the use of such files and responded that the files were consulted an average of 2.6 times per week. Calls between emergency departments either seeking or responding to requests for information about patients listed in these files were estimated to occur twenty-three and twenty times per year respectively. Rarely were explicit policies established for limiting access to these files and information was added to the records in an informal fashion.²⁰

In 2000, Pope, et al., from Vancouver described a case management program for frequent visitors to their inner-city tertiary care emergency department serving a large number of patients with multiple psychosocial problems, including homelessness and substance abuse.²¹ Of twenty-four patients described in this study, five were said to exhibit drug seeking behavior, and eight patients suffered from alcohol and drug abuse, personality disorders, and chronic pain. These twenty-four patients accounted for a staggering 616 visits annually (median 26.5 visits per year). After the imple-

cedures to govern their use. The author noted that such files have never been demonstrated to be effective in either reducing emergency department use by drug seeking patients or in altering care patterns and suggested the need for a research program to explore the impact of their use. Finally, the author called for a coordinated and comprehensive program of physician education to promote the identification and treatment of emergency department patients with substance abuse disorders.

**Pain and Substance Abuse:
A Balanced Perspective**

In managing pain, emergency physicians are responsible for beneficence as well as nonmaleficence. We must treat pain and ameliorate suffering while minimizing the extent to which our treatment strategies enable substance abuse by our patients. For the vast majority of patients presenting with acute monophasic pain, whether from trauma, acute medical illness, or procedures performed in the emergency department, there is little danger of enabling substance abuse and a great deal of room for improvement in the quality of analgesic practices. Multiple published studies have documented the continued prevalence of oligoanalgesia among children and adults treated in our emergency departments.²³

For a small subset of emergency department patients, particularly for those presenting with chronic or recurrent pain syndromes, the physician may have legitimate concerns regarding an underlying substance abuse or related disorder. Our task is to balance the often unclear risk of fostering substance abuse, and even diversion, in this subset of patient with the well-known and well-documented risk of undertreating painful conditions.

To the extent we can clarify the nomenclature used to classify patients with pain and substance use disorders,

we can begin to identify more effective approaches to both problems. To aid in this effort, we will attempt to clarify various phenomena that have been lumped within the term, “drug seeking behavior.”

To begin, it must be said that “drug seeking behavior” is a term best abandoned by our profession. For the patient in pain, seeking an analgesic of proven effectiveness is the height of rationality. In contrast to the search for controlled substances, it is likely that the most common variety of drug seeking behavior is the well documented and relentless quest by patients with self-limited viral upper respiratory infections (or parents of such patients) to obtain antibiotics. The medical profession has a long history of inappropriately prescribing such antibiotics, encouraging antibiotic resistance among common bacterial strains while risking antibiotic side-effects without a justifiable expectation of concomitant benefit.

The concern of physicians is that patients may seek controlled substances, particularly opioids and benzodiazepines, for reasons other than those strictly related to pain relief. Such actions are best termed “aberrant drug-related behaviors” as this term suggests that there is a broad range of behaviors that are more acceptable or less acceptable in the context of pain therapy. Although addiction is the most commonly assumed explanation for such aberrant behaviors, there is an extended differential diagnosis for such behaviors that the clinician should consider.

Although confirmatory research is lacking, expert consensus suggests that aberrant drug-related behaviors reflect a broad range of observed activities that are either more, or less, suggestive of an addiction disorder. (Table 1) Certainly, the presence of an obvious painful condition (e.g., appendicitis, fracture) should preempt concerns about illegitimate drug-seeking behaviors. At the other extreme, even behaviors that are clearly unacceptable do not necessarily indicate addiction or diversion. Hay and Passik have even reported one case of prescription forgery that was seemingly unrelated to addiction or criminal intent. The forgery occurred when the patient’s caregiver was leaving for vacation, prompting excess anxiety and fear of abandonment.²⁴ Addiction is but one of many diagnoses that may lead to aberrant drug-related behaviors. (Table 2)

Given the high prevalence of chronic pain and the widespread unavailability of chronic pain management resources, particularly for populations served by the emergency department, pseudoaddiction is the most likely cause for a large proportion of drug-related behaviors deemed aberrant. In particular, patient reports of distress associated with unrelieved symptoms, aggressive complaining about the need for higher doses of analgesics, and unilateral dose escalation by the pa-

tient are suggestive of pseudoaddiction. Establishing the diagnosis of pseudoaddiction is particularly difficult if the patient has both pain and a comorbid substance use disorder; however, the two can obviously coexist. The signature of pseudoaddiction is that aberrant behaviors disappear when adequate analgesics are given to control pain.

The condition that best exemplifies the problem of emergency department-based pseudoaddiction is sickle cell disease. Vaso-occlusive pain crises are the most common reason for emergency department visits by patients with sickle cell disease and the genetics, molecular biology, and pathophysiology of this disease are relatively well understood. Although the management of sickle cell vaso-occlusive pain crises is viewed as challenging by emergency physicians, it has been a relatively neglected area of research investigation by the specialty.²⁵ Despite the fact that almost all of the 75,000 annual hospitalizations for pain crises occur after emer-

Table 1

Spectrum of Aberrant Drug-Related Behaviors that Raise Concern about the Potential for Addiction.

Less suggestive of addiction:

- Aggressive complaining about the need for more drug
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Openly acquiring similar drugs from other medical sources
- Occasional unsanctioned dose escalation or other non-compliance
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician
- Resistance to a change in therapy associated with “tolerable” adverse effects with expressions of anxiety related to the return of severe symptoms

More suggestive of addiction:

- Selling prescription drugs
- Prescription forgery
- Stealing or “borrowing” drugs from others
- Injecting oral formulations
- Obtaining prescription drugs from non-medical sources
- Concurrent abuse of alcohol or illicit drugs
- Repeated dose escalation or similar noncompliance despite multiple warnings
- Repeated visits to other clinicians or emergency rooms without informing prescriber
- Drug-related deterioration in function at work, in the family, or socially
- Repeated resistance to changes in therapy despite evidence of adverse drug effects

From C. L. Shalmi, “Opioids for Nonmalignant Pain: Issues and Controversy,” in C. A. Warfield, Z. H. Bajwa, 2nd ed., *Principles and Practice of Pain Medicine* (Columbus, OH: The McGraw-Hill Companies Inc., 2004): 607.

gency department treatment, the *Annals of Emergency Medicine*, emergency medicine's premier research journal, has published no clinical research on sickle cell pain management within the past ten years.

Despite our understanding of the sickle cell disease process, many health professionals are reluctant to prescribe adequate doses of opioids for these patients experiencing pain largely due to addiction concerns.²⁶ In one survey study, fifty-three percent of emergency physicians were of the belief that more than twenty percent of patients with sickle cell disease were addicted to opioids, while only twenty-three percent of hematologists shared this belief.²⁷ Also, in this survey thirty-five percent of hematologists reported that they followed pain management protocols when treating painful crises as compared to only seventeen percent of emergency physicians.

Nurses' attitudes regarding the prevalence of addiction among this patient population are even more extreme, with sixty-three respondents reporting that addiction was prevalent.²⁸ Thirty percent of nurses in this survey reported that they were hesitant to administer high-dose opioids for painful vaso-occlusive crises.

A hesitant approach to emergency department opioid administration in the setting of vaso-occlusive pain

crises will predictably lead to continued pain, increased anticipation of pain, and increased patient anxiety. This experience may generate pain-avoidance manifestations by patients than are interpreted by physicians as aberrant drug-related behaviors. Eventually, larger doses of opioids may be administered to control pain that is spiraling out of control with resultant excessive sedation. This apparent sedation in the setting of a painful condition may reinforce the physician's disbelief in the reality of his or her patient's initial pain reports.

It has been demonstrated that this cycle of inadequate care can be broken by the institution of pain management protocols that emphasize continuous opioid infusions and sustained courses of orally administered controlled-release opioids. In 1992, Brookoff and Polomano reported the institution of such a structured analgesic regimen on hospital use by patients with sickle cell disease presenting to the emergency department of an inner-city university hospital in Philadelphia with remarkable results.²⁹ After institution of the pain management protocol, the number of hospital admissions for sickle cell pain decreased by forty-four percent, the number of total inpatient days by fifty-seven percent, the hospital length of stay by twenty-three percent, and the number of emergency department visits by sixty-seven percent.

The authors asserted that these positive results were seen without a subset of patients being "chased away" from the hospital. Others have reported marked decreases in aberrant drug-related behaviors and the number of emergency department visits by patients with sickle cell disease after instituting long-term management of pain with chronic opioid therapies typically used to treat malignant pain.³⁰

Aside from considerations of pseudoaddiction, chronic pain is often accompanied by mood disorders and psychiatric comorbidities that complicate the management of these challenging patients.³¹ The presence of aberrant drug-related behaviors in patients with borderline personality disorders may represent an expression of fear and anger or an attempt to cope with chronic boredom. Patients may use opioids and alcohol in attempts to lessen symptoms of anxiety, panic disorder, depression, or insomnia. Emergency physicians often receive limited training in dealing with such disorders and the specialty's deficiencies in dealing with such problems have been documented.³² Psychiatric consultation, if available, may be useful in both suggesting alternative causes for aberrant behaviors and tailoring the physician's therapeutic approach to deal with these complicating factors.

For some patients, aberrant drug-related behaviors represent criminal intent to divert or sell controlled

Table 2

Differential Diagnosis Considerations for Assessing Aberrant Drug-Related Behaviors.

Addiction Out-of-control behavior; compulsive, harmful drug use

Pseudoaddiction Under-treated pain leads to desperate acting out; patients may turn to alcohol, street drugs, or doctor-shopping; these behaviors subside once pain is adequately treated

Organic mental syndrome Patients often confused and have stereotyped drug-taking behavior

Personality disorder Patients impulsive, have sense of entitlement, and may engage in chemical-coping behaviors

Chemical coping Patients place excessive emphasis on meaning of their medications and are overly drug focused

Depression, anxiety, and situational stressors Patients marked by desire to self-medicate their mood disorder or current life stress

Criminal intent Subset of criminal's intent of diverting medications for profit

From S. D. Passik, K. L. Kirsh, "Addiction in Pain Management," in B. McCarberg, S. D. Passik, eds., *Expert Guide to Pain Management* (American College of Physicians; Philadelphia, 2005): 293.

substances. The prevalence of behaviors occasioned by such intent is unknown and it is likely that in many cases, multiple etiologies of aberrant behaviors coexist. Certainly, patients with active or past substance use disorders are at increased risk for injuries and illnesses that can lead to chronic pain (e.g., motor vehicle injury). Thus, the conditions listed in Table 2 are not mutually exclusive.

Barriers to Improvement

Barriers to the treatment of pain are discussed by other authors in this issue. There is also a paucity of treatment guidelines and best practice standards for emergency department pain care, in part because of the lack of research in this area by emergency medicine investigators. Although the American College of Emergency Physicians has adopted a statement of general principles regarding pain management (Figure 1), the specialty lacks clearly articulated standards to drive pain care and healthcare systems do not include adequate mechanisms to ensure accountability for inferior practice.³³

Given the concentration of patients with substance abuse disorders, the emergency department is an appropriate site for screening and intervention for both alcohol and drug problems; however, emergency physicians received limited training in recognition and appropriate interventions for such problems, and an air of pessimism characterizes physicians' estimation of success for many substance abuse therapies. Translating our knowledge of therapeutic strategies into action against these disorders will require overcoming much clinical inertia.

Although federal regulators and state medical boards do not perceive emergency medicine as a specialty prone to inappropriate prescribing, and investigations of emergency physicians are rare, if not unheard of, many emergency physicians express fears of such scrutiny or sanctions related to prescribing or administering opioids. While this concern is often voiced, it seems likely that this fear represents concern about other, less obvious physician uncertainties related to pain management and substance abuse disorders. Emergency physicians may be concerned about being overburdened by the inherent difficulties of managing patients with complicated pain syndromes and coexisting substance abuse disorders.

In dealing with complex chronic pain patients, the emergency physician practicing in isolation may exhibit symptoms of despair and direct his or her anger toward the patient with pain, resulting in more alienation of patients who may have already been abandoned by other sectors of the healthcare system. This is particularly likely to happen in communities without

Figure 1

ACEP Policy Statement, Pain Management in the Emergency Department

The majority of emergency department (ED) patients require treatment for painful medical conditions or injuries. The American College of Emergency Physicians recognizes the importance of effectively managing ED patients who are experiencing pain and supports the following principles.

1. ED patients should receive expeditious pain management, avoiding delays such as those related to diagnostic testing or consultation.
2. Hospitals should develop unique strategies that will optimize ED patient pain management using both narcotic and non-narcotic medications.
3. ED policies and procedures should support the safe utilization and prescription writing of pain medications in the ED.
4. Effective physician and patient educational strategies should be developed regarding pain management, including the use of pain therapy adjuncts and how to minimize pain after disposition from the ED.
5. Ongoing research in the area of ED patient pain management should be conducted.

multidisciplinary treatment centers for either substance abuse disorders or chronic pain and for those with inadequate healthcare insurance. Thus the patient with chronic pain joins the larger group of those with unmet healthcare needs that currently crowd our emergency departments. The hectic nature of emergency medicine practice often does not allow sufficient time for precisely characterizing patients with complex pain complaints and clinicians may lump legitimate pain behaviors with the ploys of those seeking opioids inappropriately. Both groups of patients may be ultimately mistrusted and treated with disdain.

Finally, the true prevalence of addiction and aberrant drug-related behaviors is unknown and unstudied. There is little research on risk factors for prescription drug abuse to guide the emergency physician. When the prevalence of such problems is overestimated, oligoanalgesia is the predictable result.

Conclusion

Relieving pain and reducing suffering are primary responsibilities of emergency medicine and much can be done to improve the care of patients in pain. We have a concurrent duty to limit the personal and societal harm that can result from prescription drug abuse. Our specialty should continue to refine our approach to the

problem of pain and substance abuse and reduce the current large amount of variability in our practices. We should continue to more precisely define our own standards for excellence in pain practice and substance abuse interventions while promoting quality improvement initiatives to achieve these goals.

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