

An Internet based Questionnaire to Identify Drug Seeking Behavior in a Patient in the ED and Office

Opinion

For a busy physician, one of the more problematic patients is one complaining of a painful condition, and reporting that he or she needs narcotics to alleviate the pain. Of course, pain is the presenting symptom of the majority of the problems a physician sees. In one study, on 22,977 primary care patients, seen in "low-resource" communities, the most common presenting symptoms were general pain, upper respiratory tract symptoms, skin disorders, eye irritation, dyspepsia, and nonspecific abdominal complaints [1]. With increasing frequency, the Emergency Department is being used to replace the primary care physicians [2]. Of the 975 patients questioned, 70.4% (686/975) stated that they had a Primary Care Provider, and 38.1% (252/661) of the sample had attempted to contact their physicians before presenting to the ED. Of the group who attempted to contact their physicians, 62.8% (130) were neither spoken to nor seen by any doctor [2]. In one study of 3163 emergency rooms visits, the most common symptoms were abdominal pain (13%), chest pain (13%), and dyspnea (9%). The complaints of the remaining patients (29%) were primarily traumas, infections, and other diagnoses [3].

Family physicians, pain treatment centers, any other physician specializing in diagnosing and treating pain, and Emergency Department (ED) physicians must constantly be aware of drug seeking behavior of patients. Family physicians and ED doctors are on the "front line," since they usually see patients before other specialties. In one study conducted at two academic EDs, there were 544 patient visits from June 2011 to January 2013, seen by thirty-eight emergency department providers [4]. Emergency providers were able to predict drug seeking behavior with only 41.2% accuracy (34.4% to 48.2%) [4]. Predictors for drug-seeking behavior, using criteria of a prescription drug monitoring program, were patient requests for opioid medications by name, (nearly twice as frequently than other ED patients), multiple visits for same complaint, at 2 ½ times the level of other ED patients, and the subjective rating of symptoms out of proportion to examination. However, the best predictor of drug seeking behavior was the hospital site. One site had three times the level of drug seekers as the other site. The chief complaint of back pain, dental pain or headache were most associated with drug seeking behavior. Drug-seeking behavior was objectively defined as present when a patient had greater than or equal to 4 opioid prescriptions by greater than or equal to 4 providers in the 12 months before emergency department evaluation [4].

While the above methods of predicting drug seeking behavior had some success, they lack a refined approach to accessing patient symptoms, and focus more on behavioral and psychological components. A team of physicians, primarily from Johns Hopkins Hospital and other institutions, have developed a questionnaire, focusing not on the issues of drug seeking behavior per se, but

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rather on the validity of the complaint of pain. Patients are using pain as the reason to request narcotics. Therefore a test which can determine if there is a valid, organic basis for the subjective complaint of pain would reduce any subjective errors and add a medical dimension to the evaluation.

The Pain Validity Test was originally designed to determine if a patient had a normal response to pain for pre-operative patient selection for the Department of Neurosurgery at Johns Hopkins University School of Medicine. It divides patients into objective pain patient and subjective or exaggerating pain patient categories. It was retrospectively derived by reviewing the answers to medical questions in patients who had documented organic pathology, proven by objective medical testing [5]. There was a consistent pattern to the answers to the medical questions in patients with documented organic pathology, and likewise, there was a consistent pattern to the answers in patients in whom no organic pathology could be found [5]. The questions were then asked in a group of patients prior to any medical testing, to see if the answers could predict the presence or absence of organic pathology on medical testing. In a series of multi-authored articles on 794 patients, using predictive analytics techniques, the Pain Validity Test could predict which patient would have medical test abnormalities with 94%-95% accuracy, and could predict which patients would not have any abnormalities with 85%-100% accuracy [5-10]. These findings were independent of any pre-existing or co-existing psychiatric disorder. Therefore, the histrionic patient, who might, under the subjective assessment of the prescription drug monitoring program criteria of "symptoms out of proportion to examination" be judged as a drug seeking patient would conceivably be considered an objective pain patient, with a co-existing histrionic disorder. More simply put, hysterics get disc disease, and schizophrenics get brain tumors. A psychiatric disease does not confer immunity to having organic

disease. There two types of disorders exist on two independent axes [12]. Clearly, a patient with a psychiatric disease or a history of drug seeking behavior, can also have a real organic problem severe enough to warrant the use of medication to reduce the pain and suffering associated with such a problem.

The predictive capability of determining if a patient has a valid pain complaint with 94%-95% accuracy far exceeds the accuracy of the prescription drug monitoring program criteria of 34.4% to 48.2%, reported for the 38 ED physicians who saw patients. The wide inter-rater reliability range of 34.4% to 48.2% is not unusual for assessment tools of a subjective nature. On the other hand, the Pain Validity Test is available in either English or Spanish, as a questionnaire on the Internet. Since the questions asked the patients are always the same, and the interpretation of the answers is done by a computer program, there are no inter-rater reliability issues. It is 100% consistent in the questions it asks, and how it interprets the answers. Restated, there is only one "person" asking the questions, and interpreting the answers as opposed to 38.

The legal issues surrounding the denial of care are complex. As Ballentyne says "...many ethical dilemmas arise, especially in relation to patients' right to treatment competing with physicians' need to offer the treatment selectively" [13]. To this end, the Pain Validity Test has been admitted as evidence in over 30 cases in 8 states, and would offer strong support to a physicians, if he or she chose to or not to prescribe a narcotic to an ED patient [14]. The Pain Validity Test would also allow a physician to determine if there is objective medical pathology, unlike The Opioid Risk Tool (ORT), a screening tool used to assess risk of opioid misuse by rank ordering drug-seeking behaviors and/or identifying risk factors associated with drug abuse [15]. The risk factors associated with abuse include, but are not limited to, family and personal history of alcohol, illegal drug, and prescription drug abuse [15].

Moreover, there is little or no training involved in implementing the Pain Validity Test in the ED. With only 15 minutes of training, and the use of a training manual, with step by step screen shots, any non-medical personnel can administer the Pain Validity Test. It takes five minutes to set up the patient to take the test, in either English or Spanish, and 15 minutes for the patient to complete the test, Within 5 minutes of completion of the test, the results are available, and it takes the non-medical personnel less than 3 minutes to retrieve the results, which are sent in a HIPAA compliant, encrypted fashion back to the requesting physician. In conclusion, the Pain Validity Test administration takes no medical personnel time, gives consistent results, without any training or inter-rater reliability issues, gives a physician objective information on which to make a decision with 95% accuracy, and supports the decision of the physician medico-legally. The test is available at www.MarylandClinicalDiagnostics.com.

Disclosure

The author is CEO of Mensana Clinic Diagnostics, which offers the Pain Validity Test.

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