

## FORENSIC PAIN MEDICINE

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# Medico-legal Rounds: Medico-legal Issues and Breaches of “Standards of Medical Care” in Opioid Tapering for Alleged Opioid Addiction

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### ABSTRACT

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*Objectives.* The objectives of this medico-legal case report are the following: 1) To present an example of a medico-legal problem that developed as a result of reports of alleged opioid addiction that resulted in a decision to taper a chronic pain patient (CPP) from opioids; 2) To present both the plaintiff's and defendant's expert witness opinions as to if and how the care of that patient fell below the “standard of medical care”; and 3) Based on these opinions, to develop some recommendations on how, in the future, pain medicine physicians and other physicians should proceed in similar circumstances in order to avoid allegations of breach of “standard of medical care.”

*Design.* Case Report

*Setting.* Regional Hospital Pain Clinic

*Patient.* CPP

*Interventions.* Opioid tapering because of aberrant drug-related behaviors (addictive behaviors).

*Results.* During the tapering process, the CPP committed suicide. This had medico-legal consequences. Expert witnesses could not rule out the possibility of pseudoaddiction in this CPP.

*Conclusion.* Further research into the concept of pseudoaddiction is required.

*Key Words.* Aberrant Drug-related Behaviors; Addictive Behaviors; Addiction; Pseudoaddiction; Suicide; Medico-legal; Standards of Medical Care; Expert Witness; Drug Toxicology Screens

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### Introduction

The use of opioids for the treatment of chronic nonmalignant pain was mired in controversy for many years [1]. It was once thought that long-term opioid use led to a “downhill spiral” associated with a loss of functional capacity and depressed mood [2]. We now know that this is not the case [2]. Recent

evidence also indicates that a subpopulation of patients with chronic nonmalignant pain can achieve sustained partial analgesia from opioid therapy without the occurrence of intolerable side effects or the development of aberrant drug-related behaviors (addictive behaviors) [1,3]. With long-term opioid treatment for this population, impairment of daily activities, psychomotor speed, sustained attention, and mood have also been reported to improve [4]. A recent meta-analysis [5] of the opioid treatment literature for chronic nonmalignant pain has also indicated that, in general, this group of patients will respond to long-term opioid therapy. Thus, at the

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present time, there is little controversy over whether opioids can be used for the treatment of chronic nonmalignant pain when other options have been exhausted.

Although it appears that there has been a literature consensus reached on the need for chronic opioid treatment for chronic nonmalignant pain patients if other treatments fail, there is a subpopulation within this group that is problematic. These are patients who demonstrate aberrant drug-related behaviors (addictive behaviors) during chronic opioid treatment [1,6]. Aberrant drug-related behaviors are behaviors such as prescription forgery, which can be utilized to operationalize the definition of addiction [1]. These behaviors appear to be a very common “dilemma” situation encountered in general practice impacting on a decision as to whether opioids should be prescribed [7]. It is unclear if these patients should be tapered from opioids by pain medicine specialists, terminated from treatment and referred to addiction facilities or addiction specialists, or maintained on opioids and referred for concurrent treatment by addiction specialists. The case presented below describes such a dilemma and the medico-legal consequences of a decision to taper such a patient based on reports of aberrant drug-related behaviors.

#### **Case Report (please refer to Table 2 for timeline)**

Mr. X was a 57-year-old white male who presented to a regional hospital with chronic low back pain. Psychiatric evaluation noted the following problems: 1) Alcohol abuse history (resolved, but not in Alcoholics Anonymous); 2) History of panic attacks; 3) History of chronic depression; 4) Myocardial infarction with subsequent quadruple bypass 11 months prior to index presentation; and 5) History of oxycodone (Percocet®, Endo Pharmaceuticals, Inc., Chadds Ford, PA) abuse. Mr. X was placed on sertraline with a follow-up appointment.

Primary medicine noted that Mr. X’s chronic low back pain began at age 23 after a motorcycle accident causing a collapsed L4 vertebra. Mr. X was never operated on. For the last 5 years, Mr. X had been managing his chronic pain with oxycodone (Percocet®) at approximately 120 tablets per month. A magnetic resonance imaging scan and an electromyogram corroborated the orthopedist’s diagnosis of lumbar spondylosis and degenerative disk disease. Surgery was not advised. Primary medicine then continued oxycodone as per the original schedule.

Six months after index presentation, Mr. X lost his oxycodone prescription and admitted to abusing oxycodone (Percocet®). His depression had worsened as his wife was ill, they had lost their home, and he had brought out an unloaded gun. A substance abuse counselor diagnosed Mr. X with opioid abuse. As a consequence of this diagnosis, the primary medicine physician made a decision to taper oxycodone. Reasons for this decision were, however, not documented. Referral to the pain clinic for pain education did not help his pain.

Three months after beginning his oxycodone taper, Mr. X presented with severe pain and suicidal ideation, and threatened to kill himself. Pain medicine findings and recommendations were the following: 1) Mr. X was unable to tolerate his pain on the lower dose of 60 oxycodone (Percocet®) tablets per month; and 2) Controlled-release morphine sulfate (CRMS) at 15 mg twice a day was started. Subsequent physical therapy, trigger point injections, and epidurals did not help. Behavior psychology noted that Mr. X did not demonstrate any secondary gain issues; was not a worker’s compensation patient; was not involved in litigation; and was then working full time installing electronic equipment on cars and boats, which increased his pain. Subsequently, controlled-release morphine sulfate was increased to 60 mg per day and immediate-release morphine sulfate was added for breakthrough pain. This seemed to improve Mr. X’s depression and controlled the suicidal ideation. However, on two occasions it was noted that Mr. X had increased the dosage of his controlled-release morphine sulfate by himself without pain medicine’s knowledge.

At 17 months post-index presentation, Mr. X was on 90 mg of controlled-release morphine sulfate per day with pain well controlled. The pain medicine physician referred Mr. X back to primary medicine with the following note in his chart: “I don’t think that at this time it is justified to taper Mr. X off opioids. Mr. X is concerned that this may happen if he returns back to primary medicine.” At primary care, in spite of good pain control, a decision was made to taper Mr. X off opioids. The primary care medicine physician put the following note in the chart, “I do not agree with pain medicine’s treatment plan and recommendations.” It is to be noted here that Mr. X’s primary care treatment was performed by nurse practitioners with supervision by primary care physicians. On a number of occasions, Mr. X’s case was “discussed” with the primary care physician by the nurse practitioner, but the physician did not see Mr. X.

At 26 months post-index presentation, Mr. X had been tapered to 75 mg of controlled-release morphine sulfate per day and requested a pain medicine consultation. The pain medicine physician recommended an increase in the controlled-release morphine sulfate to 90 mg per day and subsequently, to 120 mg per day. However, information from the wife indicated that Mr. X was actually taking 210 mg per day while he was divulging that he was on 90 mg per day. Mr. X was then again referred back to primary medicine where tapering was again initiated.

At 29 months post-index presentation, Mr. X had been tapered to 90 mg per day controlled-release morphine sulfate and presented to psychiatry for increasing depression and suicidal ideation. Evaluation by the psychiatric social worker noted the following: 1) Mr. X was anxious and depressed because his pain had increased; 2) He was contemplating suicide and claimed that he had a gun; 3) There was, however, no suicide plan; and 4) He had been getting pain medications from other sources besides the regional hospital. Diagnosis was major depression and Mr. X was referred to see the psychiatrist.

Psychiatric evaluation revealed the following: 1) Mr. X was not homicidal or suicidal “as when pressed for specifics he showed that he wanted adequate treatment and is not suicidal”; and 2) “Mr. X’s anger at his pain management has caused him to express suicidal thoughts.” The psychiatrist took the following actions: 1) Asked Mr. X to give all his guns to his wife to which Mr. X agreed; 2) Increased the dosage of sertraline; 3) Asked Mr. X and his wife to return immediately if any emergencies arose; and 4) Called primary care, interceding on Mr. X’s behalf to have his opioids increased. Primary care saw Mr. X that day and increased his controlled-release morphine sulfate to 120 mg per day. However, because of administrative problems at the regional hospital pharmacy, Mr. X could not get the increased controlled-release morphine sulfate until 3 days later.

One day after Mr. X received his medications, psychiatric phone contact was initiated. Mr. X claimed that he was not having any suicidal ideation. Three days later, Mr. X was again contacted by phone by the psychiatrist. Here, Mr. X again divulged that he was not suicidal and had given his guns to his wife. The next day, Mr. X died from a self-inflicted shotgun blast to the head. The death was ruled a suicide. Two years later a wrongful death suit was initiated by Mrs. X against the regional hospital and three physicians: Primary care; Pain Medicine; and Psychiatry.

A number of other issues are important to this case. A number of other professionals were involved in Mr. X’s care. These were a social worker, a substance abuse counselor, the psychiatric social worker, a behavior psychologist, and nurse practitioners. Because nurse practitioners are unable to write opioid prescriptions, these would have had to be obtained from the primary medicine physician who was allegedly his/her supervisor. Thus, the nurse practitioner filtered pain medicine information to the primary care physician.

In the litigation process (discovery), both the plaintiff (Mrs. X) and the defendants (regional hospital and regional hospital physicians) were allowed to name expert witnesses. The purpose of the expert witness was to determine whether Mr. X’s medical care fell “below the standard” of the medical community. Table 1 presents the opinions of the plaintiff’s and defendant’s medical experts on the alleged breach of standards of medical care. The author was the defendant’s expert witness. In addition, in the third column of Table 1, the importance of each allegation to pain medicine is outlined. The items in this last column will be discussed further below.

As can be seen from Table 1, the plaintiff’s medical expert alleged that the regional hospital, its physicians, and other professionals fell below the standard in 18 areas. The defendant’s medical expert disagreed and concluded that 6 standards, marked with asterisks, (Table 1) were breached. These were the following: #5, #6, and #7, relating to the psychiatrist; #13, #16, and #18, relating to the primary care physician; and #18, relating to the pain physician. Based on these opinions, the regional hospital decided to settle the case in favor of the plaintiff for an undisclosed sum.

## Discussion

The nature of Mr. X’s case and the subsequent comments of the expert witnesses bring to light a number of issues recently presented in the pain literature. These issues are now becoming important to patient care. In addition, Mr. X’s case also illuminates other older issues, which have also been important to good patient care for many years. Together, these issues appear to be coalescing into expected standards of medical care for chronic pain patients (CPPs). These issues are the following.

First, as pointed out by the plaintiff’s expert witness, pain physicians will be expected to coordinate the treatment of CPPs under their care if they are the primary treating physician (allegation #1). Second,

**Table 1** Plaintiff's and defendant's expert witnesses opinions as to alleged breach of standards of medical care and the medical/legal practice importance of these allegations to pain medicine

Plaintiff's Expert Witness' Allegations of Medical Care Areas "Below the Standard"	Defendant's Expert Witness' Response to Allegations of Medical Care Areas "Below the Standard"	Medical/Legal and Practice Importance of Allegation to Pain Medicine
1. The pain medicine physician failed to adequately coordinate Mr. X's care.	The pain medicine physician did not fall below the standard, as he/she made numerous referrals (coordination) in an attempt to control Mr. X's pain. In addition, he/she made appropriate recommendations to the primary care physician.	Pain physicians may be held to the standard of having to coordinate care of patients under their care.
2. The primary care physician fell below the standard by not adequately assessing the complexity of Mr. X's pain management needs and failed to recognize that he did not have the appropriate training to assume full responsibility for Mr. X's care.	The primary care physician did not fall below the standard here. This allegation would be more appropriate to someone practicing in a nonregional hospital setting where the primary care physician is able to refer the patient out of the system.	Nonpain medicine physicians may be held to the standard of being able to recognize that cases such as Mr. X are outside of their area of expertise requiring referral to pain medicine physicians.
3. The primary care physician fell below the standard of care by not delegating Mr. X's care to a physician experienced in pain medicine.	The primary care physician did not fall below the standard here. The primary care physician had no opportunity to involve pain medicine except through the consultation process, which was done.	As in #2 above.
4. The primary care physician and the pain medicine physician fell below the standard of care by assuming that Mr. X was drug addicted without taking an adequate pain medicine and substance abuse history.	Neither the primary care physician nor the pain medicine physician fell below the standard here. The pain medicine physician took an excellent pain substance use history. Mr. X also had a regional hospital substance abuse evaluation. The primary care physician had access to these evaluations and acted according to the information from these evaluations. Even if these evaluations labeled Mr. X incorrectly as addicted, the fact that these evaluations were performed fulfills the standard.	All physicians, including pain medicine physicians, may be held to the standard of getting an adequate substance abuse history in order to determine the risk/nonrisk for addiction.
*5. The psychiatrist fell below the standard of care by failing to recognize the sense of desperation and suicidal intent and to have taken adequate steps to prevent Mr. X's suicide.	The psychiatrist fell below the standard of care here because he did not appear to be aware of the pain-depression relationship and the significant risk of suicide in pain patients.	All physicians, including psychiatrists, may be held to the standard of understanding the pain-depression relationship and treating pain patients as individuals at high risk for suicide.
*6. The psychiatrist fell below the standard of care by failing to recognize that Mr. X required immediate intensive inpatient treatment to prevent suicide.	The psychiatrist fell below the standard of care here because he failed to contemplate psychiatric hospitalization for Mr. X and failed to document that this was an option, which he had considered and not utilized for relevant clinical reasons.	All physicians, including psychiatrists, may be held to the standard of determining whether a suicidal pain patient requires immediate psychiatric hospitalization. Nonpsychiatric physicians, unable to make this determination, will be held to the standard of referring these patients immediately to psychiatric colleagues.
*7. The psychiatrist fell below the standard of care by failing to perform a comprehensive assessment of suicide risk.	The psychiatrist fell below the standard of care here because such an evaluation is not documented in the chart.	Physicians performing suicide evaluations on pain patients may be held to the standard of documenting a comprehensive suicide examination.
8. The nurse practitioners fell below the standard of care by failing to recognize that Mr. X's pain problem was so complex as to be beyond their area of expertise.	The nurse practitioners did not fall below the standard of care. They are supervised by the primary care physician, and essentially, work under his/her license. As such, it is his/her responsibility to decide, according to the information transmitted, whether further consultations with pain medicine are indicated.	Pain physicians working through and with other medical professionals in a supervisory relationship need to understand that the ultimate responsibility is theirs in any breach of standards.

(continued)

**Table 1** Continued

Plaintiff's Expert Witness' Allegations of Medical Care Areas "Below the Standard"	Defendant's Expert Witness' Response to Allegations of Medical Care Areas "Below the Standard"	Medical/Legal and Practice Importance of Allegation to Pain Medicine
9. The nurse practitioner fell below the standard of care by failing to transmit to the pain physician that Mr. X denied drug abuse and alcohol abuse since 1994. This information could have prevented the taper.	The nurse practitioner did not fall below the standard of care here. The note indicating that Mr. X denied drug and alcohol abuse was signed by the primary care physician. As such, this information was noted by the treating physician and was available to the pain physician. In addition, Mr. X on a number of occasions demonstrated addictive behaviors in reference to opioids. As such, the decision to taper can be medically justified on that basis.	Pain physicians need to be aware that any information gathered by ancillary medical professionals and recorded in the chart can be utilized in determining if a standard has been breached. In addition, they need to treat communications that appear to be inconsistent with the treatment plan in a very careful fashion.
10. The substance abuse counselor fell below the standard of care because, without any particular training in pain medicine addiction or in psychiatry, he diagnosed Mr. X with opioid abuse without any substantiation.	The substance abuse counselor did not fall below the standard of care here for a number of reasons: 1) In the real world, such as a regional hospital system, ancillary personnel are allowed to make pain medicine and psychiatric diagnoses without apparent training in the area; and 2) There was significant evidence in the chart that Mr. X was abusing opioids and demonstrating addictive behaviors.	Organized pain medicine will need to make a decision if it will develop a position on whether patients like Mr. X should or should not be evaluated and treated by ancillary medical personnel.
11. The social worker that last evaluated Mr. X in the psychiatry clinic fell below the standard of care because he did not recognize the complexity of Mr. X's pain problem, and therefore, did not assist in a more aggressive treatment for his depression.	The social worker did not fall below the standard of care here as he evaluated Mr. X and determined that Mr. X was potentially suicidal, and as a consequence, immediately referred Mr. X for psychiatric evaluation. As such, his responsibility was discharged.	As in #8 above.
12. The regional hospital's pain clinic fell below the standard of care because it did not adequately coordinate the care of Mr. X, a complex pain patient.	The regional hospital's pain clinic did not fall below the standard of care here as primary medicine was the entity responsible for coordination of care. In addition, while Mr. X was under the care of pain medicine, numerous consultations were requested and obtained.	Organized pain medicine will need to make a decision if it will develop a position on whether patients like Mr. X should or should not be referred to multidisciplinary pain treatment facilities when other available treatments have been exhausted. This is the only type of treatment that Mr. X did not receive during the 29 months of treatment at the regional hospital.
*13. The primary care physician fell below the standard of care by not adequately explaining why he did not agree with the treatment plan of the pain physician, choosing instead to detoxify Mr. X from opioids.	The primary care physician fell below the standard of care here because he/she did not document the reasons for disagreeing with the consultant's recommendations.	Although the primary treatment physician may disagree with and choose not to follow the recommendations of the consultant, reasons for that decision need to be carefully documented.
14. The primary care physician fell below the standard of care because he did not provide adequate pain treatment.	It is arguable whether a physician can be held to the standard of providing <i>adequate</i> pain treatment, as this cannot be achieved in some situations. However, a physician can be held to the standard of <i>attempting</i> to control pain adequately. As the primary care physician chose not to pursue pain treatment here, but chose opioid tapering because of addiction issues, he cannot be held to this standard.	The provision of adequate pain treatment and of attempting to provide adequate pain treatment in the light of the new JAYCO standards will become major medical malpractice issues.
15. The primary care physician fell below the standard of care because he relinquished the care of a high-risk complex chronic pain patient to a nurse practitioner.	The primary care physician did not fall below the standard of care here, as according to the system, he/she supervises the nurse practitioner and is, therefore, responsible for that patient's care. Therefore, he/she did not relinquish care.	As in #8 above.

(continued)

Table 1 Continued

Plaintiff's Expert Witness' Allegations of Medical Care Areas "Below the Standard"	Defendant's Expert Witness' Response to Allegations of Medical Care Areas "Below the Standard"	Medical/Legal and Practice Importance of Allegation to Pain Medicine
*16. The primary care physician fell below the standard of care because he/she did not adequately supervise the nurse practitioner. This was evidenced by the nurse practitioner's notes where she indicated that she discussed the case with the primary care physician who did not see Mr. X.	The primary care physician fell below the standard of care here because on a number of occasions he/she did not actually see or evaluate Mr. X but relied on the nurse practitioner's verbal reports.	Pain physicians and other physicians involved in the care of a patient being treated by other professionals, need to see and evaluate that patient. Otherwise, they may fall below that standard.
17. The regional hospital fell below the standard of care because although it provided Mr. X with multidisciplinary treatment, that treatment did not generate an interdisciplinary treatment plan.	The regional hospital did not fall below the standard of care here, as this standard can only be fulfilled by multidisciplinary pain centers that provide an interdisciplinary treatment plan. It is unclear whether the regional hospital should be held to the standard of providing such treatment.	As in #12 above.
*18. The primary care physician and the pain physician fell below the standard of care because they did not recognize that alleged drug-seeking behaviors could have been a manifestation of "pseudoaddiction."	The primary care physician and the pain physician may have fallen below the standard of care here because nowhere in their notes do they address the possibility that Mr. X's drug seeking behavior was a manifestation of "pseudoaddiction."	Pain physicians noting "addictive behaviors" in their opioid treatment patients will need to consider the possibility of "pseudoaddiction" before deciding to taper or terminate treatment based on "addictive behaviors."

\* Breached standards.

primary care and other physicians may be held to the standard of needing to recognize that certain CPPs, by the nature of their complexity, are out of their specific area of expertise. Such recognition should/would necessitate either a consultation or referral with a pain medicine physician (allegation #2). Third, pain and other physicians have the right to disagree and not to follow the recommendations of a consultant. However, that decision and the reasons for that decision should be carefully outlined in the chart. Failure to do so, especially if something happens to that patient as a result of that decision, will be viewed as a breach of standards (allegation #13). Fourth, pain and other physicians working with and through ancillary personnel need to clarify if that relationship is consultative or supervisory. If the relationship is supervisory, then that physician will be held liable for any deleterious action of the ancillary medical personnel (allegations #8, 9, 11, 15, 16). In addition, in a supervisory relationship, physicians will be held to the standard of actually seeing the patient versus discussing the patient with ancillary medical personnel (allegation #16). Finally, physicians in both consultative and supervisory roles with ancillary medical personnel need to watch for any documentation by such personnel, which may be inconsistent with the physician's treatment plan. Such documentation can later be used as proof of breach of standards (allegation #9). The fifth issue relates to Mrs. X's expert witness alleging that a

number of standards were breached by the psychiatrist in reference to Mr. X's actual suicide. These breaches essentially related to current knowledge about the pain/depression/suicide relationship in CPPs. It is now well accepted that there is a direct relationship between pain and depression, with greater levels of pain manifesting as greater depression [8]. In addition, CPPs may be at a greater risk for suicide than the general population [9-11]. It is, therefore, incumbent upon all physicians, and especially pain physicians and psychiatrists evaluating pain patients, to be aware of these relationships. Psychiatrists dealing with suicidal CPPs will now need to evaluate these patients as being at particular risk for suicide. Their documentation will need to reflect this fact in order not to fall below the standard (allegations #5,6,7).

The sixth issue relates to the allegation that the primary care physician failed to provide adequate pain treatment (#14). In the opinion of the defendant's expert witness, this is not a reasonable standard to which any physician should be held. However, it is reasonable to hold physicians to the standard of attempting to adequately control patient's pain. In order to demonstrate compliance with such a standard, physicians would then need to document their attempts to adequately control a patient's pain, and in failing to do so, their reasons for such failure and reasons for not proceeding further in attempts to adequately manage pain.

**Table 2** Case of Mr. X. Timeline of events.

Time in Days	Event
-12,204	Beginning chronic pain (motor vehicle accident).
-1800	Beginning regular opioid use for pain control.
-330	Myocardial infarction.
0	Regional hospital presentation. Continued on oxycodone.
+150	Oxycodone prescription loss. Admission of oxycodone abuse. Diagnosed opioid abuse. Decision by primary medicine to taper opioids.
+270	Unable to tolerate pain on reduced dosage opioids. Suicidal. Placed on controlled-release morphine by pain medicine.
+510	Pain well controlled. Not suicidal. Pain medicine signs off. Primary medicine decides to restart tapering.
+780	Unable to tolerate taper. Pain medicine increases opioids even higher. Aberrant drug-related behaviors noted. Pain medicine signs off. Primary medicine restarts tapering.
+870	Unable to tolerate taper. Becomes suicidal. Psychiatric evaluation. Opioids increased slightly.
+873	Begins slightly increased dosage opioids.
+878	Mr. X suicides.
+1608	Wrongful death suit.

The seventh issue relates to the complex problem of whether Mr. X was an addict or a pseudoaddict. Pseudoaddiction is operationally defined as the pain patient who demonstrates aberrant drug-related behaviors that make that patient look like an addict. However, these behaviors stop if opioid doses are increased and pain improves [12]. This indicates that the aberrant drug-related behaviors were actually a search for pain relief, i.e., pseudoaddiction. The issue of addiction/pseudoaddiction is important, as the alleged reason for tapering Mr. X was the belief that he was an addict, as he demonstrated aberrant drug-related behaviors (addictive behaviors). In addition, Mr. X did not belong to Alcoholics Anonymous, members of which are less likely to abuse opioids [13]. However, when Mr. X was on high doses of controlled-release opioids, he appeared to be stable, and he did not resist transfer [14] to controlled-release opioids from immediate-release opioids. These last two observations would lead one to suspect that maybe Mr. X was manifesting pseudoaddiction. In any case, for the issue of whether there was or was not any breach of standards, evidence for *the consideration* of aberrant drug-related behaviors, addiction, and pseudoaddiction should have been provided in the chart. Re-

view of the records indicated that, although substance abuse histories were taken, nowhere in the chart were aberrant drug-related behaviors noted as such and delineated as reasons for tapering. In addition, nowhere in the chart was the possibility of pseudoaddiction considered and discussed as a diagnostic possibility (allegations #4, 10, 18). Thus, all physicians who undertake CPP opioid treatment will need to be cognizant of the concepts of aberrant drug-related behaviors and pseudoaddiction. In addition, in deciding if a CPP is to be tapered from opioids because of aberrant drug-related behaviors, the physician will need to consider the possibility of pseudoaddiction. Otherwise, he/she may open him/herself to charges of breach of standards. In addition, although this was not one of the allegations and was not performed on Mr. X, recent pain literature indicates that toxicology drug screens [15-17] should be an integral part of the management of CPPs on chronic opioid treatment. Thus, drug monitoring may in the future become one of the standards by which decisions as to whether to continue or not continue chronic opioid treatment will be reached. As such, pain physicians will need to consider the need for drug screening and document this in the chart before making a decision to taper or refer CPPs for aberrant drug-related behaviors. Otherwise, they could be accused of a breach of standard.

In spite of the above, it is to be noted that there is little specific evidence for the concept of pseudoaddiction. This concept emanates from one case report [12]. Outside of one large-scale study reported as an abstract [18] no studies on pseudoaddiction exist. In this last study of 500,000 patients, 316 were identified as "problem" opioid patients. Most of these patients were, however, not "problem" patients but appeared to be pseudoaddicts. This last study may then support the concept of pseudoaddiction. There is also some collateral evidence for the pseudoaddiction concept. Arthritic rats appear to intake opioids at rates required to control their pain rather than for the rewarding effects of the drug [19]. This indicates that the two behaviors may be separated in humans also. In addition, addicts as a group appear to be less tolerant of chronic pain than other chronic pain patient subgroups [20]. Thus, it is possible that the pseudoaddiction concept may apply even to addicts. Mr. X's case demonstrates that the concept of pseudoaddiction is not only clinically relevant but is also becoming medico-legally relevant. As such, organized pain medicine should encourage research in this area.

Finally, there are two organized medicine issues that emanate from the case of Mr. X, which are of

importance to pain medicine. The first of these is whether ancillary medical personnel, who may have little training in pain medicine, should be allowed to deal with these complex CPPs (allegation #10). At the present time, with the advent of managed care and other economic issues, a position indicating that ancillary medical personnel may not treat these patients may be unrealistic. However, this issue should be debated. The second issue relates to allegations #12 and #17. Here it was alleged that the complexity of Mr. X necessitated an interdisciplinary treatment plan. Such treatment is generally not available except in multidisciplinary pain centers. Organized pain medicine, then, needs to decide if it will take a position requesting entities, such as regional hospitals, to make such care available to their CPPs.

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### References

- Portenoy RK. Opioid therapy for chronic nonmalignant pain: a review of the critical issues. *J Pain Symptom Manage* 1996;11:203-17.
- Ciccone DS, Just N, Bandilla EB, Reimer E, Ilbeigi MS, Wu W. Psychological correlates of opioid use in patients with chronic nonmalignant pain: a preliminary test of the downhill spiral hypothesis. *J Pain Symptom Manage* 2000;20:180-92.
- Savage SR. Opioid use in the management of chronic pain. *Med Clin North Am* 1999;83:761-86.
- Haythornthwaite JA, Menefee LA, Quatrano-Piacentini AL, Pappagallo M. Outcome of chronic opioid therapy for non-cancer pain. *J Pain Symptom Manage* 1998;15:185-94.
- Graven S, de Vet HCW, van Kleef M, Weber WEJ. Opioids in chronic nonmalignant pain: a meta-analysis of the literature. Ninth World Congress on Pain, Vienna, Austria, 1999, Abstract 339.
- Savage SR. Addiction in the treatment of pain: significance, recognition, and management. *J Pain Symptom Manage* 1993;8:265-78.
- Bendtsen P, Hensing G, Ebeling C, Schedin A. What are the qualities of dilemmas experienced when prescribing opioids in general practice? *Pain* 1999;82:89-96.
- Fishbain DA, Cutler R, Rosomoff HL, Steele-Rosomoff R. Chronic pain-associated depression: antecedent or consequence of chronic pain? A review. *Clin J Pain* 1997;13:116-37.
- Fishbain DA. The association of chronic pain and suicide. *Semin Clin Neuropsychiatry* 1999;4:221-7.
- Fishbain DA, Goldberg M, Steele-Rosomoff R, Rosomoff H. Completed suicide in chronic pain. *Clin J Pain* 1991;7:29-36.
- Fishbain DA. Current research on chronic pain and suicide. *Am J Public Health* 1996;86:1320-1.
- Weissman DE, Haddox JD. Opioid pseudoaddiction: an iatrogenic syndrome. *Pain* 1989;36:363-6.
- Dunbar SA, Katz NP. Chronic opioid therapy for nonmalignant pain in patients with a history of substance abuse: report of 20 cases. *J Pain Symptom Manage* 1996;11:163-71.
- Raggi RP. Methadone therapy compliance as a clinical measurement of chemical dependency. American Pain Society Meeting, San Diego, 2001, Abstract 618.
- Fishbain DA, Cutler RB, Rosomoff HL, Steele-Rosomoff R. Validity of self-reported drug use in chronic pain patients. *Clin J Pain* 1999;15:184-91.
- Fishman SM, Wilsey B, Yang J, Reisfield GM, Bandman TB, Borsook D. Adherence monitoring and drug surveillance in chronic opioid therapy. *J Pain Symptom Manage* 2000;20:293-307.
- Belgrade MJ, Ismail M, Yoon M, Panopoulos G. Non-compliant drug screens during opioid maintenance analgesia for chronic nonmalignant pain. American Pain Society Meeting, San Diego, 2001, Abstract 787.
- McCarberg BH, Laskin M, Permanente K, Escondido CA. Opioid tracking in a managed care environment. American Pain Society Meeting, San Diego, 2001, Abstract 788.
- Colpaert FC, Tarayre JP, Alliaga M, Bruins Slot LA, Attal N, Koek W. Opiate self-administration as a measure of chronic nociceptive pain in arthritic rats. *Pain* 2000;91:33-45.
- Compton P, Charuvastra VC, Kintaudi K, Ling W. Pain responses in methadone-maintained opioid abusers. *J Pain Symptom Manage* 2000;20:237-45.