Re: confusion about the Joint Commission standards

From:

Mike Miller <asamdrmike@gmail.com>

To:

June Dahl <jldahl@wisc.edu>

Cc:

DoctorHLM <doctorhlm@aol.com>, DonKurth <donkurth@aol.com>, drgitlow <drgitlow@aol.com>, Howard204 <howard204@aol.com>, lshomette <lshomette@asam.org>, pmills <pmills@asam.org>, doug_gourlay <doug_gourlay@camh.net>, ESalsitz <esalsitz@chpnet.org>, dgourlay <dgourlay@cogeco.ca>, "Seddon.R.Savage" <seddon.r.savage@dartmouth.edu>, jldahl <jldahl@facstaff.wisc.edu>, Aleksandra Zgierska <aleksandra.zgierska@fammed.wisc.edu>, Dr Douglas Gourlay <dlgourlaymd@gmail.com>, drrichbrown <drrichbrown@gmail.com>, "lori.karan" <lori.karan@gmail.com>, mcmaste1 <mcmaste1@mail.msu.edu>, ecurtis <ecurtis@meriter.com>, emariano <emariano@meriter.com>, ipowell <ipowell@meriter.com>, "louis.baxter" <louis.baxter@papnj.org>, Aaron Gilson <amgilson@uwcarbone.wisc.edu>, "dean.krahn" <dean.krahn@va.gov>, "Steven.d.passik" <steven.d.passik@vanderbilt.edu>, awalaszek <awalaszek@wisc.edu>, joranson <joranson@wisc.edu>, rtbrown <rtbrown@wisc.edu>

Date:

Thu, 21 Apr 2011 11:33:16 -0500

It's good that June and David have been brought into this email exchange.
I have read below 'postings' by Heit, Gourlay, Rich Brown, and Dahl; all good postings.

As I said in my email to ASAM colleagues, and CC to Rich and some UW and Meriter colleagues, I know June and David, have been on panels with them, like them, and they are good teachers.

June has clarified that she was not part of David's group, but she collaborated with them and would join them on panels while on faculty at the dept of pharmacology at the med school.

The need to assure that palliative care and cancer care patients get adequate pain relief, here and abroad, was a real problem, and still is in some quarters; the need to work with FSMB was real, to get them to not sanction docs based on agents prescribed, dosages authorized, or census lists of pain patients ALONE. They have helped a lot.

The problem with the JCAHO standard is that it is applied in inpatient and outpatient settings, for every single patient (yes, a 'fifth vital sign'), and it is a standard about a 'symptom' which never should have happened; the docs on the JCAHO PTAC were uniform back in 2000 in saying there should be no standards about symptoms; otherwise, we'd need to have standards on sleep, sadness, exercise, etc etc. The real problem with the JCAHO standard is that is conveys to patients that they have a 'right' to opioid therapy, which is extremely dangerous for them clinically if they have major depression, primary anxiety, addiction, and especially a somotoform disdorder. Pain is a symptom. [Yes,there are some cases where it IS 'the pathology' and not just a manifestation of a primary disease, but that's quite rare relative to all patients with pain complaints that are 'identified' by the JCAHO standard of 'asking every patient.']

I have no problem with 'connecting the dots' as McLellan and Volkow have done. The standard changed the culture; it changed the expectations of patients and doctors alike; it is a part of the attitude/behavior changes that have led to more prescriptions being written and more prescriptions being diverted, and more people dying.

The newspaper story is about PHARMA support of the Pain and Policy project. The dots are to messages that changed the culture,and now we have an epidemic and ONDCP developing action plans with the CDC about an emerging public health problem. The JCAHO piece is, for me, an 'I was there' story, that I'm willing to share.

Howard allluded to PHARMA being 'a part of the solution.' They can be. So can Dave Joranson's group. Pain Policy isn't just 'let's loosen the restrictions and overcome opiophobia." Pain policy is now needed to deal with the epidemic.

I look forward to ASAM being in a leadership position on this.

Mike Miller
On Thu, Apr 21, 2011 at 10:35 AM, June Dahl <jldahl@wisc.edu> wrote:

> I am writing to eliminate the confusion that appears to have crept into the dialog. I have never been a member of the Pain & Policy Studies Group (PPGS) but have had the privilege of working with the members in various capacities. I can in no way take credit for their work. David Joranson and I met way back in 1977 when I was appointed to the State Controlled Substances Board and David staffed the Board. We created the Wisconsin Pain Initiative in 1986 - later David created the PPSG and has done (more recently with his colleague Aaron Gilson) an amazing job of highlighting the tragic fact that in many countries of the world, opioids are not available to treat pain even in persons who are dying. They have also called attention to laws and regulations in the US which are barriers to appropriate use of opioid analgesics and I was privileged to be able to work with David and Aaron and the FSMB in the early days to address medical board-related barriers. I focused attention on state pain initiatives. However, in the last 15 years, I I have focused on changing the culture of institutions which care for patients in pain because as we all know: education by itself does not change practice. I was able to obtain funds from the Robert Wood Johnson Foundation to work with the Joint Commission to put pain assessment and management in the standards they use to accredit the nation's health care facilities. The PPSG was not involved. Yes, I remember Mike's opposition well. But I have always believed that without standards, there would be no real attention paid to one of nation's major public health problems: the under treatment of pain of all kinds and that without such a mandate clinicians could continue to ignore pain. I am disturbed that the Joint Commission standards have somehow become implicated in our additional current public health problem: the diversion and abuse of prescription pain medicines. There is nothing in the standards about drugs. I was frustrated with the statement on the Commentary by Volkow and McLellan in the April 6th issue of JAMA. They wrote "it is also likely that part of this increased abuse is due to much greater access to and availability of opioid analgesics. This is likely to reflect more aggressive management of noncancer pain, facilitated in part by the regulatory mandate from the Joint Commission to screen and manage pain....." It is really a stretch to go from standards that apply to health care facilities to aggressive management of noncancer pain. If anyone can connect the dots for me, I would like to hear from you. I must confess that I can definitely relate to Steve Passik's comment: I also underestimated the potential problems associated with the use of opioids. When I started in the "business," physicians were fearful of prescribing adequate doses of these drugs to relieve the agonizing pain of persons who were dying. Opioids were essential to provide some measure of comfort to these patients, but they weren't being given in adequate doses at appropriate dosing intervals. We have long emphasized that opioids are just one part of the therapeutic armentarium. Fortunately, the dangers and thousands of deaths related to the use of NSAIDs are finally appreciated. And everyone struggles (or should struggle) with the lack of evidence to support many pain management practices. All involved in finding solutions to our current drug abuse crisis must remember that pain is still inadequately treated (even post-op, trauma and cancer pain); I fear that the angst and emotion of some involved in the debate may move the pendulum back once again and diminish even the appropriate use of opioids.
>
> On 4/21/2011 9:03 AM, Dr Douglas Gourlay wrote:
>
> > I would add a slightly different take on things.
> >
> > In some respects, we're watching a pendulum swing. I can recall some angry debates between members of the Wisconsin Group and those of us who advanced the argument that under treatment of pain could not be used as a rational defense against appropriate assessment and management of risk. "Show me just one credible study that demonstrates that opiates, when used to treat pain 'cause' addiction!" (to paraphrase somewhat) was a common offering by those who felt that opioiphobia had to be stamped out (at all costs). More often than not, the folks shouting the loudest were not clinicians and those of us who suggested a balanced approach were

often looked on with some contempt.

In some respects, the "Iatrogenic Addiction" label has been a red herring. In our fumbling to try and define/prove or disprove its very existence, some lost sight of the fact that many people who did poorly on a trial of opioid therapy actually did better off the drug rather than on. Counterintuitive yes but true never the less. "Problematic users" became stigmatized, sometimes labeled as addicts simply because they were reluctant to accept the notion that they might well do better off rather than on these medications. Especially true when the 'exit strategy' was non existent and the patient was asked or sometimes forced to suffer terrible withdrawal.

As Steve Passik once said as the closing speaker of one of the last Pain and Chemical Dependency meetings Howard and I did, "I think we oversold the benefits of opioids while under appreciated the risks". It struck me as a courageous statement coming from someone who early on truly championed the use of opioids. As Howard would say "the fellow on the wrong path who turns around first is making the most progress".

So, where does Big Pharma come into all of this? Some would say "too little and too late" but how can we exclude a group that has been part of the problem, from being allowed to support the solution? I honestly believe it's naive to pillory the pharmaceutical industry, and banish them from the table. We do have to develop appropriate safeguards that allow some of the money they have in research and education to come into the mix in an unrestricted, optically untainted fashion. After all, "They" are part of the society that is adversely affected by prescription drug abuse.

I don't think we should fear pharmaceutical funds, as long as we have in place credible safeguards to ensure that there truly is no marketing agenda behind the sponsorship. Anyone shouting too loudly that their polar extreme is "right" will almost certainly be found, in the tincture of time to be at best genuinely misguided but misguided none the less.

As usual, the answer to these problems almost certainly resides 'in the middle'. Unfortunately, this is not always a place everyone feels comfortable at.

Sorry for the long post.
Take care,
Doug

On Thu, Apr 21, 2011 at 9:15 AM, <Howard204@aol.com> wrote:

> I agree with Rich.
> Let talk realty here on this subject whether it be pain, addiction, both or a rash.
>
> The tail is wagging the dog: Rotten Johnny who diverts or abuses the medication with a resulting in death of himself or others gets headlines across the nation. Chronic pain patients who are helped with appropriate assessments, rational pharmacotherapy and other modalities as needed never get a line in the media.
>
> Millions of people SUFFER secondary to the under treatment of pain (cancer and non-cancer). Despite this the interface of pain and addiction is ***not*** part of the core training of the healthcare professional in their early education. Therefore, they are woefully under prepared to treat chronic pain. NASPER is not funded.
> Then the height of hypocrisy is blaming the opioid molecule and placing the majority of blame on the pharmaceutical industry. The pharmaceutical industry's funding of CME programs, salaries and grants for research is essential in today's economic climate.
>
> I have one simple question for anyone who disagrees with the above opinions: who would go to an ASAM Med Sci Conference or any other conference if registration was in the thousands of dollars as supposed to hundreds of dollars as a result of dropping all pharmaceutical unrestricted grants? Therefore, everyone who goes to a national medical conference is on the take and in the pocket of Big Pharma because the registration fee was markedly less to pharmaceutical economic support.
>
> Until federal government subsidizes all conferences, mandatory core education and research in the Interface of Pain and Addiction we are concentrating on the wrong target to solve the problem of diversion, abuse and addiction to prescription medications. In these economic times this will not happen in the near or far future.
>
> The above is solely my opinion and I state it as a doctor who treats ***good*** patients in chronic pain with or without a history of addiction plus I was in terrible chronic pain for over 20 years.
> Peace,
> Howard
>
> ***Howard A. Heit, MD, FACP, FASAM**
> **Assistant Clinical Professor of Medicine**
> **Georgetown University School of Medicine**
> **1097 Old Cedar Road**
> **McLean, Virginia, 22102-2439**
> **Office:** 703-442-0109
> **Fax:** 703-442-0234
> **Cell:** 703-472-3634
> **E-mail:** Howard204@aol.com
>
> In a message dated 4/21/2011 8:01:34 A.M. Eastern Daylight Time, drrichbrown@gmail.com writes:
>
> > Thanks, Mike, for bringing everyone this news. I feel compelled to add my perspective.
> >
> > I know June, David and the group's current leader Aaron quite well. Yes, they got started in their work decades ago because of the terrible underprescribing of opioids for patients who sustained terrible pain for weeks and months before dying horrendous deaths from cancer. This is still a huge issue, and it goes way beyond cancer. My cousin's wife died two years ago of complications of severe, disfiguring rheumatoid arthritis after suffering pointlessly from terrible pain for several months. She had never tried illicit drugs and barely drank at all. Her physicians in Tennessee were afraid to treat her pain more aggressively because they feared disciplinary action.
> >
> > June and David worked on a shoestring for a long time. Like many of us at one time or another, they struggled to find funding for causes they believe strongly in. I think they did a great job educating physicians and others about the need to better address chronic pain. Yes, in retrospect, it would have been better if there had been more balance to some of the message, but this is true of so many innovations whose true place (eg, cardiac anti-arrhythmic agents who hurt more patients than they helped, diagnoses of fibromyalgia and chronic fatigue syndrome) in healthcare can only be appreciated after the test of time. People like Mike struggled to balance the message, but way too many of our colleagues still think addiction is physical dependence, don't realize the importance of objective functional measures as outcomes in treating chronic pain, and have a hard time saying no to patients.
> >
> > We still have a long way to go in figuring out how to strike the balance between treating pain and preventing opioid diversion, abuse and addiction. In the mean time, I'm very sad that June, David, Aaron and their colleagues are being cast as villains. They are unsung heroes to countless people around the world who benefited from their work, and to many more whose legitimate pain continues to elicit doubt and neglect from their physicians.

Rich

Richard L. Brown, MD, MPH
Professor, Department of Family Medicine
University of Wisconsin School of Medicine and Public Health

Clinical Director
Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)
www.wiphl.org

330 East Lakeside Street
Madison, Wisconsin 53715
Voice: 608-263-9090
Fax: 608-263-8529
E-mail: tlbrown@wisc.edu

On Apr 21, 2011, at 6:00 AM, Mike Miller wrote:

> i hope you can read the 'comments' and link to the story
> i did not know of the investigation by the Milwaukee paper
> i did not know what was going on behind the scenes with Dean Golden and Chancellor Martin
> Dave Joransan is a nice guy: they began as part of the Carbone Comprehesive Cancer Center at UW, trying to address opiophobia on the part of cancer docs, domestically and then internationally, saying cancer patients should get adequate dosages and 'fear of creating addiction' in a patient should not lead oncologists to be hesitant.
> Then they became the UW Pain and Policy Studies group, a spin off of the Cancer center, and worked on policy changes: working with the Federation of State Medical Boards to stop having policies that said you'd lose your license if you prescribed doses too high.
> Then they brought their idea to the Joint Commission.
> Dave Joranson PhD teamed with June Dahl PhD from Madison to go to the JCAHO to get them to put in that standard about pain assessment. I was chair of the JCAHO Hospital Accreditation Program PTAC at that time. I led efforts to shoot down their proposal. It did not pass during my year; after my term ended, they came back and got staff at JCAHO to re-introduce it and it passed.
>
> I like Dave and June very much; we have collaborated on talks many times. I have always disagreed with the JCAHO standard.
>
> I hope you can read the story from this morning's paper below.
>
> ---------- Forwarded message ----------
> From: <asandrmike@gmail.com>
> Date: Thu, Apr 21, 2011 at 5:49 AM
> Subject: UW group ends drug firm funds - JSOnline
> To: asandrmike@gmail.com

Milwaukee Journal Sentinel

* Please note, the sender's email address has not been verified.

This was discussed in the hallways during the Pain and Addiction Course: where did the epidemic come from, and I said "from the UW Pain Group" and people said "no, they're just promoting things internationally where cancer patients are not given opioids" and I said that this group was the spearhead of the JCAHO standard which made pain the '5th vital sign' and led patients to that notion that they have a 'right' to an opoid script.' And now, this story, which I see as significant.

Click the following to access the sent link:

UW group ends drug firm funds - JSOnline*

SAVE THIS link | FORWARD THIS link

Get your EMAIL THIS Browser Button and use it to email content from any Web site. Click here for more information.

*This article can also be accessed if you copy and paste the entire address below into your web browser.
http://www.jsonline.com/watchdog/watchdogreports/120331689.html

--
Michael M. Miller, MD, FASAM, FAPA

Immediate Past President, ASAM

Director, American Board of Addiction Medicine and The ABAM Foundation

Vice Speaker, Wisconsin Medical Society House of Delegates

Medical Director, Herrington Recovery Center: mmiller@rogershospital.org
Voicemail 262 646 1056 (desk phone at Herrington Recovery Center, RMH)
Cell 262 354 4247 or 608 695 8913
To Page, dial 800 767 4411 and ask the Rogers Memorial Hospital switchboard to page me

=

--
Michael M. Miller, MD, FASAM, FAPA

Immediate Past President, ASAM

Director, American Board of Addiction Medicine and The ABAM Foundation

Vice Speaker, Wisconsin Medical Society House of Delegates

Medical Director, Herrington Recovery Center: mmiller@rogershospital.org
Voicemail 262 646 1056 (desk phone at Herrington Recovery Center, RMH)
Cell 262 354 4247 or 608 695 8913
To Page, dial 800 767 4411 and ask the Rogers Memorial Hospital switchboard to page me

CA Trial Exhibit No.:P-CA-1594

BegControl:WIS_PPSG_005818

EndControl:

System Created On:10/23/2018 2:49 AM GMT

Folder Name:20181019

Custodian:/001-118/001-118/PPSG-Ohio (17M0284)/WIS_PPSG_000001.7z

Custodian - All:Pain & Policy Study Group (Univ. of Wisconsin)

Original Folder Path:

Date Created:

Date Last Modified:5/25/2018 12:00:00 AM

New Text Field - Empty-01:WIS_PPSG_005818

CT1A TREX List:

CT1B Exhibit List:

CT2 Exhibit List:

Oklahoma Trial List:

NY Exhibit List:

MDL Depo Exhibit:

PSJ/D - ECF NO.:

Defendant Used Documents:

Plaintiff Used Documents: