

PAINinfo



NEWS FROM THE FLORIDA ACADEMY OF PAIN MEDICINE ♦ VOL 8, NO. 2 ♦ Fall 2003

PRESIDENT'S MESSAGE

Ashraf F. Hanna, M.D., Clearwater Spine Institute

Medical malpractice/tort reform is the number one issue FAPM members wish me to concentrate on during my term as FAPM president. As we all know, Florida's 2003 Legislative body turned out a bill that established a \$500,000 limit on non-economic damages. Here is some additional information about the new legislation that comes from both a consultation with my attorney, Alan S Gassman (agassman@gassmanpa.com), and the Florida Medical Association's website at this location: http://www.fmaonline.org/tort/cap_summary.html

LATEST UPDATES AND INFORMATION ON MALPRACTICE INSURANCE

1. Caps in Routine Medical Malpractice Cases:

The cap on non-economic damages is split into two categories for physicians and health care providers, and a separate category applies to hospitals, HMOs, etc.

In the physician category, the bill established a \$500,000 cap on non-economic damages per claimant, regardless of the number of defendant physicians. Any one physician, however, regardless of the number of claims, is not responsible for more than \$500,000. The maximum amount of non-economic damages all claims can recover in the aggregate against all physicians is \$1,000,000.

2. Situations in Which the Cap Can Be Pierced:

In cases involving wrongful death and permanent vegetative state, all claimants may recover a total of \$1 million from all physicians without any special findings by the court. Briefly summarized, a catastrophic injury is defined as paralysis, amputations, severe brain injuries, severe burns, blindness, and loss of reproductive organs. It is important to note that regardless of whether the cap is right or not, and regardless of the number of defendants or the number of claimants, the maximum amount of non-economic damages awardable in any one case in the physician category is \$1 million.

3. Litigation Reform:

This provides for the increased exchange of information in the presuit process, which remains unchanged at 90 days. The change is that the defendant will be able to take the unsworn statement of the plaintiff's treating physicians, but must provide notice and the opportunity for all parties to be present.

Provides for new standards as to who can testify as expert witness in a medical negligence trial. The bill provides that the expert who signs the presuit affidavit which starts the process rolling must have the same qualifications as the expert who testifies at trial. This is a key change.

Provides for mandatory mediation of all medical negligence suits within 120 days after suit is filed.

Removes unlimited recovery of damages provision from negligence cases where defendant refuses to arbitrate. This is important to ensure that the plaintiff cannot use arbitration to get around the cap on non-economic damages.

Mandates a study to determine whether medical review should be included as part of the presuit process.

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PRESIDENT'S MESSAGE CONTINUED

Ashraf Hanna, M.D. (Continued)

Requires a statement in each malpractice settlement to note that a decision to settle may reflect an economic decision and is not an admission of a deviation from the standard of care.

4. Vicarious Liability:

The bill overrules the Villazon decision and provides that the fact an HMO provides for the provision of health care does not create an actual or apparent agency relationship for purposes of vicarious liability. Hopefully this change will eliminate suits against physicians in which the real objective is to get to the deep pockets of the HMO and cause HMOs to drop the requirement that physicians on the panel carry malpractice insurance.

5. Safe Harbor:

The bill provides a medical malpractice insurance company cannot be held in bad faith if it tenders policy limitations. If either party is responsible for unreasonable delays, they lose the benefit of the more favorable safe harbor. The failure to offer to settle during the safe harbor period does not create a presumption that the insurance company acted in bad faith.

6. Malpractice insurance rate reductions:

Earlier versions implemented a rate rollback of insurance, but this bill reflects a reduction factor determined by the Florida Office of Insurance regulation. This bill also makes a number of other changes in how rates are calculated and approved.

7. Physician Financial Responsibility:

This bill does not change the ability of a physician to self insure (or "go bare" as it's commonly referred to). It does prohibit "wasting" insurance policies. These policies however, are rare in Florida.

8. Patient Safety:

The bill contains a number of provisions recommend by the Governor's Task Force that are designed to improve patient safety.

In addition, while the law does require that there be a claims made malpractice policy in place while a physician is practicing, the law may not require a physician to purchase a tail or retroactive coverage when he or she switches carriers.

An alternative to the malpractice insurance liability requirement is to post cash or a bond or letter of credit under an arrangement permitted by the Statute. The bond or letter of credit must be in the amount of \$750,000 and will then be exposed up to \$250,000 per claim for a physician with hospital or ambulatory surgical center (ASC) staff privileges. The numbers go to \$300,000 posted, and \$100,000 exposed per claim, for a physician who does not have hospital staff privileges. Banks usually will not provide letters of credit without significant collateral.

Except for the alternative, the statute requires \$100,000/\$300,000 coverage for physicians who do not have staff privileges at any hospital or ASC and \$250,000/\$750,000 coverage for physicians who have hospital and/or ASC staff privileges at any hospital. These policies are claims made policies. To have continuing coverage after policy term, the physician can purchase a tail coverage or have subsequent carrier provide retroactive nose coverage.

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Going Bare: The physician may meet the Florida statutory requirements by assuring the Agency for Healthcare Administration (AHCA) in writing that if there is a malpractice judgement, the physician will pay the plaintiff the amount of the judgement up to \$250,000. The statement the physician signs must indicate that arrangements have been made for this to occur. If a patient obtains a judgement against the physician and the physician does not pay the patient the \$250,000, then there could be serious licensing and bankruptcy right issues. Payment must be made

PRESIDENT'S MESSAGE CONTINUED**Ashraf Hanna, M.D. (Continued)**

within 60 days of the judgment becoming final unless a timely appeal is filed. A physician who goes bare must post a sign in his or her reception area stating this fact.

As you can see from this article, there are misconceptions and many traps for the unwary. Florida physicians contemplating anything other than a conventional malpractice insurance policy should contact qualified advisors to determine how best to proceed.

Regarding the new law, there is little that is deleterious to our position with the exception of the \$500,000 cap on non-economic damages, especially for physicians with a number of penetrations or exceptions. From organized medicine's perspective, a cap of \$250,000 is preferable. From each individual physician's perspective, please see Attorney Gass' "Advantages and Disadvantages of Lowering Malpractice Insurance Limits," located elsewhere in this issue of PainInfo. All in all, a cap amount of \$500,000 could be beneficial with stabilization of premiums and a reduction in premiums up to 12%.

FAPM supports Florida physicians continuing to work with the Florida Medical Association to bring the medical malpractice crisis even further in-hand. Citizens for a Fair Share is just such an effort. Please see the article on Citizens for a Fair Share on page 10 of this issue of PainInfo.

Executive Director's Message***Lorry S. Davis, M.Ed.***

***Mark your calendars and plan to be with us for FAPM's
2004 Annual Meeting, /FSPMR's Spring Meeting/FSIPP's Spring Meeting***

FAPM, Tort Reform and Work Comp Reform

FAPM has been busy. Not only are we involved in organized medicine's efforts towards tort reform (see Dr Ashraf Hanna's President's Message, front page), we are also participating in the Florida Medical Association's Advisory Panel to the Three Member Panel. The 3MP is the rate-setting body for workers' compensation physician services reimbursement in this state.

In addition to FAPM's \$1,000.00 contribution to Citizens for a Fair Share (tort reform), FAPM has contributed financially to the work comp reform effort. FAPM's work (physicians' and executive director's time) and financial contributions have helped (in concert with many other specialties all under the FMA banner) to bring about a \$500,000.00 cap in non-economic damages, and a work comp reimbursement rate of 110%/140% (nonsurgical, surgical) of Medicare to go into effect January 1, 2004.

These two initiatives are ongoing projects in which FAPM continues to participate. Neither the tort reform nor the work comp reform is all that we want or need, but it is progress.

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***Interested in placing a business card
ad like the one to the right in the
Spring 2004 PainInfo?
Contact Lorry Davis,
Tel: 904-270-8886,
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Executive Director's Message *(continued)*

Florida Pain Medicine Accreditation and Standards, Inc.

You heard about Florida Pain Medicine Accreditation and Standards, Inc., at our 2003 Annual Meeting. FPMA&S is moving towards becoming operational. FPMA&S' certification of a pain clinic will let insurers, patients, other physicians, and the public know that the clinic has been found to be in line with best practices, both clinical and administrative.

FAPM's 2004 Annual Meeting

We are excited about FAPM's 2004 meeting to be held June 11 – 13 at The Ritz Carlton, Coconut Grove, Miami. Coconut Grove is a beautiful waterfront village in which it is fun to walk around and sightsee, shop, and dine. The Ritz-Carlton, as always, is a tastefully appointed hotel with all the amenities.

Dr. Sanford Pollak (President-Elect) has put together a wonderful program for our 2004 meeting. Please see the insert "Schedule at a Glance." Again, workshops will be held on Friday, lectures all day Saturday and half a day Sunday.

Registration packets will be mailed out after the first of the year, and will also be posted on FAPM's website: <http://fapm.med.new.net>. Registration materials will also be included in the Spring 2004 issue of PainInfo, as well as being on the website.

For Ritz-Carlton Reservations and FAPM Membership

For Ritz-Carlton Coconut Grove reservations, call 305 365 4500 or 888 564 8660. Room rate is \$155.00. Tell them you are with the Florida Academy of Pain Medicine (even if you are with FSPMR or FSIPP) to receive this excellent Ritz-Carlton rate.

Enclosed in this issue of PainInfo is an FAPM Membership Application. If you would like to join, you will receive discounted registration rates at the annual meeting. Other benefits include, but are not limited to:

- Educational programs designed to keep you up-to-date on the latest developments in pain medicine include
- Information resources to provide practical insight into dealing with third party payers and staying out of trouble with regulatory agencies
- Opportunities for the exchange of information and experiences with colleagues who have encountered problems similar to those with which you are dealing
- PainInfo, the Academy's periodical newsletter, which keeps you informed as to upcoming meetings, Academy activities, and economic, legislative and regulatory information (both state and national) which affects your practice
- The Pain Clinic, FAPM's official journal, published every other month
- Representation within Florida's recognized organized medicine body, the Florida Medical Association, both via a seat in the FMA House of Delegates, and a seat on the FMA Specialty Council.

FSPMR to Meet Again in Conjunction with FAPM Annual Meeting

The Florida Society of Physical Medicine and Rehabilitation will, for the second year in a row, have their spring meeting in conjunction with FAPM's Annual Meeting. FSPMR's business meeting and luncheon will take place on Sunday, June 13, 12:30 – 3 pm, at the conclusion of the FAPM meeting. If you are a member of FSPMR and plan to attend the luncheon meeting (whether you are or are not attending the FAPM Annual Meeting), please RSVP to Lorry Davis (904 270 8886, Lorry4@earthlink.net).

FSIPP to Meet in Conjunction with FAPM's 2004 Annual Meeting

And for the first time, the Florida Society of Interventional Pain Physicians will meet in conjunction with FAPM's Annual Meeting. Dr. Andrea Trescot (Past President) is President of FSIPP. FSIPP's business meeting and dinner will take place on Saturday, June 12, 7 – 9 pm. Please RSVP to Dr Trescot (904 276 9311, amt57@aol.com) if you plan to attend FSIPP's dinner meeting.

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Continuing Education Schedule-at-a-Glance

FAPM 2004 Annual Meeting

June 11 – 13, 2004, Ritz Carlton Coconut Grove, Miami

Friday, June 11, 2004 - Morning Workshops:

Use of the C-Arm in Injection Therapy for Pain Management of the Lumbar Spine (Cadaver Class)

Robert D. Gruber, D.O., Physical Medicine & Rehabilitation, Clearwater, FL

Botulinum Toxin and Pain (Live Subject/s)

Gary W. Jay, M.D., Neurology/Pain Medicine, Tamarac, FL

Afternoon Workshops:

Regenerative Injection Therapy (Cadaver Class and Lecture)

Felix S. Linetsky, M.D., Orthopaedics/Pain Medicine, Palm Harbor, FL

Peter W. Taraschi, D.O., Family Practice/Pain Medicine, Palm Bay, FL

X-rays, MRIs, and CTs for the Non-Radiologist

Lydia Linetsky, M.D., Radiology, Clearwater, FL

Saturday, June 12, - Morning:

“**Interventional Headache Management,**” Andrea M. Trescot, M.D., Anesthesiology/Pain Medicine, Orange Park, FL

“**Traumatic Spinal Injuries,**” Richard J. Boehme, M.D., Neurology, Jacksonville Beach, FL

“**Orofacial Pain,**” Ralph Garcia, Jr. D.D.S., Tampa, FL

“**Pain in the Elderly,**” Laura Yard, M.D., Interventional Pain Medicine, Venice, FL

“**Medicare Update,**” Jim Corcoran, M.D., Medical Director, First Coast Options, Jacksonville, FL

Afternoon:

“**Proper Use of Opioids in the Pain Management Setting,**” Raphael Miguel, M.D., Anesthesiology, Tampa, FL

“**Biomechanics and Imaging and Pain,**” Joseph D. Fortin, D.O., Interventional Pain Medicine, Ft. Wayne, IN

“**Differential Diagnosis of Headache,**” Gary W. Jay, M.D., Neurology/Pain Medicine, Tamarac, FL

Sunday, June 13, Morning:

Required Courses for Florida Physician Licensure Renewal (MD and DO):

“**Domestic Violence,**” Walter Lambert, M.D., Miami, FL (1 hr)

“**Prevention of Medical Errors,**” Linda Blythe, FPIC, Jacksonville, FL (2 hrs)

“**HIV/AIDS,**” (1 hr) Speaker to be announced

**This program is almost “carved in stone,” but FAPM reserves the right to make changes in program content and/or speakers if necessary.*

Executive Director's Message (continued)***2004 Meeting Sponsors/Exhibitors and FAPM's Website***

FAPM's website (<http://fapm.med.new.net>) has the latest information on our upcoming meeting, including a Sponsor/Exhibitor Prospectus which you can download and share with vendors whom you think might like to participate. Or you can simply give them the website address and let them get the information. The Exhibit Hall is always a major center of activity for the meeting. At this year's meeting, we made it even more enticing for conference-goers by having a drawing for a \$500.00 gift certificate to Best Buy. Every attendee who visited every exhibit booth got to enter the drawing. Dr. Ruben Gonzalez, an FAPM member, was this year's winner. We have not yet decided what the 2004 prize will be!

FAPM's Website

FAPM's website also includes recent issues of PainInfo, meeting minutes and other communications, related links (if you have a website you would like linked to FAPM's website, or if you have information you think should be on FAPM's website, please contact our webmaster, callrob@comcast.net), member listings, and much, much more. Check it out! <http://fapm.med> or <http://fapm.med.new.net>.

The Need for a Federal Prescription Drug Database

Dr. Andrea M. Trescot, FAPM Past President, and President of the Florida Society of Interventional Pain Physicians, forwarded this ASIPP Fact Sheet for the benefit of all FAPM members.

The National All Schedules Prescription Electronic Reporting Act, or NASPER, is a bill proposed by the American Society of Interventional Pain Physicians to provide and improve patient access with quality care, and protect patients and physicians from deleterious effects of controlled substance misuse, abuse and trafficking.

For more information about NASPER, go to <http://www.nasper.org>. This website includes, among other things, the actual bill (H. R. 3015, To amend the Public Health Service Act to establish an electronic system for practitioner monitoring of the dispensing of any schedule II, III, or IV controlled substance, September 4, 2003), and legislative sample letters.

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS**FACT SHEET ON THE NEED FOR*****A FEDERAL PRESCRIPTION DRUG MONITORING DATABASE******All content copyright 2002, American Society of Interventional Pain Physicians***

Public Health Issues: Health care practitioners and pharmacists desperately need a federal electronic monitoring system to ensure that they are prescribing and dispensing Schedule II, III, and IV controlled substances that are medically necessary. Without such a databank, practitioners and pharmacists have no way of knowing whether a particular patient is receiving the same medication from other practitioners. Patients may be receiving Schedule II, III and IV prescriptions from multiple practitioners who are unaware of the potential for drug interactions or of the potential for abuse and trafficking of certain medications. All of these situations pose serious public health issues. A federal electronic databank would allow physicians to access the information necessary to ascertain that a particular prescription is unnecessary. This proposal means good patient care and good medical practice.

States' Recognition of the Need for Such Databanks: The need for an electronic monitoring system is evident from the fact that 15 states, including California, Hawaii, Idaho, Illinois, Indiana, Kentucky, Michigan, Nevada, Oklahoma, Texas and Utah, have created such systems. Florida and Virginia are enacting such programs. The state programs vary with respect to the schedules of substances for which reporting is required. Most states, like California, capture data only for Schedule II prescriptions, while a few, like Kentucky, capture data for Schedule II - V prescriptions. The NASPER that ASIPP is proposing would require reporting Schedule II, III and IV prescriptions. Systems that only target Schedule II drugs fail to track many of the moderately abused drugs.

The Need for a Federal Prescription Drug Database (*continued*)

U.S. GAO Suggests Further Action Needed Than That Taken through the State Databases: In May 2002, the GAO reviewed existing state monitoring programs and concluded that they indeed provide an efficient tool for stemming the growing problem of illegal diversion of prescription drugs. They offer quick access to comprehensive information on drugs most likely to be abused and deter abusers from doctor shopping within the state. Further, only a few programs operate proactively, while most operate reactively. *Incidents of drug diversion, however, are on the rise in neighboring states, indicating the problem is proliferating or shifting to states without monitoring programs. This underscores the interstate nature of the problem and the need for a national database.*

The Need for a Federal Databank: Most states unfortunately, do not have electronic monitoring systems in place. *The GAO explains this as a problem of awareness about the magnitude of the problem.* GAO explains that with a highly effective KASPER program in Kentucky, which shares boundaries with seven states, only two of which have prescription monitoring programs, drug diverters have moved their diversion activities to nearby non-monitored states. Consequently, OxyContin diversion problems have worsened in Tennessee, West Virginia, and Virginia – all contiguous non-monitoring states – because of the presence of Kentucky's KASPER program, according to a joint federal, state, and local drug diversion report. The GAO report also stated that one challenge faced by states attempting to control diversion and abuse of controlled substances, is a lack of awareness of the seriousness of this public health and law enforcement problem.

Nationally, prescription drug abuse involves a multibillion-dollar illegal diversion market, resulting in deaths of abusers, and is as significant a problem as abuse of illegal drugs. Multiple states also have created controlled substance task forces and OxyContin task forces. The first prescription drug monitoring program was established in California in 1940. The number of states with prescription drug monitoring programs has grown only slightly over the past decade, from 10 in 1992 to 15 in 2002. In addition, state programs that are in place are neither uniform nor integrated. Patients moving from one jurisdiction to another (as in cases involving Virginia, the District of Columbia, and Maryland) will typically be able to obtain multiple prescriptions by merely crossing state lines. The conscious and more prevalent unconscious misuse of Schedule II, III and IV controlled substances are a national problem that cannot be effectively addressed on a state-by-state basis. NASPER allows states to have their own systems so long as they share data with the federal databank to deal with cross-borders.

Prevalence of Drug Abuse: The National Institute of Health-National Institute on Drug Abuse (NIH-NIDA) reported that in 1999, about 14.8 million Americans were current users of illicit drugs. The 2001 National Household Survey on Drug Abuse, found statistically significant increases between 2000 and 2001 in the use of multiple drugs including marijuana, cocaine, and non-medical use of pain relievers and tranquilizers.

Based on the 1997 survey, 4.2 million people used analgesics (pain medications), 2.1 million people used tranquilizers (sleeping and anxiety pills) and an additional 2.3 million people used various other drugs. This survey also indicated that the non-medical use of prescription drugs exceeds that of all illicit substances except for marijuana and hashish.

The principle drug of abuse for nearly 10% of US patients in treatment is a prescription drug.

The National Household Survey on Drug Abuse of 2001 reported the number of persons reporting use of OxyContin for non-medical purposes at least once in their lifetime increase four-fold from 1999 to 2001.

Between 2000 and 2001, there was a significant increase in the estimated number of persons needing treatment for an illicit drug problem from 4.7 million in 2000 to 6.1 million in 2001.

Adults who used illicit drugs were twice as likely to have serious mental illness as adults who did not use an illicit drug.

Marijuana is the most commonly used illicit drug, which functions as a gateway for use of other illicit drugs.

The Need for a Federal Prescription Drug Database (continued)

- In 2001 survey, 3.5 million used pain relievers, 1.5 million used tranquilizers, 1 million used stimulants, and 0.3 million used sedatives. All of these drugs are controlled substances.
- Current substance abuse at the time of estimation was 19% in chronic low back pain patients. Others have shown in chronic pain variable from 10% to 34% of the patients.
- In interventional pain management settings, it was shown that in Kentucky, 24% of patients were abusing controlled substances. In another larger study in western Kentucky, including 500 patients, it was shown that 17.8% of the patients were abusing illicit drugs.
- In a study in western Kentucky (bordering Illinois, Tennessee, and Missouri), which evaluated 1,000 patients who were already identified and confirmed as having been prescribed controlled substances, physicians were unable to obtain through the state prescription monitoring system any information about prescription drug usage on 226 of these patients, or 26.6%. Further, of these, 72, or 7.2%, of these patients were from Kentucky.
- **Integration with HIPAA:** The NASPER is consistent with the privacy rules set forth in the Privacy Standards promulgated under the Health Insurance Portability and Accountability Act (“HIPAA”). HIPAA permits disclosures of protected health information (“PHI”) whenever required by law. The NASPER would create a legal requirement for disclosure and would, therefore, fit squarely into the existing HIPAA regulatory scheme that became effective on April 14, 2003. If the NASPER were enacted, there would be no need to amend HIPAA or the Privacy Standards.
- **Privacy Concerns:** Under the NASPER, only a practitioner or pharmacist who is currently treating a patient may request information. Each request must be certified by the treating practitioner or pharmacist that the information is necessary for the purpose of providing medical or pharmaceutical treatment or to evaluate the need for such treatment for a *bona fide* current patient. Thus, the NASPER provides for limited disclosure to the patient’s treating physician or pharmacist after the physician or pharmacist has certified that the information is necessary for treatment purposes. With these safeguards, the NASPER is narrowly tailored to serve its purpose. Law enforcement agencies may obtain information, but only when the request is based on a legitimate need and evidence for cause.
- All states, regardless of whether there is state prescription drug monitoring program, have the authority under their laws to conduct investigations of the records of individuals alleged to be involved in prescription drug diversion and abuse, including the records of prescribing physicians and dispensing pharmacies.
- **Costs:** Data from the various states suggests that the costs would be modest and, in any event, outweighed by savings from the public health benefits of implementing such a system. The annual data collection costs for the Kentucky program, which requires reporting of Schedule II - V prescriptions are \$500,000 annually. This figure includes equipment costs, operating expenses and contract services as well as salaries, fringe benefits, and travel expenses for certain personnel. Significant cost savings will be realized by having an integrated system covering all jurisdictions. Based on the costs of the various state programs, we believe that the costs of data collection and maintenance to the federal government would be modest. Generally, the state programs do not assess fees for practitioners or pharmacists. ASIPP strongly opposes funding a federal databank from fees assessed to practitioners and pharmacists who would access the information. The costs for NASPER are estimated to be \$20 million initially and \$10 million each year.
- **Definitions:** Schedule II substances are drugs that have a “currently accepted medical use” and “high potential for abuse... that may lead to severe psychological or physical dependence.” 21 U.S.C. § 812(b)(2). Schedule III substances are drugs that have a “currently accepted medical use” and potential for abuse and dependence that is slightly less than that of Schedule II substances. *Id.* § 812(b)(3). Schedule IV substances are drugs have a “currently accepted medical use” and potential for abuse and dependence that is slightly less than that of Schedule III substances. *Id.* § 812(b)(4).

For more information, please contact the ASIPP General Counsel, William A. Sarraille, Sidley Austin Brown & Woody, LLP (202-736-8195 or wsarraille@sidley.com) or Randi Hutchinson at Dickstein Shapiro Morin & Oshinsky, LLP at (202) 955-6600 or HutchinsonR@dsmo.com).

Pain Management in Pilots Fred A. Furgang, M.D.

Note: This article was written for the non-medical reader and was published in the American Bonanza Society magazine. Nevertheless, some of the points in this article may not be known by pain management physicians. Particularly, the prohibition by the FAA on the use of almost all analgesic drugs except Tylenol, NSAIDs, and COX-2's. Virtually all "adjuvant" type drugs are prohibited including all anti-depressants and anti-convulsants. Clonidine might be acceptable if there are no side effects following a stable 30 day dosing period. Local anesthetic/steroid injections are not disqualifying. Oral steroids are acceptable in small doses if there are no side effects. All narcotics, partial opioids, and tramadol are not acceptable. If you have any question regarding the impact of your proposed therapy on a patient/pilot's ability to continue flying, I suggest you contact the pilots regular Aviation Medical Examiner.

In my role as director of a large university based pain center, I have had the opportunity to treat patients with many different pain problems. Pain in our society is a pervasive: it effects over 10% of people at any one time, and pilots are not immune. More than half the population will suffer from low back pain sometime during their lifetime.

There are three potential concerns with respect to pilots, pain and flying. What is the cause of pain and the likelihood that it may cause difficulty or incapacitation in flight? Will the pain itself become a distraction and effect the safety of flight? What effect may pain medication have on pilot performance? There are two types of pain: acute and chronic. Acute pain is usually due to an injury or inflammation that has a known cause, and will tend to decrease over time as healing takes place. Chronic pain often does not have an obvious cause, may persist even though healing appears complete, and does not diminish over time.

Hopefully, pilots with acute pain will ground themselves and seek medical help if indicated. Since the duration of acute pain is relatively short, grounding oneself for a short while may not be a problem. Chronic pain, however, presents a much greater problem for a pilot. Pain, and the drugs used to treat chronic pain, may result in a more permanent grounding.

Low back pain is the most common form of chronic musculoskeletal pain, and may radiate into the leg ("sciatica"). Since the ability to change position in the cockpit of most general aviation aircraft is extremely limited, this pain can become progressively more annoying and distracting as the flight continues, potentially interfering with flying duties. Turbulence can result in waves of increasing pain as the spine is subject to additional loading.

The use of medication in the treatment of chronic pain usually follows a stepwise progression. We begin with the use of non-steroidal anti-inflammatory drugs (NSAIDs), a typical example of which is ibuprofen (Advil) or aspirin. Newer NSAIDs are available by prescription, which have less side effects and are sometimes more effective (Vioxx, Celebrex). Although not an NSAID, acetaminophen (Tylenol) is a common over-the-counter analgesic (pain reliever); however, this drug can be toxic to the liver when used in high doses.

When NSAID's are insufficient, we add the so-called adjuvant drugs. These are not in themselves analgesics, but rather effect how pain signals are processed in the nervous system. They include anti-convulsants, anti-depressants, muscle relaxants, and a variety of other drugs. If pain still persists, a narcotic analgesic will be added. In the past, narcotics were reserved for patients in pain who were dying of cancer, however it is now considered appropriate to use these drugs for moderate to severe chronic pain when other drugs fail to provide relief. Therapy for pain is often combined with physical therapy and rehabilitation. If the patient fails to obtain adequate relief of pain with drugs, we must consider "alternative" therapies or interventional techniques. Intervention may include nerve blocks, implantation of a morphine pump or spinal cord stimulator. There are many alternative approaches, however, most would not be practical while flying. The surgical treatment of pain has been very disappointing. In fact, there are many patients who have had spine surgery for back pain, who have nevertheless continued to have pain for years after surgery. In the pain clinic they are referred to as "failed back surgery syndrome." Spine surgery today is usually reserved for patients with back or leg pain who develop other neurological problems.

If the pilot's pain is controlled with NSAID's and he/she does not suffer any drug-related side effects and can function normally in the cockpit, then it should be possible to continue flying. Unfortunately, many chronic pain problems do not respond to NSAID therapy alone. The FAA will not allow a pilot to fly if they are taking most adjuvant or any of the narcotic drugs, even if they obtain excellent pain relief and do not suffer any drug related side-effects.

Pain Management in Pilots
Fred A. Furgang, M.D. (continued)

The treatment of pain in pilots, if they are to continue flying, is a challenging problem. More emphasis must be placed on interventional techniques that do not rely on drugs unacceptable to the FAA. We have had some outstanding success with this approach in selected cases. The goal of treatment of the pilot in pain is no different than that of other patients: the relief of pain. However, the methodology can be selected to obtain the dual goals of pain relief and return to flying status.

Dr. Furgang is a commercial-rated pilot, an FAA Senior Aviation Medical Examiner, and an FAA Aviation Safety Counselor. He has written and lectured extensively on aeromedical safety issues. The above article is being published in the November issue of the American Bonanza Society Magazine.

Citizens for a Fair Share

The Florida Medical Association and other interested parties have formed a political committee called Citizens for a Fair Share, to pursue the passage of a constitutional initiative in 2004. Organized medicine in the state of Florida is working hard to address the crisis that exists with medical liability insurance, and the goal has been to achieve California-style MICRA reforms in Florida. One of the most important components of the California law is a cap on attorney contingency fees. This cap ensures that the patient gets their fair share of the award in a medical liability case.

FAPM is in support of this initiative.

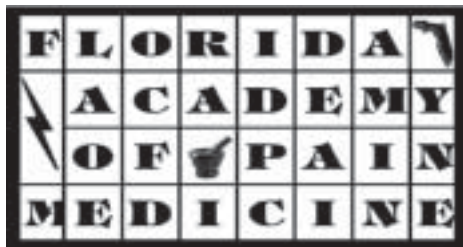
Currently, trial attorneys walk away with 30-40% of a medical liability award as their fee. I do not believe this is fair to patients. Under the proposed amendment, patients will receive 70% of the first \$250,000 awarded, and 90% of the remainder of the award, minus the costs of bringing the lawsuit.

In order to get this issue on the ballot, each Florida physician needs to get 1,000 petitions signed by Florida registered voters. These signed petitions need to be sent to your county medical society by **January 15, 2004**. **FAPM members were sent via email or fax, all the information necessary to start gathering signed petitions. If you are not aware of this communication, petitions forms in English or Spanish can be downloaded at <http://www.citizensforafairshare.org/petition.html>.**

In addition to the petitions, financial contributions are necessary. Per Citizens for a Fair Share, the estimated cost for a successful campaign is more than \$12 million. In order to raise the necessary resources to ensure patients receive their fair share, EVERY Florida physician is asked to help fund this initiative. Citizens for a Fair Share and the FMA are asking you to join the fight by contributing \$500.00. Don't you feel it's worth it to help the future of the medical profession in Florida?

FAPM contributed \$1000.00 to this effort. A couple of our individual members have also contributed: Lawrence Gorfine, MD, contributed \$5000.00 and Jonathan Daitch, MD, contributed \$500.00. FAPM thanks these individual members and urges others to do the same. If there are more of you we have missed, please let us know. By going to the Citizens for a Fair Share website (links above), you can download the contribution form.

Frequently asked questions and answers about Citizens for a Fair Share can be found at <http://www.citizensforafairshare.org/faqs.html>.



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