Key Patient Assessment Tools and Treatment Strategies for Pain Management

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INTRODUCTION

In the National Health and Nutrition Examination Survey (1999 to 2002), 26% of Americans aged over 20 years reported suffering from pain that persisted more than 24 hours in duration in the month prior to the interview.1 When inadequately treated, pain can negatively affect patients’ quality of life by decreasing work productivity due to disability and functional impairment and by increasing psychological stressors such as anxiety, depression, and sleep deprivation. Not surprisingly, the Joint Commission on Accreditation of Healthcare Organizations and the American Pain Society (APS) consider pain to be “the fifth vital sign,” indicating that pain intensity should be measured along with temperature, pulse, respiration, and blood pressure in all patients.2

Understanding patients’ needs could predict successful therapies to treat acute and chronic pain. Often primary care physicians are extensively involved in their patients’ treatment and may even have knowledge of the types of support (eg, family, cultural, and spiritual support); the patient can rely upon during times of stress due to pain. However, management of patients with chronic pain can be challenging and may require a multidisciplinary healthcare team approach to address medical, psychosocial, and disability problems. Physicians should work with their patients to set specific short- and long-term goals (eg, play with grandchild, plant flowers, attend concerts) to enhance functional abilities, reduce pain, enhance psychological well-being, and minimize adverse outcomes for pain patients. Goal setting and appropriate communication between the patient and clinician may help to ensure that patients receive the appropriate therapy.

Pain assessment provides the foundation for diagnosis and development of an effective treatment strategy...
for the patient. There are several validated assessment tools that are quick and convenient to help with assessing pain patients. Comprehensive patient assessment is essential in selecting the best treatment approach to potentially improve a patient’s comfort, functioning, and quality of life.

This review discusses validated and reliable tools that are currently available to assist physicians in assessing pain intensity and severity, quality of life, psychological well-being, developing treatment strategies and setting goals, and identifying abuse or risk of addiction to controlled substances.

**PAIN ASSESSMENT TOOLS**

When clinicians begin the initial assessment of their patient’s pain, they should determine the intensity, severity, and location of the pain. Many valid and reliable tools are available to help properly conduct an initial assessment of pain. The “PQRST” mnemonic was originally proposed by the APS to help clinicians remember the elements of initial evaluation.3 P stands for provocative, a point where pain triggers should be identified. Q stands for assessing the quality of pain. R stands for identifying the region of pain. S stands for rating the severity of pain. Finally, T stands for temporal, at which point, the onset, course, and fluctuations of the pain should be assessed. These points are all elements of the initial evaluation that clinicians conduct during the first visit with a patient and can be evaluated by using validated assessment tools (see Table 1).

Although many tools are available for clinicians to use for the initial assessment of pain, the Short-Form McGill Pain Questionnaire (MPQ) is one of the most commonly used instruments that tests both pain quality and severity.4 It has been validated, translated into several different languages, and used in recent clinical trials.5–7 The Short-Form MPQ questionnaire is divided into two sections. The first section is the Pain Rating Index. Sensory and affective adjectives describing the quality and severity of pain are listed, and the patient is instructed to place a check mark in the column that represents their degree of pain perception. The second section is the Present Pain Intensity that contains a visual analog scale (VAS) to help patients communicate the severity of their current pain.

The Faces Pain Rating Scale, VAS (or Numeric Pain Intensity), and verbal rating scales of pain intensity are the scales most often used in the primary care setting because of their familiarity and convenience. However, the pain scale a clinician chooses should be based upon the patient’s communication style, cognitive function, and verbal abilities. The Faces Pain Rating Scale was developed to elicit self-reports of pain from children, and it remains the most popular method for obtaining pain ratings from children and cognitively impaired adults. However, a recent study has shown little agreement between parents’ and children’s pain ratings on such scales, and the authors suggest this may be due to distractions in younger patients caused by the happy cartoon-like faces.8 Despite this finding, because of the ease with which young children relate to the scale, the Faces Pain Rating method remains the preferred method of assessing a young child’s pain intensity.

Visual analog scales are the most reliable and sensitive means of measuring pain and pain relief. Several studies compared the use of VAS with alternative methods of measuring pain across a variety of disorders and found that VAS were highly correlated with other pain scales. VAS also provided a more sensitive measure to discriminate between various analgesic treatments and changes in pain intensity. In particular, Seymour et al. demonstrated that the 10-cm VAS was more sensitive than both verbal and numerical rating scales and was able to discern small changes in pain intensity in patients with post-operative dental pain.6 The VAS scale, however, has been shown to be less effective in measuring chronic pain and assessing pain in the elderly.7

Verbal rating scales of pain intensity have proven useful but need to take into account interindividual variations in interpreting descriptive pain terms. A study by Sriwatanakul et al. found that many words that are assigned the same value on an ordinal scale did not have equivalent values on a VAS. Additionally, words such as “some” and “terrible” were found to be the least useful descriptors in verbal pain scales.9 The scale that the clinician chooses is less important than consistency in using the same scale for the patient over multiple visits, as each of the scales discussed have been validated.

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**Table 1. Pain Assessment Tools**

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<thead>
<tr>
<th>Tool</th>
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<tr>
<td>Short-Form McGill Pain Questionnaire</td>
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<td>Faces Pain Rating Scale</td>
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<td>Visual analog scale</td>
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<tr>
<td>Verbal rating scale</td>
<td>Sriwatanakul et al. 1982</td>
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Pain-Related Health and Treatment History

Medical and psychological comorbidities and other pain-related factors are important for clinicians to consider when developing a treatment plan for their patient. A pain-related medical history, along with specific psychosocial screeners that evaluate depression, will help facilitate a pain-related health history assessment.

Understanding a patient’s previous pain history is important in the determination of the appropriate treatment strategy. A pain treatment history questionnaire should allow the clinician to obtain an accurate history through questions about previous pain treatments, including surgeries, current prescription and over-the-counter medications that the patient has taken for pain, current and previous methods of pain management, current and previous physicians, and current and previous pharmacies.

IMPACT OF PAIN ON DAILY FUNCTIONING

After determining the location, severity, intensity, and history of the patient’s pain, clinicians should obtain an accurate idea of how the patient’s pain is affecting his or her quality of life. Measuring the impact of pain on daily functioning is important when assessing both acute and chronic pain patients. Detailed information on how pain impacts the patient’s quality of life helps clinicians identify the appropriate treatment strategy and set realistic treatment goals that are functional in nature. It is important that daily functioning is improved along with reductions in pain scores. Specific scales, such as the Western Ontario and McMaster University Osteoarthritis Index and the Roland–Morris Back Pain questionnaire, measure daily function associated with a specific pain.

Two scales that are commonly used to assess the impact of generalized pain on quality of life and daily functioning include the American Chronic Pain Association Quality of Life Scale and the Pain Disability Index (Table 2).

Table 2. Quality of Life Assessment Tools

<table>
<thead>
<tr>
<th>Tool</th>
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<tbody>
<tr>
<td>American chronic pain association quality of life scale</td>
<td>Cowan et al. 2003</td>
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<tr>
<td>Pain disability index</td>
<td>Pollard 1984</td>
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<tr>
<td>Pittsburgh sleep quality index</td>
<td>Buysse et al. 1989</td>
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<tr>
<td>Medical outcomes study sleep scales</td>
<td>Hays, Stewart 1992</td>
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<tr>
<td>Chronic pain sleep inventory</td>
<td>Babul, Novek 2003</td>
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<tr>
<td>Zung self-rating depression scale</td>
<td>Zung 1965</td>
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American Chronic Pain Association Quality of Life Scale

The American Chronic Pain Association Quality of Life Scale contains 10 sentences that measure function in people with pain. With this scale, patients rate their functioning to determine how much their pain is disrupting their quality of life. The range of this scale is from 0 (someone who is nonfunctioning, stays in bed all day, and feels helpless about life) to 10 (someone who has a normal quality of life, goes to work each day, does normal activities, and takes an active part in family life).

Pain Disability Index

This index measures the overall impact of pain on a patient’s life. The scale is composed of seven different domains: Family/Home Responsibility, Recreation, Social Activity, Occupation, Sexual Behavior, Selfcare, and Life-Support Activity. Patients circle the number that best describes the level of disability that they experience for each category and are specifically requested to respond to each category with regards to their overall pain, not just when pain is at its worst.

Sleep Assessments

If disrupted sleep appears to be an issue with a patient, it may be useful to have the patient complete a more detailed sleep questionnaire. Many excellent questionnaires have been designed to help clinicians assess sleep patterns in their patients. These include the commonly used Pittsburgh Sleep Quality Index, the Medical Outcomes Study Sleep Scale, and the pain-specific Chronic Pain Sleep Inventory. Each may be used to determine the extent to which pain may be interfering with sleep. Lack of sleep has also been shown to exacerbate the perception of pain, and thus it may be useful to know how sleep is affected in the pain patient.

Zung Self-Rating Depression Scale

Many patients with pain experience signs and symptoms of depression, and some may meet criteria for a depressive disorder. These signs and symptoms may also increase pain and pain-related suffering. As depression is a frequently comorbid disorder with pain, initial and ongoing assessment of patients with chronic pain should also include depression screening along with treatment, if appropriate. The Zung Self-Rating Depression Scale is a brief, validated screening instrument, commonly used by clinicians to evaluate their patient’s depression (Table 2). This scale contains 20 statements that
describe how the patient may have been feeling over the past several days. Patients indicate how often the statement corresponds with how they feel, on a scale from “a little of the time” to “most of the time”.

TOOLS FOR THE RECOGNITION OF ABUSE AND ADDICTION

In a recent survey, 84% of physicians indicated that they are reluctant to prescribe opioids because of potential patient misuse or abuse. An important part of pain therapy decision making includes assessing a patient’s history of substance use and abuse. Recent literature searches determined that the range of prevalence of opioid abuse in chronic noncancer pain populations may be anywhere from 0% to 50%, depending upon the criteria for diagnosing abuse and addiction. Because of this, abuse rates cannot be definitively determined, and the diagnosis of addiction is almost entirely accomplished through knowledge of the patient’s history, which may not include full disclosure of any prior abuse. Opioid and substance abuse risk assessment tools have been designed to help clinicians better determine the most appropriate treatment approach for the patient’s pain condition (Table 3). These tools are also useful in determining the level and frequency of patient monitoring that may be required during opioid therapy. Thoroughness, ease of use, and speed of completion are important considerations when deciding upon the appropriate screening tool for busy primary care practices. Physicians should be familiar with available screening tools for abuse and aberrant use and consider their appropriateness for use on a routine basis at their own discretion.

Symptoms of an addictive disorder can be described as “the 4 Cs”: loss of Control over the use of the drug, Continued use despite adverse consequences, Compulsive use, and Craving when the drug is withheld. When two or more of these symptoms are present, clinicians can be fairly certain that addiction may be a problem. The potential for this disorder does not mean that a patient should not be treated for pain but that these tools will determine how the patient should be individually managed (see the Management Strategies for Patients with Increased Risk of Opioid Misuse or Abuse section in this review).

Screener and Opioid Assessment for Patients in Pain Short-Form

The Screener and Opioid Assessment for Patients in Pain (SOAPP) was developed to screen patients with chronic pain who were being considered for long-term opioid therapy. Recent studies have demonstrated that the SOAPP is a valid and reliable tool when used to assess risk potential for substance misuse and abuse among patients with chronic pain. This screening instrument provides physicians with a greater awareness of particular patients who may require monitoring and management of their medical use of opioids.

The extended SOAPP assessment tool contains 24 questions, and a five-question short-form version of the SOAPP was designed for use when time is limited. Clinicians should be aware that abuse screeners, such as the SOAPP, generally identify high-risk patients and may not be as effective at identifying patients who are at low risk for abuse.

Opioid Risk Tool

The opioid risk tool (ORT) is a self-administered questionnaire that measures risk factors associated with substance abuse. These include: family history of substance abuse, personal history of substance abuse, age, history of preadolescent sexual abuse, psychological disease, and depression. Males and females are scored differently, and this tool helps to determine whether the patient is at a low, moderate, or high risk for aberrant behavior and possible abuse. In a preliminary study, the ORT exhibited sensitivity in determining which patients with chronic pain were at risk for misusing or abusing opioids. The ORT has been validated for use in patients with chronic pain, but this tool has not been validated or tested in patients with other types of pain.

CAGE Alcohol Screening Instrument

The CAGE questionnaire is a fast and reliable method of identifying a potential abuse problem. The CAGE alcohol screening questionnaire can be extrapolated to assess misuse and abuse of other substances besides alcohol, including prescription opioids. “CAGE” is a mnemonic for four words associated with questions in the test: “have you ever felt you should Cut down on drinking?”, “have you ever been Annoyed by someone

<table>
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<th>Tool</th>
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<tr>
<td>Screener and Opioid Assessment for Patients in Pain Short-Form</td>
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<td>Opioid risk tool</td>
<td>Webster et al. 2005</td>
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<tr>
<td>CAGE questionnaire</td>
<td>Ewing 1984</td>
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<tr>
<td>Drug abuse screening test</td>
<td>Skinner 1982</td>
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asking you about your drinking?”, “have you ever felt Guilty about your drinking?”, and “have you ever needed an Early morning drink?”. Because the CAGE was designed to assess potential alcohol abuse, some of the questions may not be as useful in assessing potential opioid abuse (eg, taking medications early in the morning may be a routine part of the patient’s regimen). However, because of its brevity and utility, many clinicians consider the CAGE to be useful in identifying a potential abuse problem.

**Drug Abuse Screening Test**

The drug abuse screening test is both a validated measure of drug addiction and an accurate screening device for drug abuse and dependence.²⁷,²⁸ It contains 28 statements relating to patient’s involvement with drugs over the past 12 months. This self-report questionnaire yields a quantitative index of the range of problems associated with a patient’s drug abuse.

**TREATMENT STRATEGY**

Once a clinician has conducted a thorough pain assessment, including physical examination and review of the patient’s medical history, the clinician can begin to set realistic goals with their patient and, together, develop an appropriate treatment strategy. A pain treatment strategy should contain three basic components. First, a treatment plan should be established, involving integration of the patient’s goals and therapy approaches based on information obtained during the assessment process. Second, the clinician should determine whether to treat and/or refer the patient to a pain specialist. Consulting with a pain specialist about the patient or enlisting a multidisciplinary team approach may be warranted if the patient assessment yields complexities beyond the clinician’s experience or comfort level. Reasons for consultation may include worsening pain, comorbid psychiatric disorders, or the inability to establish mutually agreeable treatment goals with the patient. Many chronic pain patients have severe pain with comorbid psychiatric conditions, and because of a lack of access to pain or other medical specialists, insurance, etc, it may be difficult to refer a patient. In many cases, primary care physicians refer only in situations where control over patient behavior or treatment is lost or if they feel uncomfortable treating the type of pain presented by a patient.

The final component is the implementation of the treatment plan. At this point, clinicians should facilitate communication with their patient regarding possible side effects associated with treatment. Once the plan is ongoing, there is a need to monitor the patient’s progress, re-evaluate the treatment plan, and possibly refer the patient to a specialist, when indicated. If the patient’s treatment plan includes the use of opioids, observing and managing abuse are important components of treatment monitoring. In addition, it is important for clinicians to specify in the patient’s chart the reasons for prescribing opioids for the patient.

**Treatment Planning and Goal Setting**

As the experience of pain is subjective, it is important to focus treatment on the achievement of specific short- and long-term goals, with corresponding obtainable milestones. Treatment goals may include overall functioning, reduction in pain, and/or reduction in psychological and psychosocial distress. A focused history concentrating on loss or change in previously enjoyable leisure and work activities since the development of pain may serve as a valuable tool in developing reasonable and agreeable goals.

**Functional Goal Setting**

A Goal Setting Form can be used to discuss and document a patient’s specific, relevant, and achievable goals for a variety of categories including self-care goals, family or social goals, mobility goals, or work goals. In addition to this form, the American Chronic Pain Association Quality of Life Scale can provide the clinician and his or her patient with direction on appropriate areas for improvement. Beyond daily function, general areas of focus for patient improvement include physical, psychological, and social well-being, spiritual or religious concerns, and financial concerns. It is important to discuss simple, every day goals with a patient. For example, clinicians may ask a patient: “If I were to make your pain better, what do you think you could do that you cannot do now?” This question will elicit practical responses from the patient and help the clinician and the patient set mutual goals. At the following visit after treatment initiation, the clinician may ask if there has been progress with the specific goal that was previously discussed.

**Care Plan Documentation**

Documentation of the treatment plan assures that both the clinician and the patient track the progress of the treatment goals. A Care Plan Documentation Form should include sections on establishing the patient’s personal goals of treatment, as well as a place to document
these goals. Specific goals may include improved sleep, increased physical activity, managed stress, along with decreased pain. The form should also include the patient’s best and worst pain levels in the previous week.  

Opioid Informed Consent and Controlled Substance Agreement Forms

The Opioid Informed Consent and Controlled Substances Agreement forms are both valuable tools for clinicians who are prescribing long-term opioid therapy to patients with chronic pain conditions. Both require the patient to acknowledge the risks and consequences of opioid therapy and to take personal responsibility to ensure appropriate use of the medications. An Opioid Informed Consent Form can help clinicians review with the patient the possible adverse events associated with chronic opioid use, including drug interactions, addiction, and the effects of withdrawal. This form is appropriate for patients who are potentially to be prescribed long-term opioid therapy. On the other hand, a treatment agreement is the understanding between the clinician and the patient on what behavior is acceptable during treatment. The informed consent form and the treatment agreement form may be combined into one document but are most often kept as separate documents.

The Controlled Substance Agreement was specifically designed to address potential opioid addiction. It can be used for patients who are at a moderate to high risk for misuse of controlled substances. Prior assessment with an abuse screening tool and observations of patient behaviors will help determine whether the patient falls into a high abuse risk category. By helping clinicians document that patients have been made aware of the risks of opioid therapy, these forms may mitigate some of the legal risk associated with prescribing opioids. Importantly, these forms also serve to educate patients on their responsibilities in working toward improved therapeutic outcomes.

Documenting treatment agreements and informed consent provides much more than legal protection. Ideally, this process provides an opportunity to review the care plan, goals, and responsibilities of both the clinician and the patient and should provide the patient with an understanding about what to expect from treatment. Importantly, agreement on patient responsibilities, such as communication with the clinician on issues impacting care including side effects, other medications used, and changes in conditions, as well as agreement on healthcare professional responsibilities such as communication with other healthcare providers and patient privacy rights, should be documented on the treatment agreement form. Many treatment agreements include a discussion of specific treatment goals and progress milestones, along with a discussion of administrative policies such as missed appointments, single pharmacy and prescription source, and clinic procedures for emergencies, pain flare up management, and early refills. Specific terms for treatment change or termination of care, such as a lack of progress in treatment, medication abuse, or inappropriate behavior, are also included in the agreement. Finally, education on selected therapies and associated addiction risks and behaviors, as well as legal considerations, should be included on the informed consent document.

TREATMENT IMPLEMENTATION AND MONITORING

The 4 A’s of Outcome Assessment

Optimal pain management begins with an initial assessment and continues with ongoing follow-up and re-evaluation of progress against the desired treatment outcomes for patients. Outcome assessment should be focused on the “4 As”: analgesia, activities of daily living, adverse effects, and aberrant behavior. Clinicians should use the VAS at each visit to measure the analgesic effect of therapy. The Function Goal Setting and/or Care Plan Documentation tools assess activities of daily living and measure the patient’s progress against the treatment goals that were set. Clinicians should ask the patient about specific adverse effects or events associated with their therapy at each follow-up visit. Finally, clinicians need to monitor the patient for any aberrant behaviors suggestive of drug abuse. In addition to considering the use of appropriate screening tools, all clinicians should be vigilant for identifying patient behavior that could signal potential addiction or abuse of opioids. While each situation must be dealt with individually, the checklist in Table 4 provides some commonly observed behaviors associated with addiction or abuse.

Management Strategies for Patients with Increased Risk for Opioid Misuse or Abuse

If clinicians observe potentially aberrant behavior from the patient, there are a number of steps that can be taken to ensure the patient receives the care that he or she needs while reducing the potential risk to the clinician’s practice. Patients should be closely monitored using a
highly structured approach. This includes the potential use of a written treatment agreement, frequent office visits that include pill counts, random urine drug testing, and limiting medication supply. Clinicians may also want to consider referral to an addiction specialist. Finally, clinicians should always carefully document the patient’s behavior observed during office visits, write detailed visit notes, and document any actions that have been taken with the patient.31,32 The discussion of management strategies can determine if a patient should undergo additional monitoring and follow-up assessments, but it should not be used as a basis for diagnosing addiction.

Physician Safeguards against Theft and Diversion

The checklist in Table 5 has been compiled to help clinicians properly safeguard their practices against theft and diversion of controlled substances.33 By employing these practice guidelines, physicians can minimize their risk of being involved in such incidents.

Ten Universal Precautions in Pain Medicine

The 10 universal precautions (Figure 1) summarize a consistent approach to ensure that patients get at least the minimum level of care with minimal risk.34

Table 4. Aberrant Drug-Related Behaviors

<table>
<thead>
<tr>
<th>Probably More Predictive of Addiction</th>
<th>Probably Less Predictive of Addiction</th>
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<tr>
<td>• Selling prescription drugs</td>
<td>• Aggressive complaining</td>
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<tr>
<td>• Prescription forgery</td>
<td>• Drug hoarding when symptoms milder</td>
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<tr>
<td>• Stealing or “borrowing” drug from another person</td>
<td>• Requesting specific drugs</td>
</tr>
<tr>
<td>• Injecting oral formulation</td>
<td>• Acquisition of drugs from other medical sources</td>
</tr>
<tr>
<td>• Obtaining prescriptions from nonmedical sources</td>
<td>• Unsanctioned dose escalation once or twice</td>
</tr>
<tr>
<td>• Multiple episodes of prescription “loss”</td>
<td>• Unapproved use of the drug to treat another symptom</td>
</tr>
<tr>
<td>• Concurrent abuse of related illicit drugs</td>
<td>• Reporting psychic effects not intended by the clinician</td>
</tr>
<tr>
<td>• Multiple dose escalations despite warnings</td>
<td>• Occasional impairment</td>
</tr>
<tr>
<td>• Repeated episodes impairment or dishevelment</td>
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Table 5. Physician Safeguards Against Theft and Diversion Checklist

- Keep all prescription blanks in a safe place where they cannot be stolen
- Write out the actual amount prescribed in addition to giving a number to discourage alterations of the prescription order
- Use prescription blanks only for writing a prescription order and not for notes
- Never sign prescription blanks in advance
- Assist the pharmacist when they telephone to verify information about a prescription order
- Contact the nearest Drug Enforcement Administration field office to obtain or furnish information regarding suspicious prescription activities
- Use tamper-resistant prescription pads

MEDICO-LEGAL CONCERNS WHEN PRESCRIBING CONTROLLED SUBSTANCES

Some physicians’ reluctance to prescribe controlled substances for chronic pain can be attributed to uncertainty over applicable federal and state regulations. Caution, care, and thoroughness are appropriate when prescribing controlled substances, but these considerations should not stand in the way of patients receiving appropriate care. By following these guidelines, clinicians can ensure that they are delivering optimal and appropriate pain care to their patient following medical, ethical, and legal guidelines. Clinicians need to follow the appropriate standards of care, with thorough assessment and monitoring of the patient and external consultation or referral if necessary. Universal precautions should be taken to protect against theft and diversion of controlled substances. Clinicians should document ongoing patient progress, informal informed consent for therapy, or use of a standard, adhered to, treatment agreement.35,36 Compliance with controlled substance laws and regulations and accurate medical documentation are critical strategies for clinicians to appropriately manage chronic pain. Familiarity with federal and state controlled substance laws is necessary for clinicians to avoid unwarranted regulatory scrutiny. There are a variety of different Internet resources available to clinicians that include information on the Controlled Substances Act, drug scheduling, as well as practitioners’ manuals on how to appropriately prescribe controlled substances (Figure 2). Knowledge of controlled substance laws and regulations will not only help clinicians protect their practice, but will also help them provide the most appropriate care for their patients.

CONCLUSIONS

This review provides clinicians with important tools to use during initial patient assessment, determination of individualized treatment strategies, setting treatment
**Make an appropriate differential diagnosis**: look for a source of pain that can be cured, thereby solving the pain problem as well as identifying any comorbid conditions.

**Perform a psychological assessment, including risk of addictive disorders**: if a patient refuses this type of assessment, he or she should be considered unsuitable for pain management using controlled substances.

**Document informed consent**: this should include a discussion with the patient about the risks and benefits of any course of therapy.

**Use a treatment agreement**: this helps to reinforce expectations and obligations for both the clinician and the patient before therapy is initiated.

**Assess pain level and function before and during therapy**: essential to help determine the success of the medication trial as well as indicating where changes may be appropriate.

**Individualize therapy with or without adjunctive medication**: opioid medications should neither be a routine first choice for pain treatment nor the treatment of last resort. Apply the principles of rational pharmacotherapy based on the needs of the patient.

**Reassess pain score and functionality**: helps document a rationale for therapy continuation or modification.

**Regularly assess the 4 “As”**: frequently revisit the patient’s analgesia, activity, adverse effects of therapy, and aberrant drug-taking behaviors.

**Periodically review pain diagnosis and comorbid conditions, including addictive disorders**: a patient’s condition may evolve over time and require a redirection of therapy.

**Document all assessments and care plans**: this helps reduce medico-legal exposure and risk of regulatory sanctions.

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Figure 1. Ten universal precautions in pain medicine.

Figure 2. Federal and state controlled substance laws and resources. All websites were accessed on May 1, 2008.
goals, and following patients’ progress during treatment. The tools discussed in this article also provide a standardized approach to medico-legal documentation that may help to protect both the clinician and the patient. These resources and tools may assist in the determination of optimal care, and at the same time protect physician practices from unwarranted and unnecessary scrutiny by regulatory agencies.

ACKNOWLEDGEMENTS

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REFERENCES


