
# What to do when you inherit a chronic pain patient on Opioids


Joe Humphry MD FACP CPHIMS

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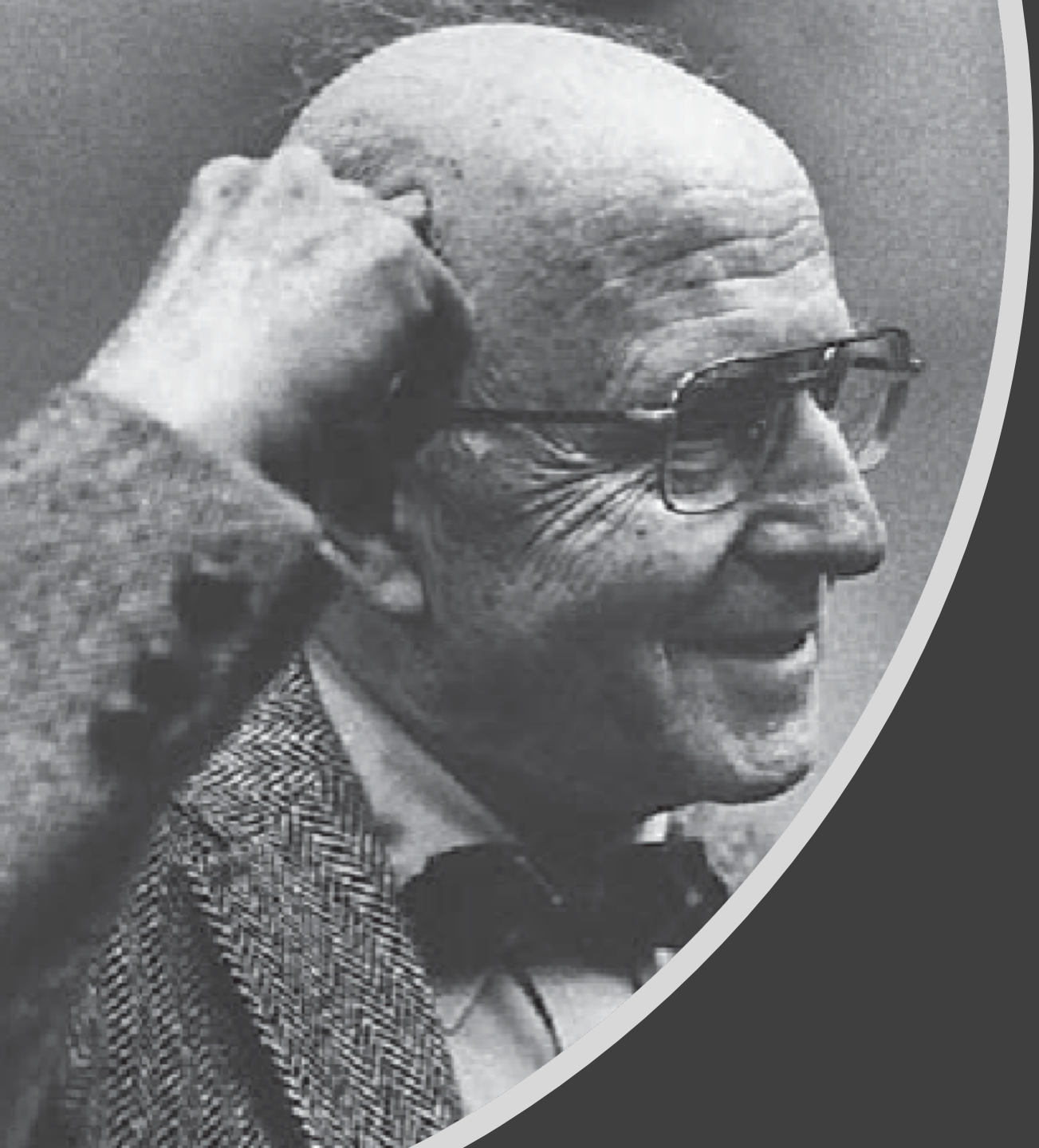


# Who is this guy?

“The need for a new medical model: a challenge for biomedicine” *Science*.1977.196(3):129-136

“The fundamental assumption of the biopsychosocial model is that health and illness are consequences of the interplay of biological, psychological, and social factors.”

# Psychosomatic Medicine Fellowship

BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S HOSPITAL

Icahn School of Medicine at Mount Sinai

Stanford MEDICINE

Cleveland Clinic

COLUMBIA | COLUMBIA UNIVERSITY DEPARTMENT OF PSYCHIATRY

Streltzer *BioPsychoSocial Medicine* (2016) 10:25
DOI 10.1186/s13030-016-0076-2

BioPsychoSocial Medicine

REVIEW

Open Access

# The International College of Psychosomatic Medicine – a personal history

Jon Streltzer

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4997776/pdf/13030_2016_Article_76.pdf

# The seven-doctor syndrome

- If a chronic pain patient is sitting in your office asking for help, the health care system has failed this patient.
- Chronic pain has been around a lot longer than OxyContin and fentanyl patches, but the promotion of opioids in the management of chronic pain greatly complicates pain management.
- Pain management has moved from a multi-disciplinary approach to a procedural approach as an anesthesiology subspecialty or medication management.
- Pain patients do not just have pain. They come with baggage, depression and other psych diagnosis, often with serious injuries, trauma is often associated with risk taking behaviors, some have congenital or acquired musculoskeletal conditions

# Where to begin

- Empathy and transparency- build trust
- All pain and other somatic symptoms are real to the patient-all pain is perception- it is easier for us to understand if it is associated with physical findings that explain the pain.
- Except for a broken contract- you must assure the patient that you may get outside consultations, but will not refer or otherwise abandon the patient
- Agree to disagree- not everything that you recommend will work and the patient can get upset/ angry without losing your assurance that you will continue working with you
- Required to contract for medication maintenance while building trust 4-8 visit
- Visit frequency and physician contact

# Realistic patient centered care

- Elimination of pain is not a realistic goal
- Living with pain is the only option- some people do it well and others always suffer
- We will work towards completing each day doing those things you have to do, and you want to do
- Pain is dynamic- you have good days and bad days
- Improve function and coping reduces pain for many patients- it is not a goal, but a result of improved management.
- Drama queens- You are not in pain if you do not show it- learned behavior

**I was told that I could not possibly be experiencing the pain that I was reporting. Yet I was.** JONATHAN D. MAYER, PhD UW

Since my surgery in 1987, I have recovered much but not all neurologic function. I lead a happy and productive life. I am sometimes troubled by back pain and radicular pain down my left leg. I have not regained my Achilles tendon reflex, have areas of numbness and diminished sensation, and cannot do certain exercises that exacerbate the pain. Occasionally, an episode of significant pain will strike, and I will spend a day lying down, but even then, I can do some of my work—reading and some writing. I seem to "float" through these episodes,
but I no longer suffer. I no longer feel that the surgery altered my fundamental quality of life, but rather that it introduced some limitations in activity and a degree of challenge and unpleasantness on some days. My experience reminds me that behind my numbers and careful analyses of pain, people like me suffer, hurt, agonize, and sometimes even bellow. We also sing; run; create; write; love; and, if we are lucky, realize that life is good.

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05323

# Accident prone and symptom drift


- Just one more thing!  Hurting in many places.

Engel, George L. and William L. Morgan. *Interviewing the Patient*. London, Philadelphia, Saunders, 1973.

- If a symptom is no long the priority of the visit,

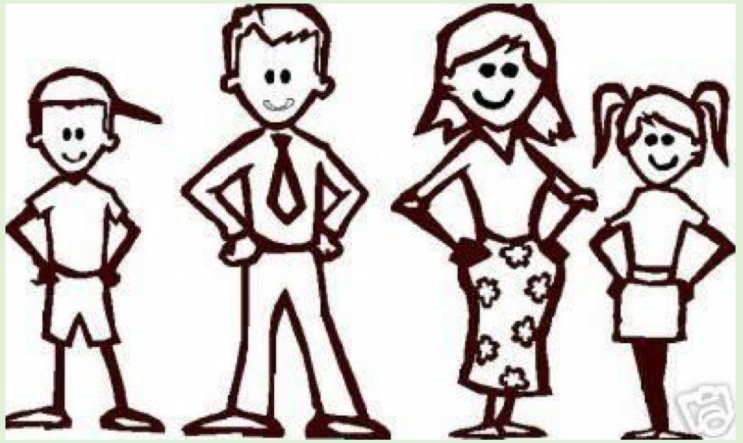
another appears.

- Frequent accidents and injuries- they can be serious
- If nothing else works, see a dentist or a surgeon and deal with post procedure pain.

# Responsibility of the patient

- Sign pain management contract
- Obtain old records- complete
- Consequences for lost medication and diversion
- Agree to random urine testing
- Expectation of honesty (expect not to get the whole story all the time)

# Family and significant others



- Pain and suffering becomes a primary focus of the relationship
- Spouse and others response often perpetuate, rather than helps the pain syndrome (enablers)
- When the patient is not “suffering”, other members ignore the patient for fear of communication drifting to suffering.
- Patients need to own their pain, not sharing- the relationship needs to change to share the good times and cope with the bad.
- It is a challenge to engage families particularly without a team

# Behavioral health- hard sell for a patient in pain

- Two patients with the same disability have very different outcomes
- BH helps the primary care provider better understand the patient
- BH can help with coping
- For psycho-social conditions- BH counsels
- Occasionally use good cop/bad cop in medication management.
- Contracting for getting beyond the first visit- there is little risk of 4 hours of your time and it will help me help you.

# Acute pain- crisis management

- Give me my medicine back-The best way to avoid dose escalation is to get the patient to agree to dose reduction
- Tolerance and dependency- separate disadvantages of opioids, but connected
- Dose and duration is at the recommended duration for situation
- Compromise, do not contest a reasonable extension once.

# PT and alternative medicine

- PT is a very valuable adjunct to pain management
- There is a mismatch between the patients desire to feel better today and tomorrow and the fact that PT and home exercises takes weeks or months to be effective
- Patient need understand the process and be committed to staying on course- need to communicate with the PT and be a real team
- Other alternative medicine options- chiropractor, acupuncture, herb are acceptable- again communication between providers significantly increased success
- A true team approach is most successful and lessens the stress on the primary care provider

# ER experience and prior interaction with providers


- Once there is trust and rapport-Ask about previous experiences with ER visits and prior providers
- The health care system has failed the chronic care patients- Previous experience allows the provider and team not to repeat the same mistakes
- ER visits are frequently negative experiences particularly if the patient seeks chronic pain relief.
- It is always good to ask about previous experience with pain clinics or pain specialist.
- Periodically check the State controlled substance registry- Ask about any medication from other providers (the contract should limit controlled substance to you)
- Request records  in most situations.

# Opioid and other controlled substances management and taper

- Share with the patient dose reduction is a recommendation and necessary
- Addressing pain is the first priority and transitioning to improved function- establish trust
- Dose reduction is much easier with the cooperation and collaboration with the patient
- I do not have a set taper schedule and it is times a bumpy road.
- Use alternative pain medication with caution- antidepressants, gabapentin, NSAIDs ,etc.
- Tapering is a bumpy road with crises management and occasional need to increase medication- any increase comes with a contract (verbal or written) as to when to lower to baseline.

# Medication management

- Patients are very use to not following recommended dosage and not reporting coming up short
- Reporting a stash – training not to take all the available medication prior to the next visit.
- Patients often test or attempt to manipulate the provider- it may be learned behavior from past experience in the health care system or an attempt at diversion.
- Obtain a drug screen periodically particularly if you sense manipulation or no progress- correlate with a report of taking the medication ( no drugs onboard is not a good sign)

# Visit frequency and Friday afternoon crisis

- Butter up the provider-The weekend script- more medicine for less time
- Running short of medication is common early on and occasionally recurrent
- Crisis occurs when the other provider is in the office- Rx is prescribed to get the patient to your next available appointment- contact the pain managing provider if possible
- Look for patterns- the Friday afternoon crisis usually resolves with the patient recognizing the pattern

# Questions?


## Lāna'i Community Health Center

**jhumphry@hawaii.rr.com**