The treatment plan must be Bio-Psycho-Social and Interdisciplinary
Step 5: Focusing on the psycho-social

“Pain is the most terrible of all the lords of mankind.”
Albert Schweitzer
I never believed anyone until it happened to me???
Grieving: Kubler-Ross Model

- Denial
- Anger
- Bargaining
- Depression
- Acceptance
What losses are they grieving?

Notion of secondary loss

- They lose their family role.
- They lose their social role, meaning their job.
- They lose their financial independence.
- They lose their avocational activities, what they liked to do for fun.
- They, often times lose their family and friends.
- They become reliant on fearful drugs.
- They lose their ability to sleep comfortably.
- They lose their ability to engage in sex.
- They lose their ability to play with their children and grandchildren.
- They lose their community mobility when they cannot drive comfortably.
- They grieve their loss of function.
- They fear loss of life
Then why do we focus on secondary gain?
When secondary gain becomes secondary loss

- Notion of self
- We are what we do
- What we do in America is our job
- What happens when we can’t do our job?
- Ex: $30/hr heavy worker
What do they want?

• They want to return to previous function
• They want the pain to be gone

Problem: *goals are probably unrealistic!*
Agenda Crisis!
What can we offer?

- Belief
- Honesty: candor with hope
- Compassion
- Communication
- Time
- Being there for them: Do not abandon!
- Importance of mutual participation model of doctor-patient communication.
- The patient includes the family!!!!!!
Always remember, they are as suspicious of you as you are of them.
They have learned not to trust...
Go for the affect...
PTSD and chronic pain

- May precede the pain disorder
- May be related to the incident which created the pain
- May be created by the non-medical system
- May be created by the health care system
Almost nobody accepts this over-night

- Expectations of Kubler-Ross model is one year; grieving beyond that is considered pathologic.
- Not true for what we are talking about chronic, non-fatal disability.
- My quadraplegic patient.
Implications for treatment

- Patience is a virtue
- Continuity of care is of utmost importance
- Interdisciplinary care is most helpful
- All must be on the same page
- Communication is critical
- Tough Love is OK
- Focus must be on the future, not the past; Lot’s wife
- To err is human, to forgive divine….Treatment must focus on healing, not revenge
Role of opioids
If we know that severe pain and suffering can be alleviated and we do nothing about it, then we ourselves become the tormentors.”

*Primo Levi, Auschwitz survivor*

- There is a role for opioids in the management of chronic pain
- There is no agreement on what that role is
- There is no agreement on how to predict who will benefit
- Excess focus on opioid abuse
- These medications are unique in that the potential individual risk/benefit must be balanced with the societal risk/benefit
- Brings all sorts of players and risks into the doctor-patient relationship
- Emotions too often dictate policy with ramifications for the doctor-patient relationship
Important Definitions

- **Tolerance** occurs when it takes more medication to achieve the same effect.
- **Dependency** occurs when abstinence from the drug results in a withdrawal state.
- **Addiction** occurs when one compulsively engages in a behavior despite negative consequences to that person or those around him; in this case the compulsive use of pain medication.
- **Pseudo-addiction** occurs when one seeks to obtain a substance illegally or inappropriately to treat a legitimate problem that is not being properly managed by health care professionals.
Remember, patients are as afraid of these medications as practitioners are...

“This research indicates that Americans would rather bear pain than take action to relieve it. They withstand pain because they fear that too much medication will cause them to become addicted or dependent.”

What do we fear?

• The nature of the pain
• Restrictive regulation
• Addiction or thought of as being an addict
• Tolerance
• Other side effects
• Fear of being labelled a “bad patient”
• Death
Who should prescribe?
Decision to prescribe is a lifetime decision

- Continuity of care is critical
- Differences of opinion on prescribing opioids between practitioners makes changing doctors traumatic
- Problems with fragmentation of care
How do you prescribe?
Understand pain, both in general and specific to the individual patient’s pain
Patient evaluation and risk stratification
Development of a treatment plan and goals
Informed consent and treatment agreement
Initiating an opioid trial
On-going monitoring and adapting the treatment plan
Periodic drug testing
Consultation and referral
Discontinuation of opioid therapy
Medical records
Compliance with controlled substance laws and regulations
Role of Opioid Agreements

Bilateral vs Unilateral Agreement
Why do people die from opioids?

• Suicide
• Unintentional over-dose: medical use
• Unintentional over-dose: non-medical use
Eight Principles for **Safer** Opioid Prescribing

Webster, Lynn, *Pain Medicine*, 2013, 14: 959-961

- Assess patients for risk of non-medical use or misuse before starting opioid tx and manage accordingly
- Watch for and tx co-morbid mental disease when it occurs
- Conventional conversion may cause harm when rotating from one opioid to another
- Avoid combining benzodiazepines with opioids, especially during sleep hours
- Use methadone as a secondary or tertiary agent, starting with a low dose and titrating very slowly
- Assess for sleep apnea in patients on high daily doses of opioids and in patient’s with a pre-disposition
- Reduce opioid doses during upper respiratory infections or asthmatic episodes
- Avoid long-acting agents for acute, post-operative, or trauma related pain
“A ship is safe in harbor, but that is not what ships are for.”

William Shedd

*Bad things will happen. The goal is not to eliminate risks, but minimize them.

*Public policy which seeks unrealistic goals may be inherently harmful to those who suffer.... The law of unintended consequences.
Role of Universal Precautions

• 75 % of diverted opiate prescription starts with a legitimate prescription
• There is no fool-proof way to predict who will abuse a prescription
• The DEA has placed physicians who prescribe opioids on the front line on the war on prescription drug abuse
• Despite our limitations, it is incumbent on the physician to take whatever steps necessary to assess risk with each patient
• The question is not if physicians should use universal precautions, rather it is how should they be used
• Remember, addiction is a disease, addicts get pain, addicts have a right to treatment; however, the level of vigilance needs to be higher.
• New Hampshire Opioid Prescribing Resource
  http://www.nhms.org/node/113
More barriers

• Time
• Excess reliance on technology
• Lack of education
• Pre-conceived notions
• $$$$$$$$
• Fragmentation
• Corporization
• Health care reform/complexity
• Legal Issues
It comes down to the golden rule...

“East and West are at cross purposes only because the West is determined, at once resolved and economically ‘determined,’ to keep on going it knows not where, and it calls the rudderless voyage ‘Progress’.”

Ananda Coomaraswamy
Overview of Pain Management

- Foreman, Judy; *A Nation in Pain*; Oxford University Press, 2014.
- Nagel, David; *You DO Have to Suffer, Just Not as Much as We Make You...*; hopefully in press soon...

Opioid Prescribing

- Nagel, David; “Bilateral Opioid Agreement;” David.Nagel@concordortho.com.