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Will You Be My Doctor? A Different Approach to Treating Patients with Chronic Pain

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Opinion

Suffering is a unifying feature for all patients with chronic pain. Responses to the unceasing presence of pain can include both physical and mental strain, resulting in intensification of other concurrent physical conditions as well as significant frustration and reduction in sense of self-efficacy for the sufferer.

Chronic pain is defined as intractable pain of more than three months duration that is unresponsive to treatment as usual. Providing adequate care requires that the physician proactively work toward what will be in the best interest of the patient, even in the presence of difficult or challenging behaviors. Through an attitude of curiosity and openness to possibility, a competent and compassionate physician may change the course of life for a patient with chronic pain.

Treatment of chronic pain with opioids may require creative and highly individualized strategies to address potential management challenges. Unlike treatment heuristics that represent a standardization of treatment across cases, a compassion-based treatment approach addressing the unique needs and response patterns of the individual patient may best be illustrated by studying specific interactions with individuals in the process of struggling both with pain and , often, with aspects of their lives. The following are examples of ways in which shifting the focus and approach can result in significantly better outcomes, one person at a time.

"Will You Be My Doctor?"

HS, a 45-year-old man, was sitting comfortably with his eyes closed when I approached him. He greeted me with a calm demeanor, and, with an expectant look, he narrated his journey with chronic pain. An accident at the age of 32 had left him with moderate pain in his lower back during all waking hours that would become severe during activities. Since the time of the accident he had been bouncing between doctors in an effort to find relief.

Showing empathy was my first plan. "I understand your discomfort," I told him. I immediately noticed his initial composure dissolve, as he struggled to express the intensity of his pain. "Really, huh? You have no idea of my misery. I am in severe pain, with no doctor to treat me." "Why no doctor?" I asked. He began to express his fear that anyone he would go to might assume him to be a drug-seeker rather than seeing him as someone seeking relief from his genuine symptoms. "Would you be my doctor if I told you that the only medication I take is for pain? Currently, I have no other medical problems."

His functional status was difficult to assess as I weathered the deluge of his past experiences, even as he expounded on his pure dissatisfaction with his medical care. It was time for me to start with the basics: "What do you want out of your pain management?" "I just want to be comfortable for few hours in a day. Do you think you can do that for me?" He was already on hydrocodone-acetaminophen 10/325 every four hours. As I brought this up, I could tell that he had heard this a thousand times. "What are you going to do now, preach at me to cut back on hydrocodone? Tell me how I will become addicted?" His frustration was evident as he added, "Just like every new doctor does. I should 'use music to calm down my nerves' and exercise regularly too, right?" I was caught off-guard but assured him that I intended to continue him on the same dose, that I had no plan to automatically reduce his medication levels. With a renewed prescription in hand, he left the office.

After the visit, I reflected and realized that I had sent the patient away with exactly the same treatment with which he had entered my office. By doing so, I was expecting a different result by repeating the same behavior, Einstein's definition of insanity. I called him back, changed hydrocodone to methadone, keeping in mind long half-life of methadone, and asked him to call me in two weeks to let me know if he had achieved his goal of a few comfortable hours a day. "You are asking me to call you about my pain?" he asked, surprise in his voice. Through the phone I smiled and nodded. Escalating hydrocodone had not controlled his severe pain because he needed a stronger, longer-acting opioid. This change in approach created a sense of hope and active treatment for the patient, in addition to the opportunity for him to look forward to his next visit instead of dreading it, as HS would later describe to me.

Sometimes trusting the genuineness of the patient's description is only a piece of the skill set required to find a creative solution. Unlike the first patient who was able to clearly describe his concerns, some patients struggle to verbalize the multiple dimensions of the problems with which they contend.

A Burden

My next challenge was a petite woman, JF, a 36-year-old schoolteacher and mother of three. The moment after I asked how she was she began to cry. It had been only a few months since she had moved here, and I had already seen her twice for pain in her weight-bearing joints. She was already taking hydrocodone as needed and etodolac twice a day. At her last visit I had increased the dose of hydrocodone, but the larger dose gave her even more side effects, with no greater relief. As I pondered this dilemma, I could sense that there was something peculiar about this pain. With conventional methods proving ineffective, I decided it was time to get help from an acupuncturist and a chiropractor.

She was on her way out of the office when she turned around and asked, "How am I going to find time for all this? I take care of my three children, maintain the house and yard and work full time." "Does your

husband realize all the work that you are doing by yourself?" I asked. "Oh, no, He has no idea of how much work it takes to maintain a house and care for three children. He takes it for granted that I am supposed to do all this work."

It suddenly clicked; I recognized this pain! This was the pain of being alone in caring for the children, the pain of lack of recognition, and the pain of being overworked for years. "Next time," I told her, "bring your husband to your appointment with you. In the meantime, on doctor's orders, once a week, you should plan time for yourself. Go to the spa, read in the library, spend time with your friends or family, all with the plan that Mom will be off the clock for at least a brief period of time. Go to sleep undisturbed, and, yes, please stop all pain medications." She smiled with relief showing on her face.

I shuddered at the thought: what if I had not recognized the real cause of pain and had just kept increasing the dose? What if I had not listened beyond the pain to the additional sources of her suffering?

Sometimes I have found myself challenged, not as much by finding the correct therapy to pursue as by the environmental hurdles that patients – and I -- encounter between themselves and the help they need.

A Valid Question

Mr. TP was a 56-year-old engineer who, having an x-ray-supported diagnosis of osteoarthritis, was placed on a stable pain medication regimen. As I entered the waiting area, he informed me that he was here for his monthly visit for a new prescription of pain pills. With just a quick glance I could see that he was agitated. "I've already signed the consent and given a urine sample to screen for drugs. Just tell me what else I need to do to get treatment," he implored.

I could understand his frustration. Here was a productive man taking a day off every four weeks just to get medications that allowed him to go about his day. I found myself wondering why we discriminate against patients experiencing chronic pain, requiring so much more of them than we ask of other patients? Is there a justification for the dissociation between a patient with chronic pain and a caring attitude of the provider? As this patient put it, "Why are there so many rules and requirements for us, all with the threat of discontinuation at the drop of the hat? Can't there be a medicine that controls the pain and is non-addictive? Every time I come in here I get the feeling that I'm unwanted by the staff." At that moment, I, too, felt trapped by the systemic demand for distrust. Treating patients with chronic pain on long-term opioids would not be so difficult if these patients were assumed to be as trustworthy as other patients and if an effective pain medication without potential for addiction, tolerance, and high street value were available.

- Remove unnecessary hurdles in acquiring opioids for chronic pain
- Seek non-addictive medication options for controlling pain
- Modify treatment if it is not working
- Be aware of discrimination based on diagnosis

In addition to being aware of the factors already discussed, another challenge to treatment of chronic pain is a willingness to continue to ask questions, even when the answer is assumed to be known.

A Curious Case of Pain

He was not my patient: I just happen to be in the emergency department at that moment. The ED attending simply asked me for my opinion on an extremely difficult patient who, despite having his narcotics increased by leaps and bounds, was still being admitted to the ED for pain. As I stood by the patient's bedside, waiting for him to open his eyes so that I could speak to him, his entire body began to spasm, and he shrieked in pain. In a few minutes, it was over. Struggling to recover, the patient told me that he had been having spasms day and night with no relief. I immediately admitted him to my service, carefully reviewed the symptoms he was describing, and diagnosed him with Isaac Syndrome. With a new and more accurate diagnosis, I was able to find a treatment that was effective in controlling his episodes. Since then he has been able to discontinue most of his pain medications and, with renewed control of his life, has been transformed from bedbound to independent and able to resume living his life. Being willing to continue to consider the possibility of differential diagnoses for a "chronic pain patient" let us find more effective and, in this case, life-altering treatment options.

Lessons:

- A clinician can make the diagnosis with history and physical examination. Ancillary tests should be the slaves of clinical management and not the masters.
- Difficult medical conditions and difficult patients should be differentiated.

In the final case, willingness to share news of improvement can potentially turn into an agent for additional distress.

Fixed May Not Last Forever

I had entered to see the patient, PK, who had previously reported having experienced chronic pain. I was surprised when she told me that her pain had been relieved for the past several months. I paused and waited as she continued, "My doctor decided to discontinue the medication since I was pain-free." PK had suffered for more than a year, unable to work, unable to take care of herself. Miraculously one morning, after having taken her prescribed pain medication for some time, she awoke with no pain. She moved around, and still no pain: she was back to her old self. She could not contain her joy, and she called the nurse in her doctor's office to share the news. Upon hearing the news, the response of her treating physician was to discontinue her pain medication.

While I considered this joyous report, I also called to mind something I had learned from previous, similar situations. There is often a paradox involved in this sequence of events. When the medication is successful, the result of sharing this success is often that the agent of success, the medication, is then withdrawn from the patient. The paradox is that later, if the pain were to return, it would likely be difficult for the patient to convince the doctor that her condition had, indeed, reversed itself and that she needed to resume the medication that previously had been demonstrated to be effective.

In this situation, the moral suffering of knowing that something could help and being denied that help is more painful than the physical pain itself.

Summary

In each of the cases described, different demands on the awareness and compassion of the physician were created by the unique elements of each individual's condition and life circumstances. Of critical importance in treating chronic pain is a commitment to the stance that

the patient is not responsible for the presence of pain in his or her life. Patients grappling with chronic pain deserve to be afforded the same respect and dignity as patients dealing with any other medical condition, without either the physician or the medical system creating additional challenges and barriers to effective treatment options. Inherent in the nuanced art of medicine is individuation of care, with treatment based on the needs of each individual. Without question, part of the responsibility of the physician includes being cognizant of the abusive potential of medications. However, that represents just one in a list of treatment considerations, and potential for medication abuse does not imply that all patients are engaged in such abuse. The presence of both compassion and awareness allow for a balanced approach to creative treatment that works. There is no substitute for clinical acumen, no heuristic that can adequately replace person-to-person interactions with a skilled and caring physician. Even in the presence of challenges, trust, optimism, and a sense of collaborative willingness can remain an inherent part of our care of patients.