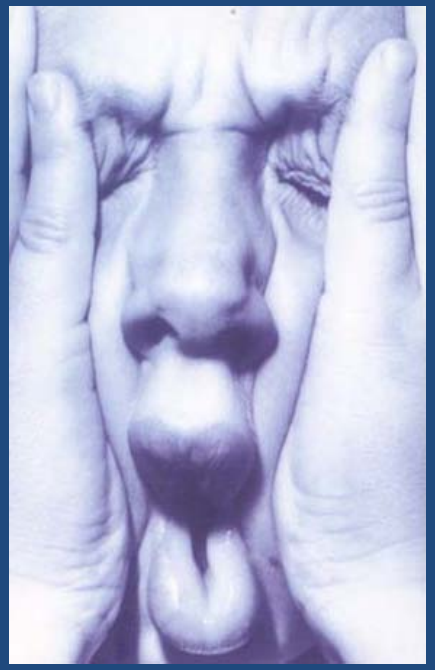
Helping the Challenging Patient: Practical Advice for Managing Difficult Patient Interactions



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Why are interactions with some pain patients so “difficult”?

For some patients we run out of appropriate and rational medical options

Overview

- Understand the causes of difficult interactions
- Advice for avoiding such interactions in the future
- How can we avoid conflict over opioid medications?

The only way avoid or get out of "difficult interactions" is to do something differently

Conclusions

- The most important thing to do differently is to stop blaming the patient
- Understand how our own efforts to help exacerbate and perpetuate these interactions
- Learn new ways of thinking about chronic pain and its treatment

Current Practice

- Chronic pain is a very common problem
- 95% chronic pain treatment is done by PCP
- Do well with 90% of patients with pain
- The other 10 % are usually referred to as “pain patients”

Useful Distinction

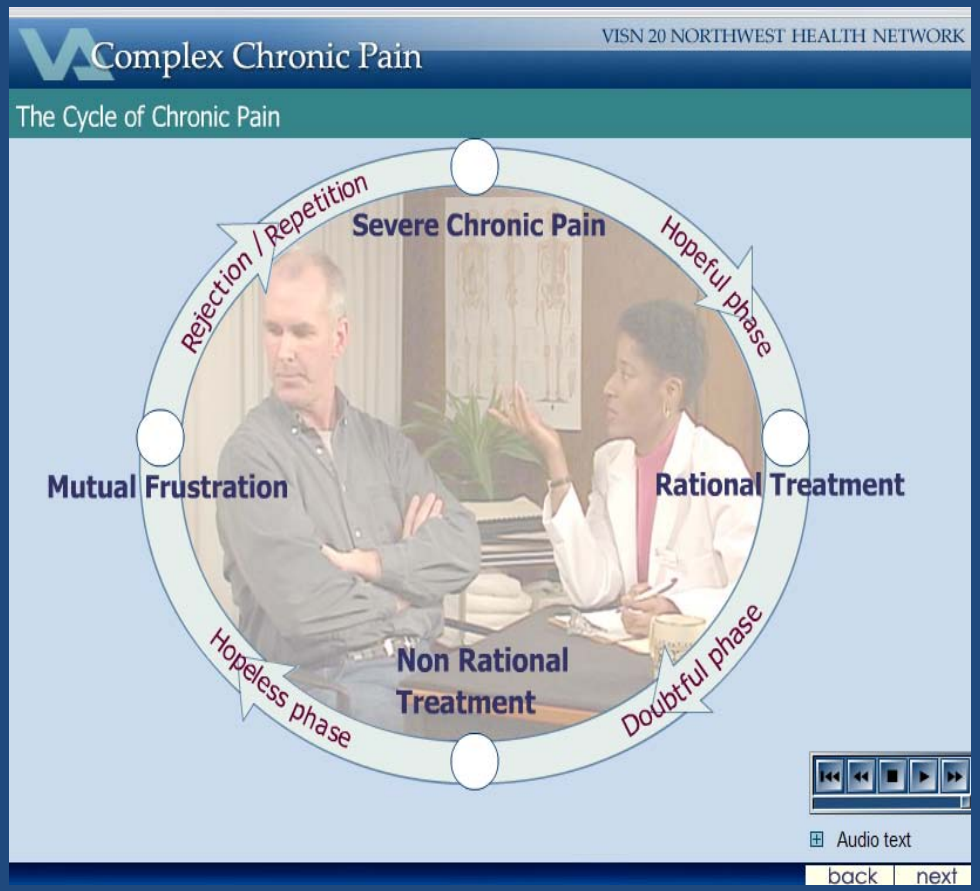
- "Simple" chronic pain responds to standard treatments
  - Pt. is generally functional
  - Interactions are mutually satisfying
- "Complex" chronic pain does not respond to standard treatments
  - Declining function over time in spite of progressively more aggressive, expensive, and risky medical treatments
  - Hx "enigmatic" presentations to multiple providers
  - Mutually unpleasant interactions
  - Perceived to be demanding, dissatisfied, and, often, drug-seeking

Complex Pain

- Best viewed as a syndrome that occurs across a wide variety of painful conditions
- Overwhelmed by pain and overwhelming the system
- Iatrogenesis is a significant problem for complex pain patients

WHY DO DIFFICULT INTERACTIONS OCCUR?

Cycle of complex chronic pain

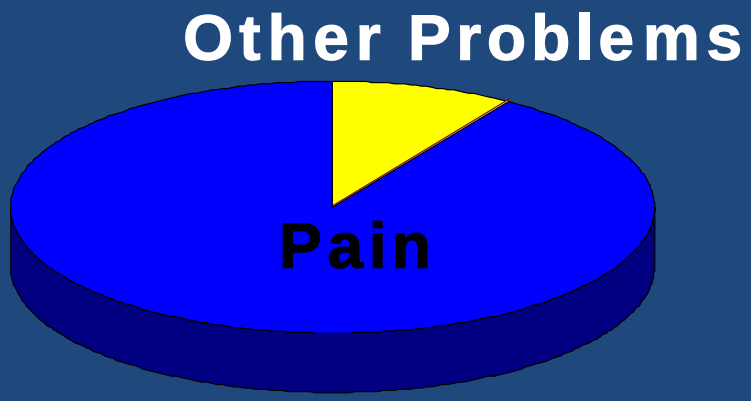


- Hopeful phase
  - Share a biomedical model
  - Urgent pain relief is the goal
  - Standard treatments tried
  - Diagnostic tests ordered
  - Consultations are made
  - Clinical decisions are rational

Hopeful Phase: Cooperation

Patient

Provider



Biomedical Model: Pain as Symptom

Nociception → Pain → Suffering
Disability

Identify the cause --- Fix the pain ---- solve the problems

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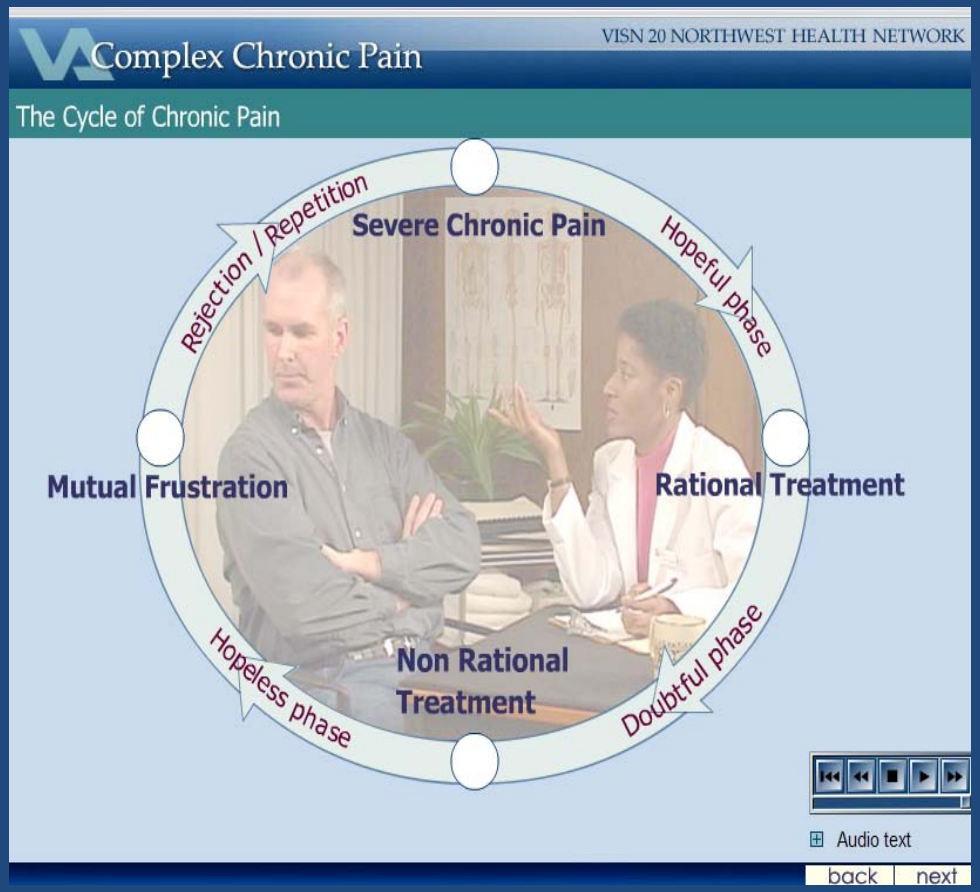
Cycle of complex chronic pain

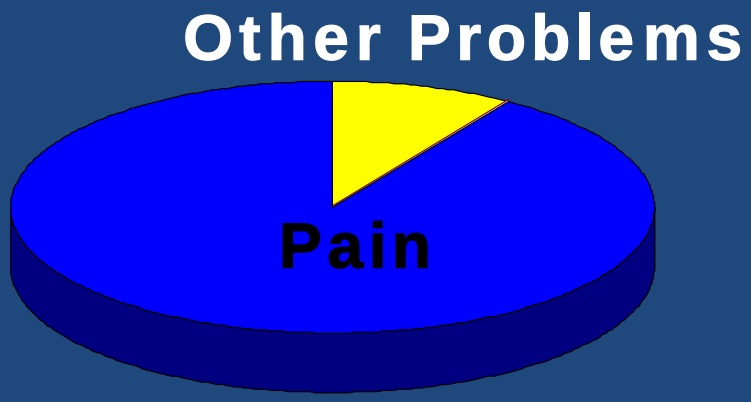


- Doubtful phase
  - Tests are negative
  - Standard treatments are not working
  - Specialist treatments fail
  - Patients are returned unchanged and more frustrated

Hopeful Phase

Patient

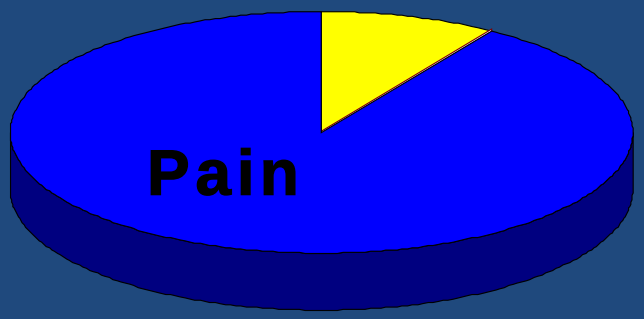
Provider



Doubtful Phase: Conflict

Patient

Other Problems

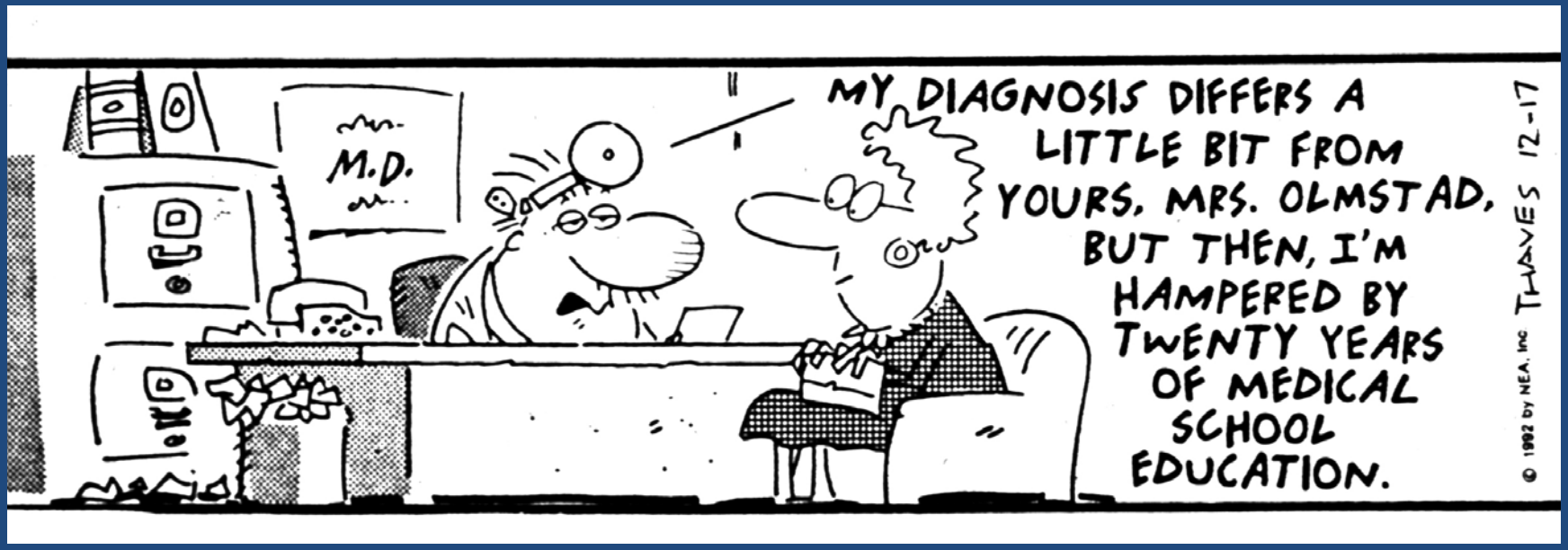


Provider

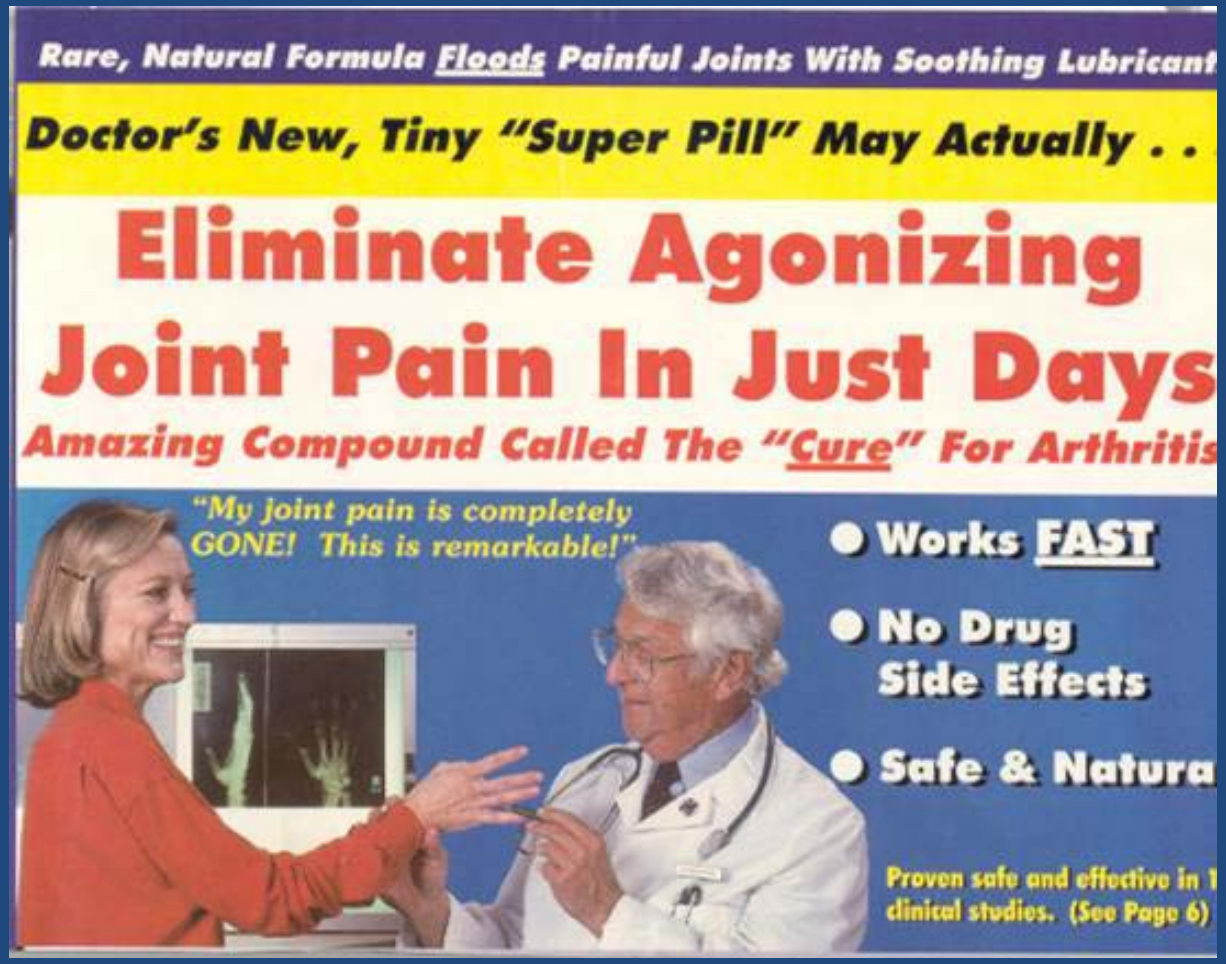
Pain

The more we communicate doubt, the more vigorously patients pursue validation they have a “real” problem

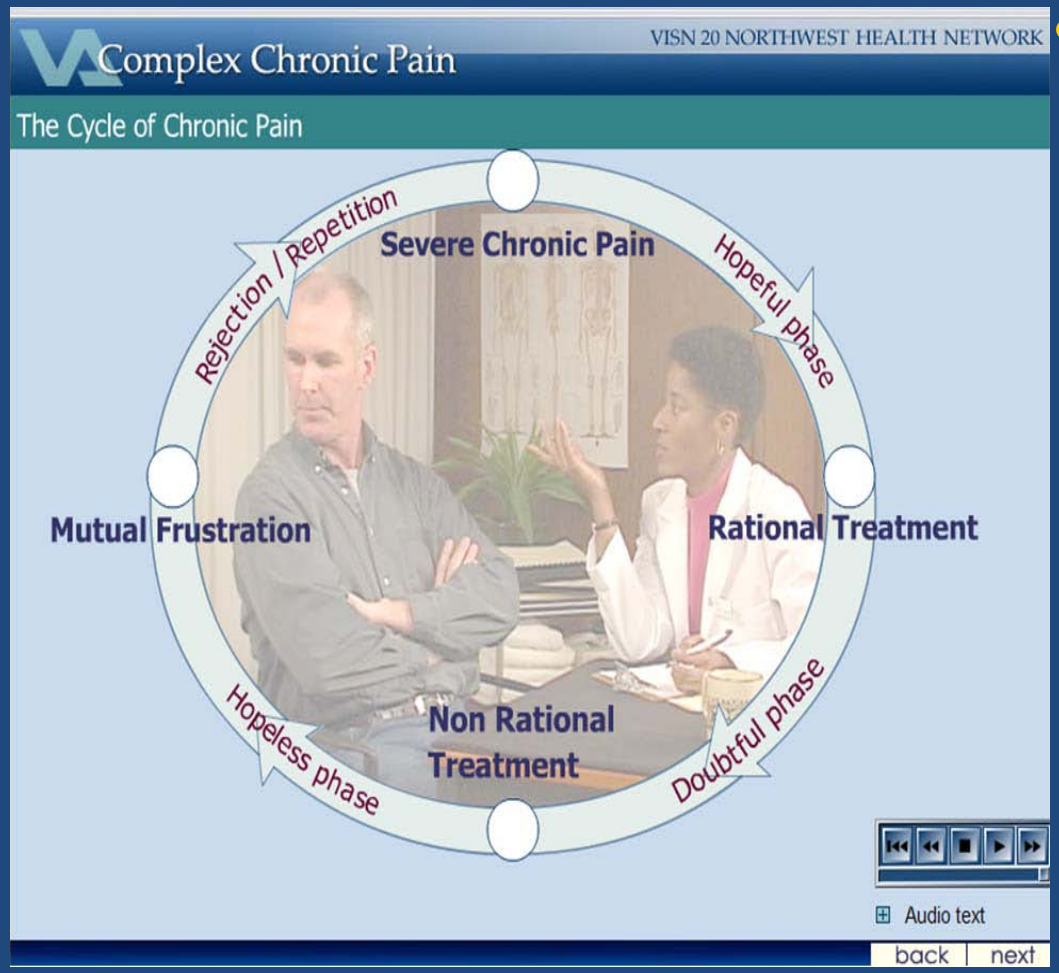
Conflict: Increased demands for validating tests that pain is “real”



Conflict: Increased demands for urgent pain relief



Cycle of complex chronic pain



- Non-rational phase
- Little to offer: more of same
  - Repeat tests
  - Escalate meds
- Improbable diagnoses
- Refer to more specialists
  - Further escalate meds
  - Consider unproven tx
- Returned to primary care

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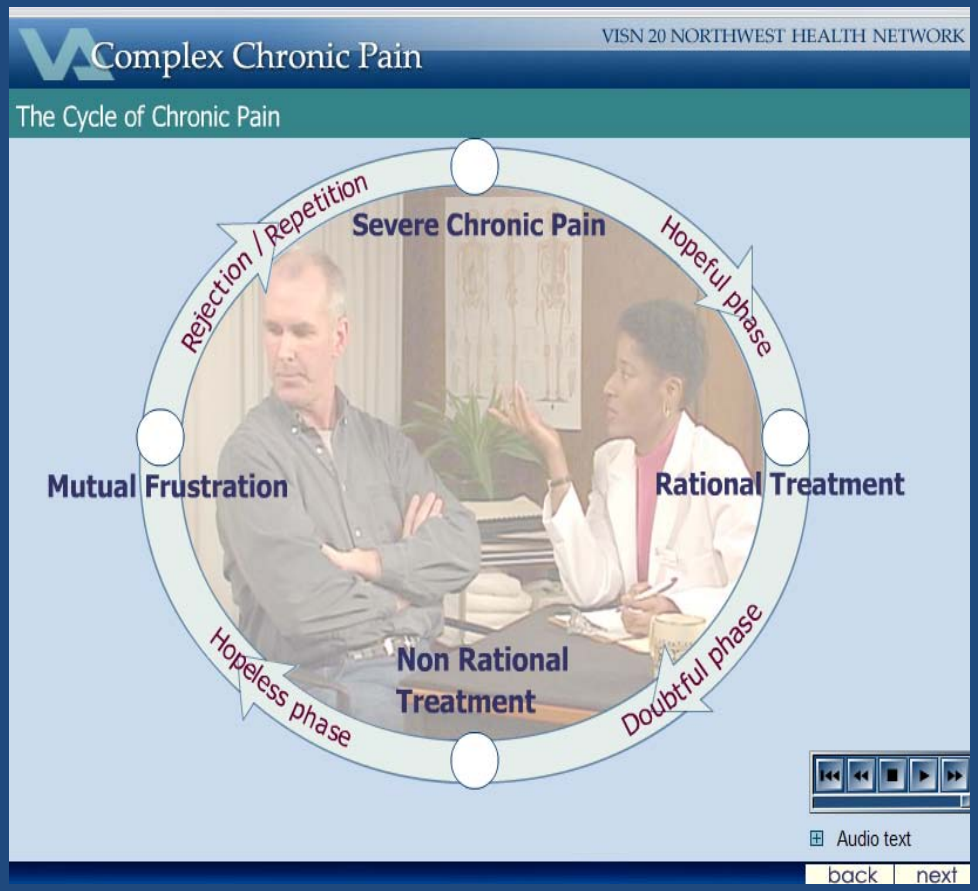
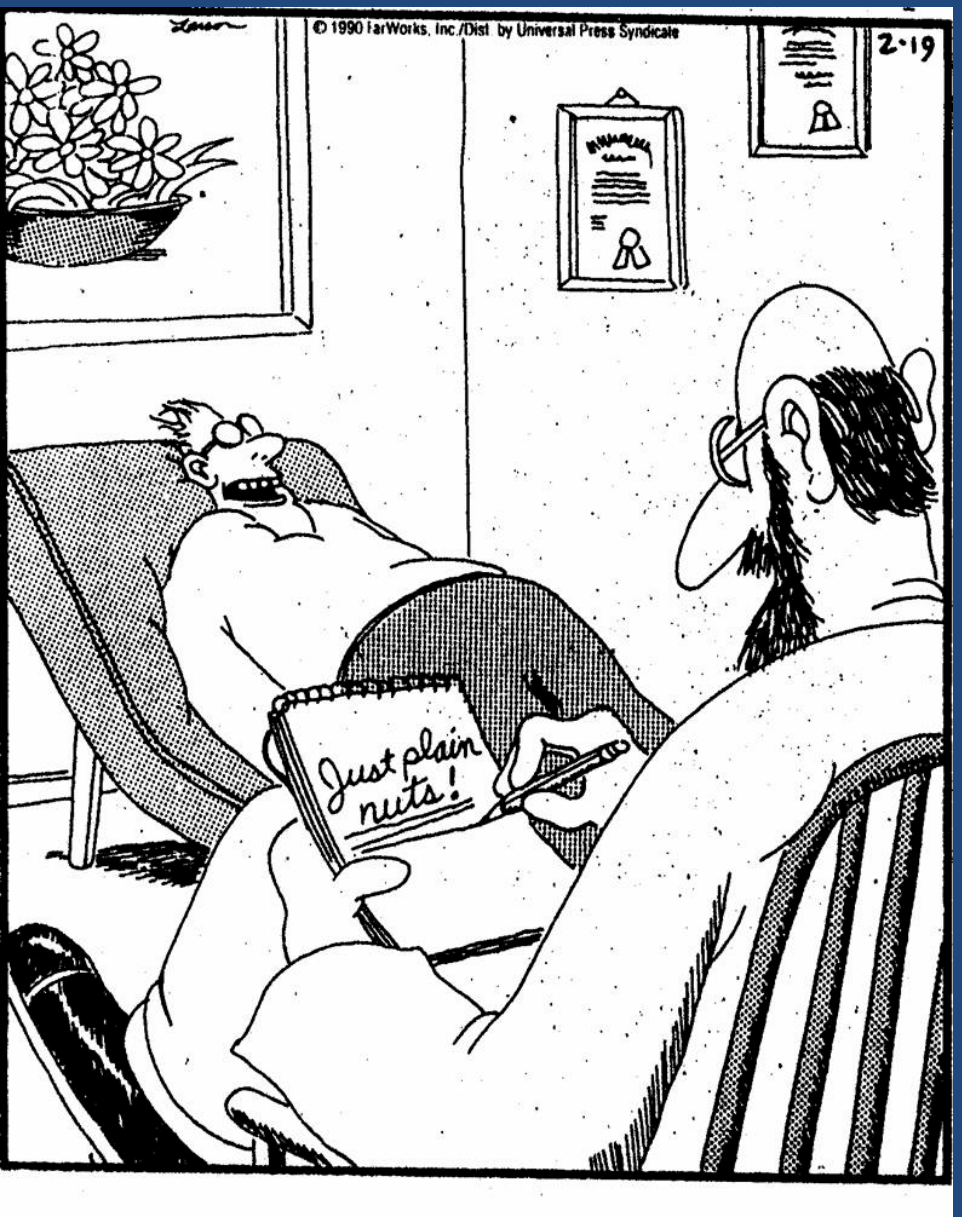
Cycle of complex chronic pain



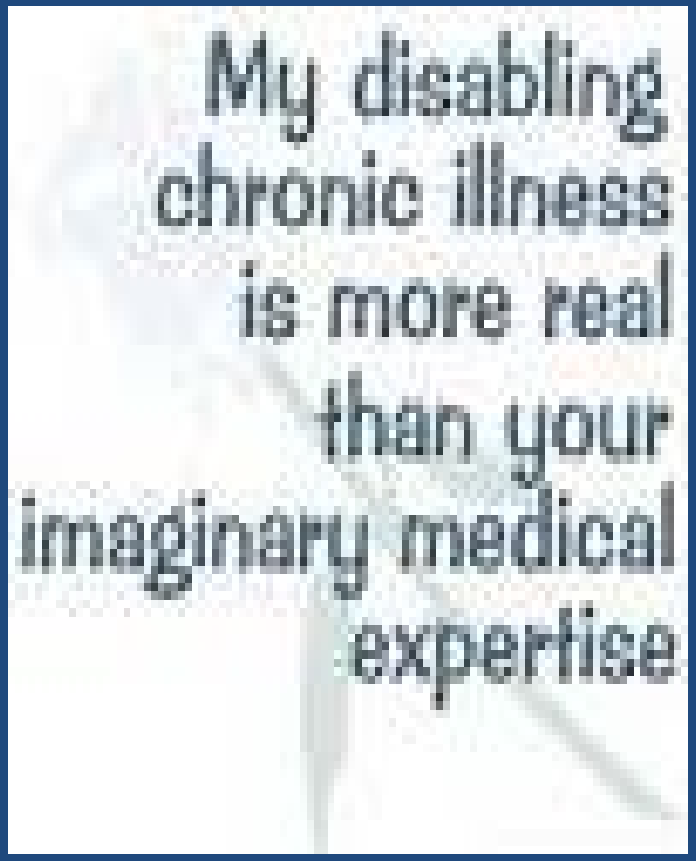
- Hopeless Phase
- Mutual Frustration
- Agree to just about anything to get them out of the office

Hopeless Phase: Provider



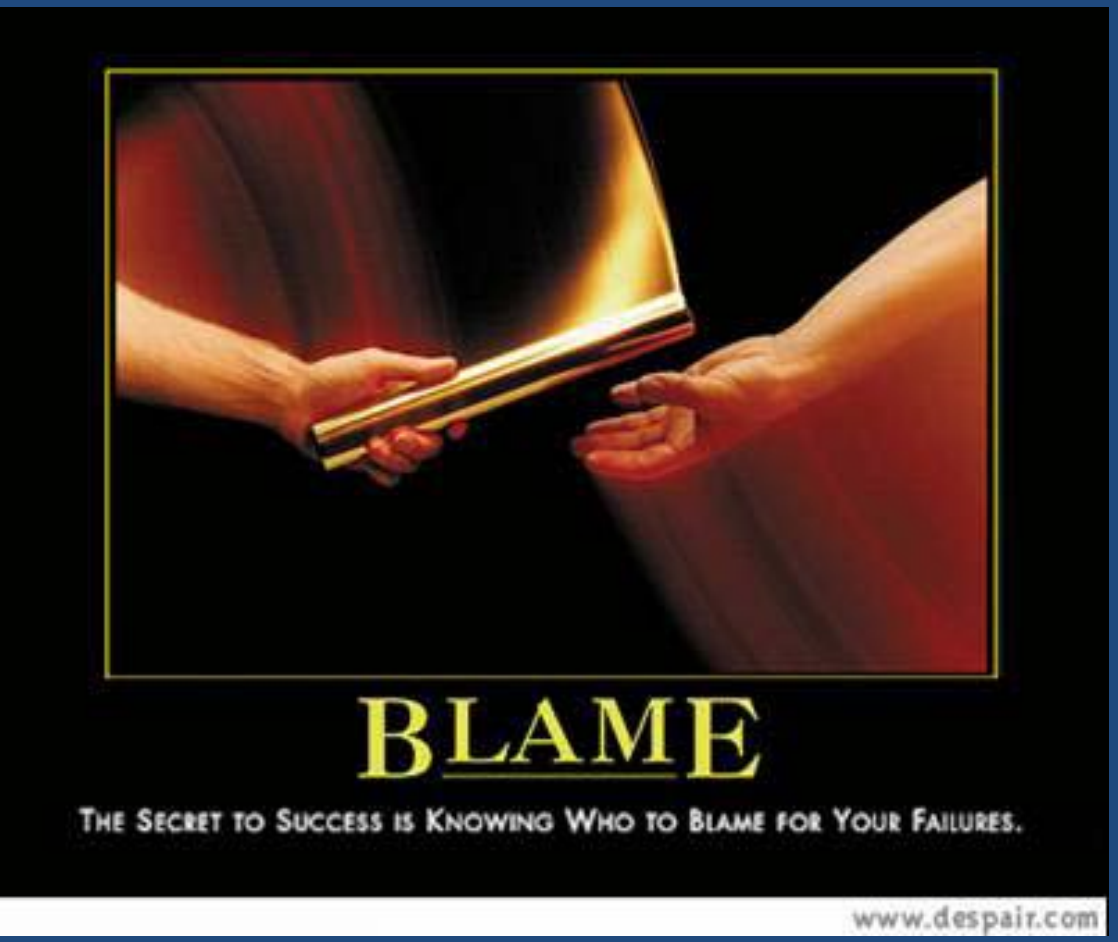
- Pain is not “real”
- Unmotivated
- Secondary gain
- Substance abuse
- Psychiatrically impaired
- Personality disordered

Hopeless Phase: Patient



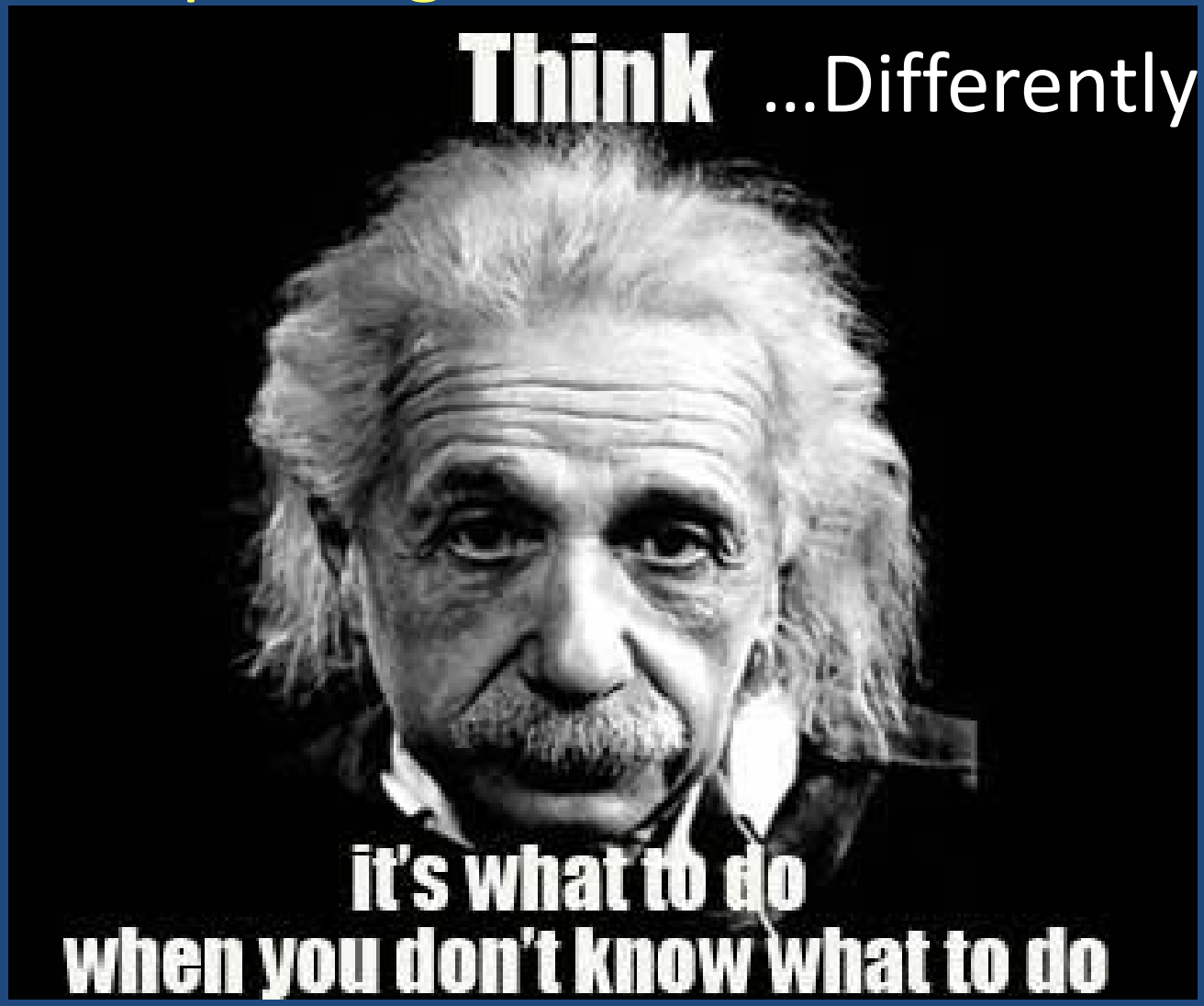
- My pain is “real”
- Incompetent
- Uncaring
- Withholding treatment because of costs, fear of regulators, etc.

Mutual Rejection/Repetition



- Provider: another crock
- Pt: another quack

Insanity: Doing the same thing and expecting different results



Conflicts develop because we doubt each other rather than doubting our assumptions about chronic pain and its treatment

Fundamental problem

- Both pt. and provider share a biomedical model that is inadequate to address the complexities of complex chronic pain

Biomedical model: problematic beliefs

- Pain is the primary problem
- Pain is a symptom of an underlying condition that can be objectively identified
- Medical solutions are possible
- Provider is the expert responsible for fixing the problem
- Pt. is a helpless victim of a disease or injury

Iatrogenic Escalation

- Iatrogenic escalation occurs because:

1) Both pt. and providers share:
   - A primary focus on urgent pain relief
   - A belief that a medical solution via opioids is possible

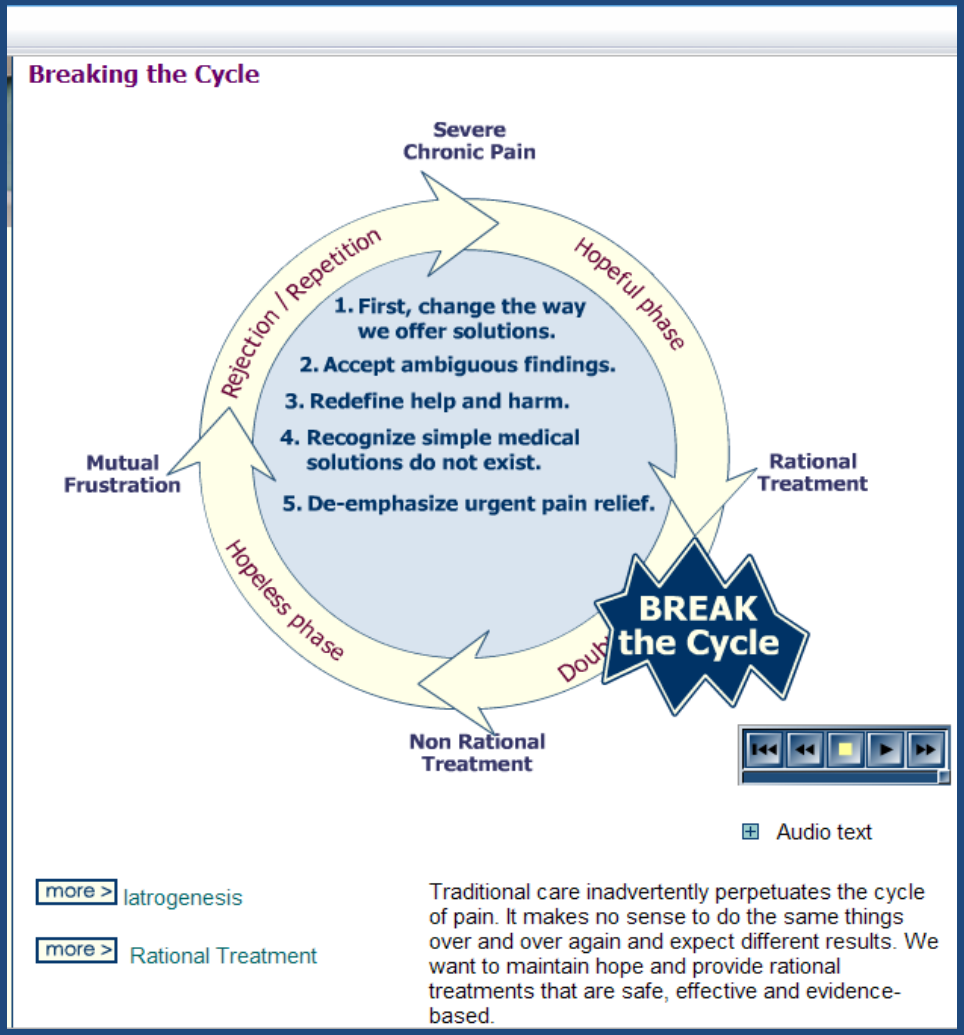
2) Providers experience significant personal and professional pressures to “help” by urgently reducing pain

3) Opioids are an “easy solution” when confronted with overwhelming suffering or difficult/ demanding patients

Iatrogenic Escalation

- Iatrogenic escalation occurs because:
- Escalation ultimately fails because complex pain is complicated by a host of psychological and social problems that are often unaddressed

Breaking the cycle



- Reconceptualize the problem
- Redefine helping
- Redefine methods, goals
- Transfer hope from medical solutions to self-management efforts

HOW CAN WE AVOID DIFFICULT INTERACTIONS IN THE FUTURE?

Clinical interactions as “dance”

- Two partners working cooperatively as a unit in response to music.
- One partner leads, the other follows.
- Music: beliefs about pain and its treatment

Difficult Interactions

Difficult Interactions

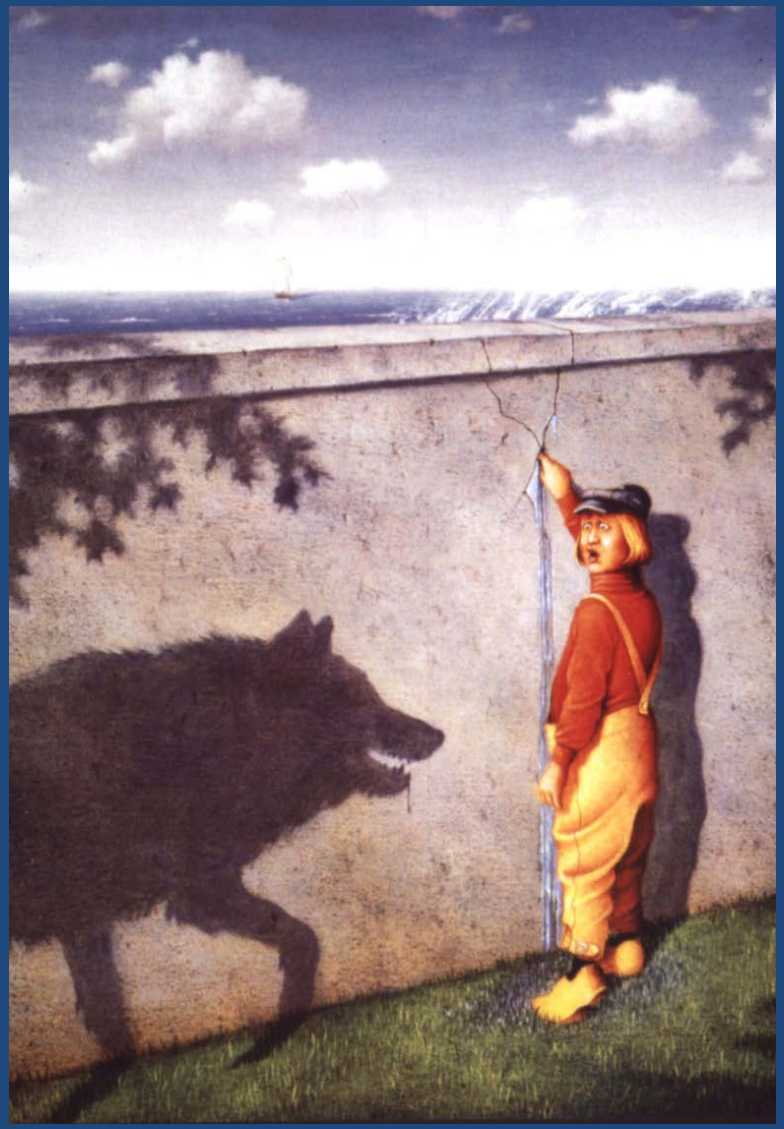
- Interactions are "difficult" when we lose control
- Focus on medical solutions with goal of urgent pain relief
- Leader: decisions are based on pt reports of effectiveness, side effects, etc.

Take the lead

- Put down the burden of being the "expert" responsible for urgent pain relief
- Medical solutions do not exist for complex chronic pain

- Chronic pain is best understood as a process that evolves over time
- The chronic pain experience results from the entire progression of the patient's illness, the sociocultural context in which it occurs, and the interactions between health care professionals and patients
  - Osterweis, M, Kleinman, A, Mechanic, D. Pain and disability: clinical, behavioral and public policy perspectives. Washington, DC: National Academy Press, 1987

Complex chronic pain is not “curable”



- Patients who are overwhelmed by complex chronic pain are always overwhelmed by life problems independently of pain

Recommendation

- Provide care within the context of a biopsychosocial model of chronic pain
  - Literature clearly supports the notion that chronic pain is a complex human experience that can only be understood in the entire context of the person's life
  - Pain Experience = Nociception X Suffering X Disability

Biomedical Model: Pain as Symptom

Nociception → Pain → Suffering
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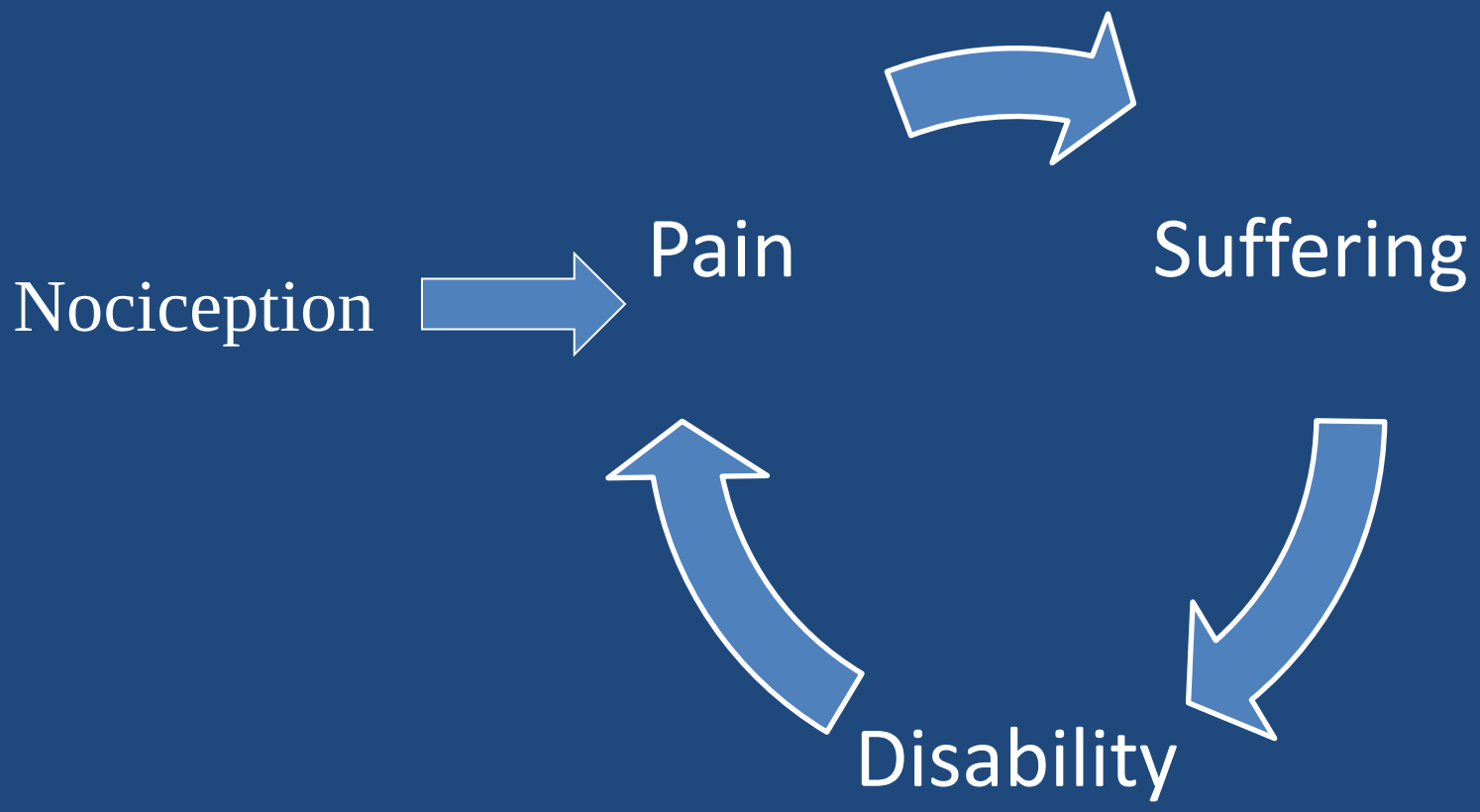
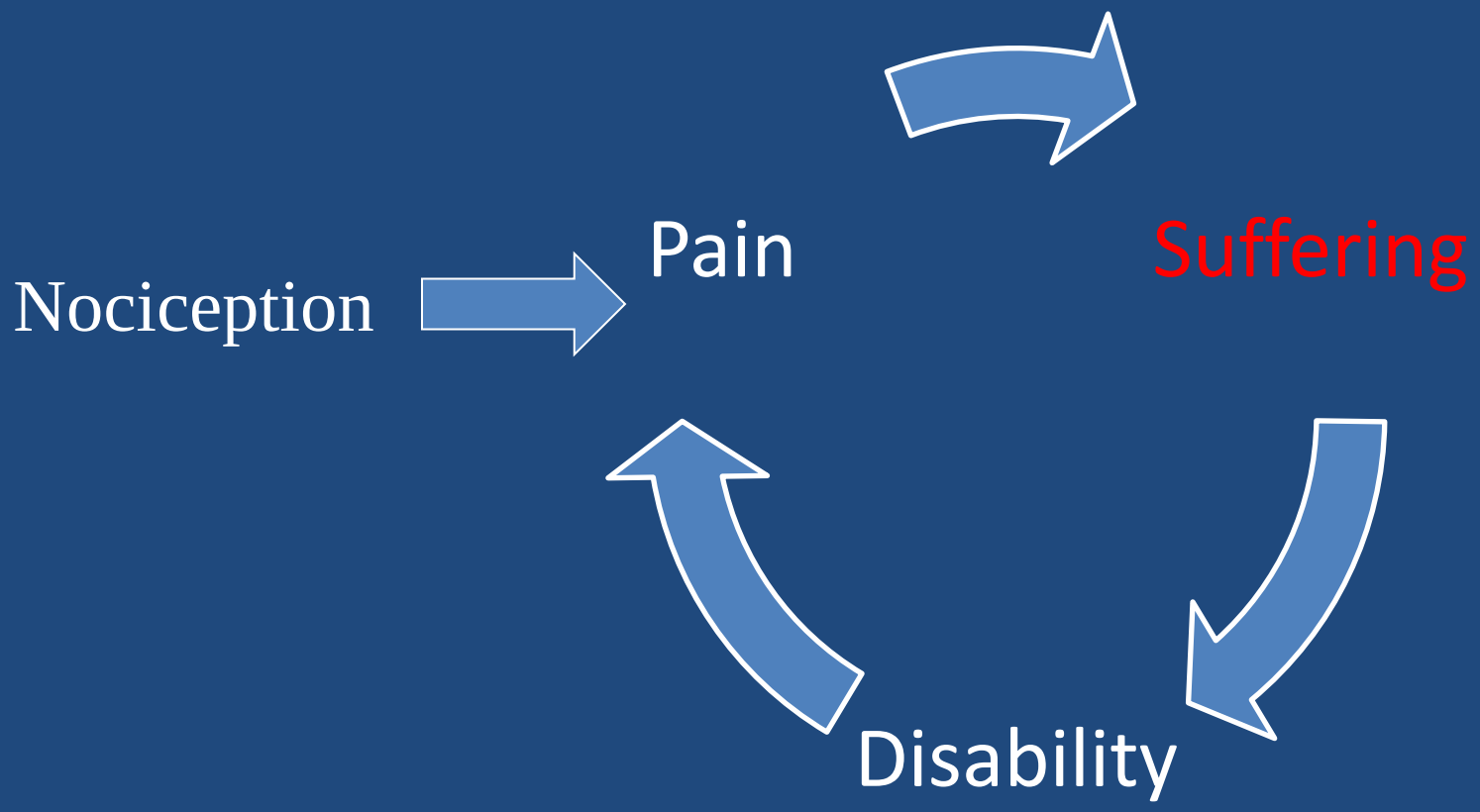
Identify the cause --- Fix the pain ---- solve the problems

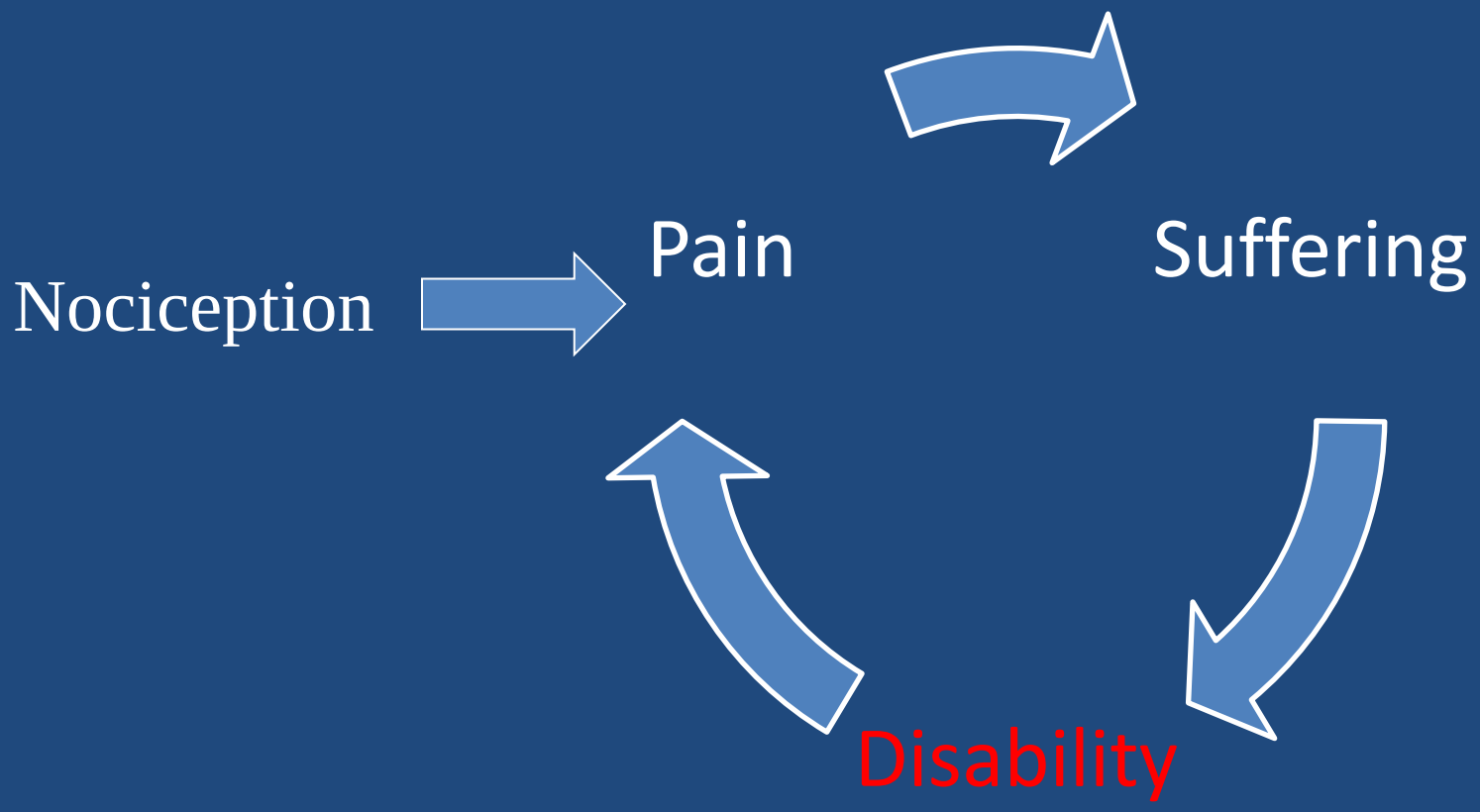
Biopsychosocial Model: Pain as Experience



Biopsychosocial Model: Pain as Experience



Biopsychosocial Model: Pain as Experience



Biopsychosocial Model: Pain as Experience

Comparing Models of Pain Management

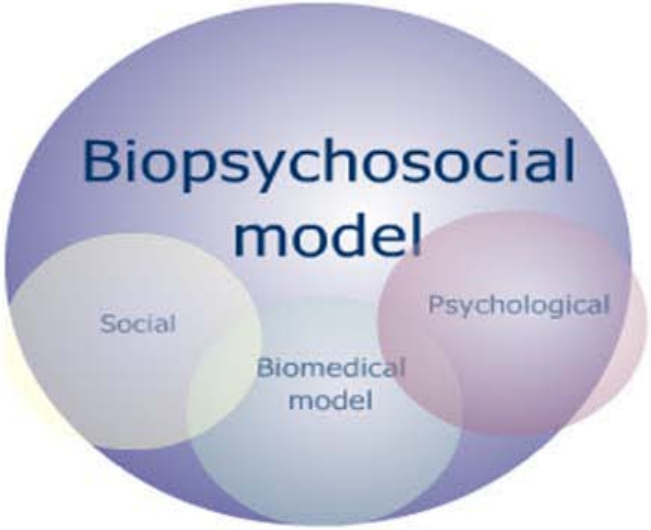
A biopsychosocial approach rewrites rules and expectations about treatment.[2]

	Biomedical	Biopsychosocial
Mind and body relationship	Body and mind separate	Holistic - "Total Person"
Pain defined as...	Symptom	Complex problem
Assessment goal...	Identify cause	Identify effects
Diagnostic strategy...	High technology	Comprehensive psychosocial
Treatment goal...	Cure	Restoring function
Time span...	Short term - pain relief	Long term - reactivation
Provider role...	Expert	Teacher/coach
Patient role...	Passive/helpless	Active/responsible
More appropriate for...	Acute pain	Chronic pain

AUDIO TEXT >

Comparing Models of Pain Management

- The biopsychosocial model subsumes the biomedical model.



Audio text

Although it's useful to compare models, it's important to understand the biopsychosocial model subsumes the biomedical model. All rational and appropriate medical treatments are offered but in a context that recognizes the complexity of the chronic pain experience.

Collaborative self-management

- Full range of medical interventions are employed but in a context that emphasizes the far greater importance of the efforts the patient makes in his or her own long term rehabilitation
- Not effort to convince pt that their pain is “caused” by psychosocial factors
- Not a grim alternative to failed medical treatments

Collaborative self-management

- Supporting the patient as a person while challenging the belief that pain is the primary problem and that opioids are the only solution
- Urgent and absolute pain relief is not the primary focus of treatment
- Long-term rehabilitation is the goal

Collaborative self-management

- Goal is to shift the locus of hopefulness from medical treatments to your patient's own rehabilitation efforts.

- Deemphasizing urgent pain relief and focusing on self-management does not absolve you from all responsibilities. It creates new ones.

Collaborative self-management

- Opioid treatment is provided in a context in which we help patients:
  - Acknowledge and identify problems other than pain.
  - Separate urgent pain relief from suffering and disability.
  - Understand how normal reactions make problems worse.
  - Engage in self-management efforts to address these issues

Collaborative self-management

Chronic Pain

VISN 20 NORTHWEST HEALTH NETWORK

VEMA Model *Click on each for more information*

Validation more >

Much of our struggle with patients relates to our communication of doubt.

Education more >

The basis of effective, long-term care is a shared understanding of chronic pain. [ref xx]

Motivation more >

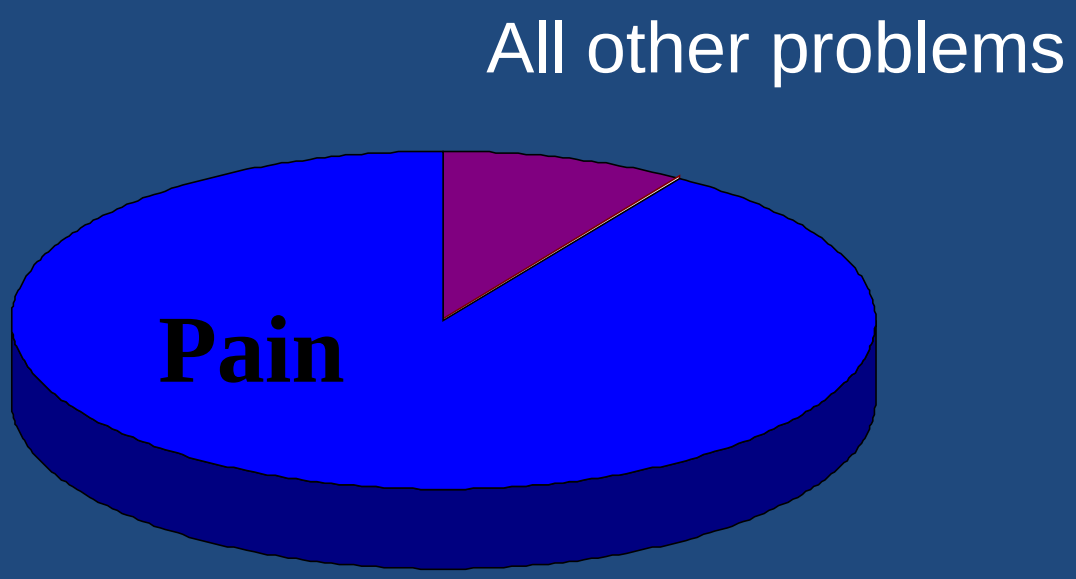
Patients vary in their willingness to engage in self-management.

Activation more >

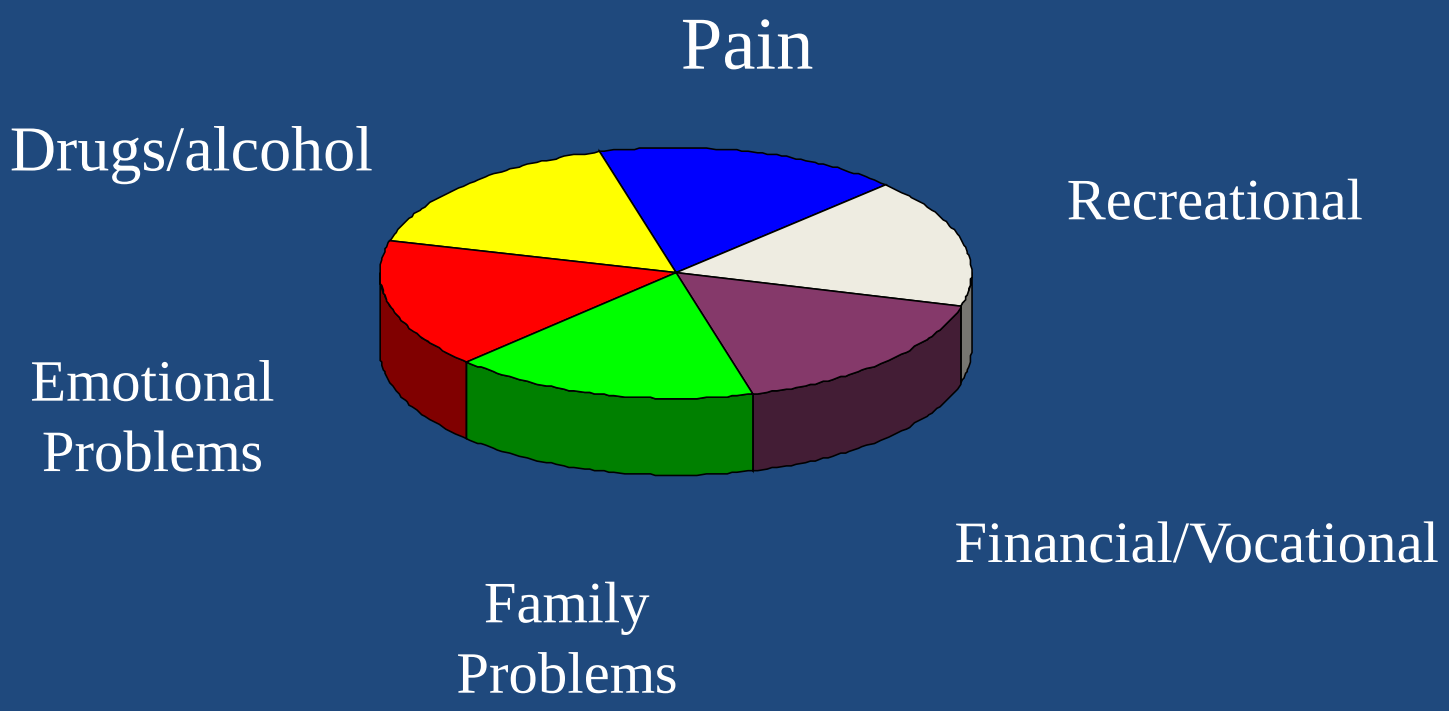
The primary clinical focus is on changing the way patients react to pain

back next

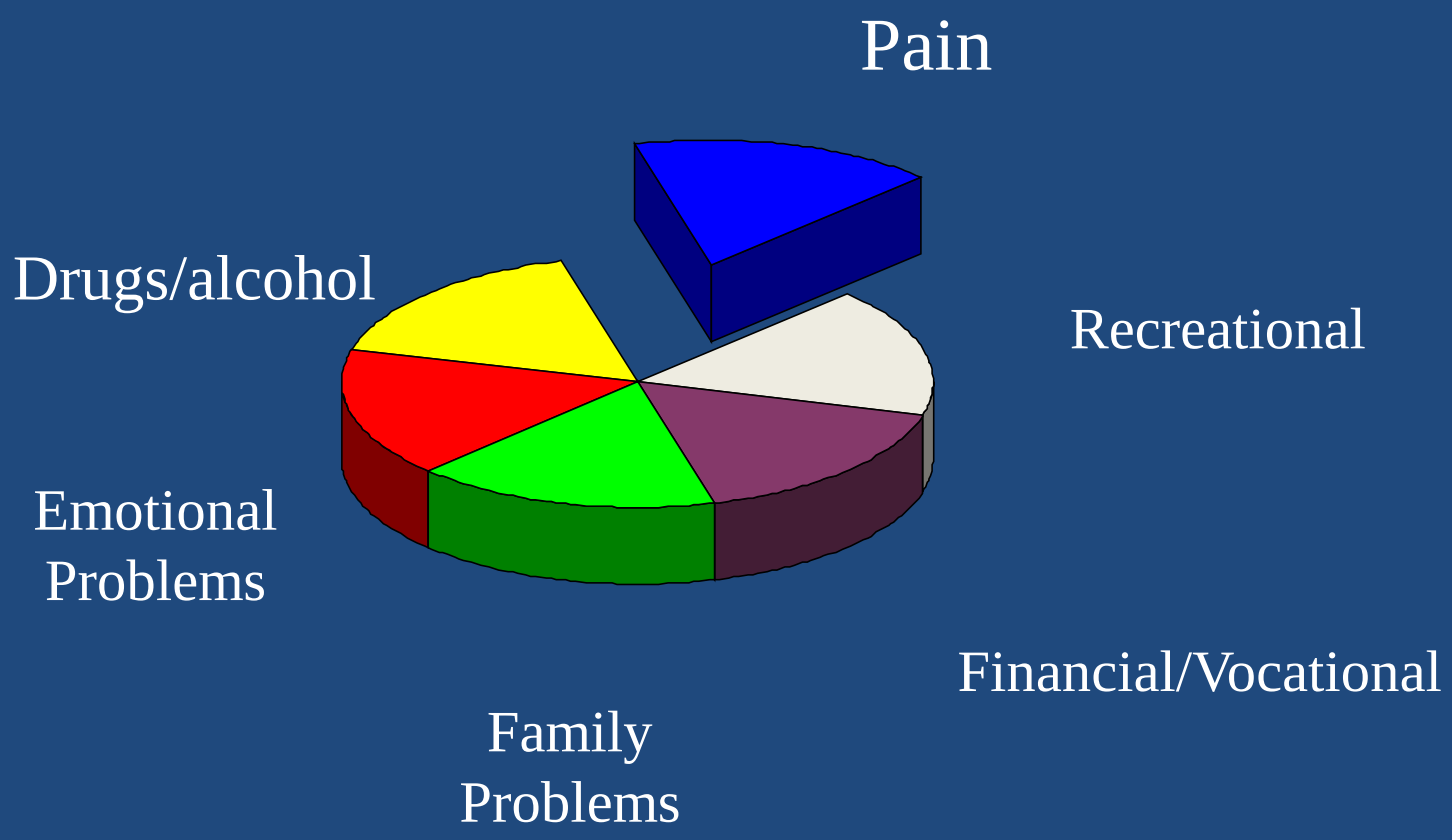
Pain is the primary problem



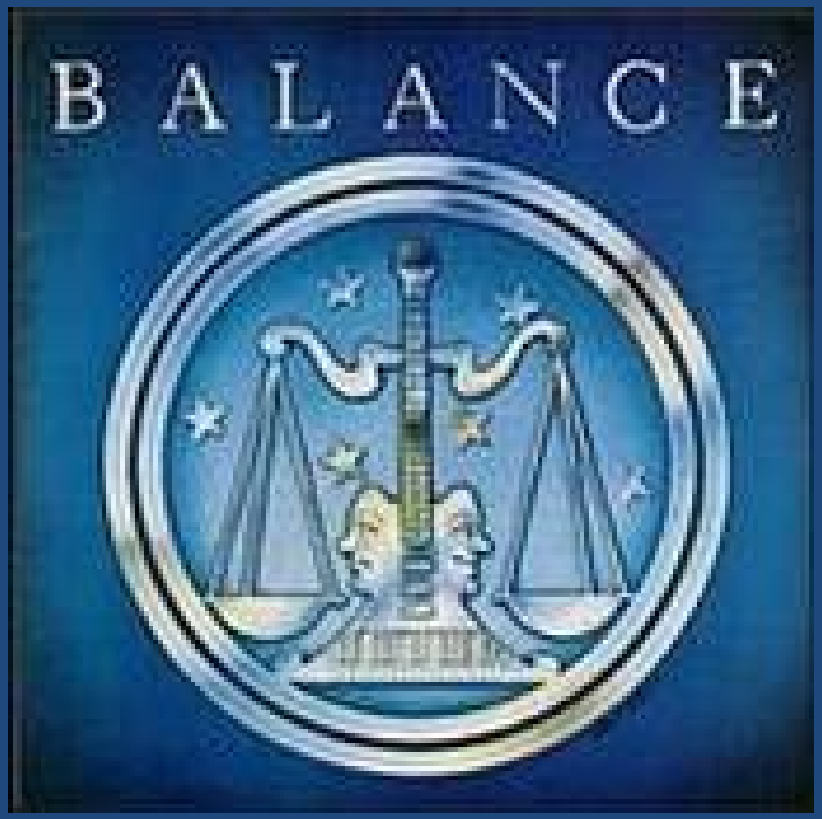
Self-management perspective



Self-management perspective

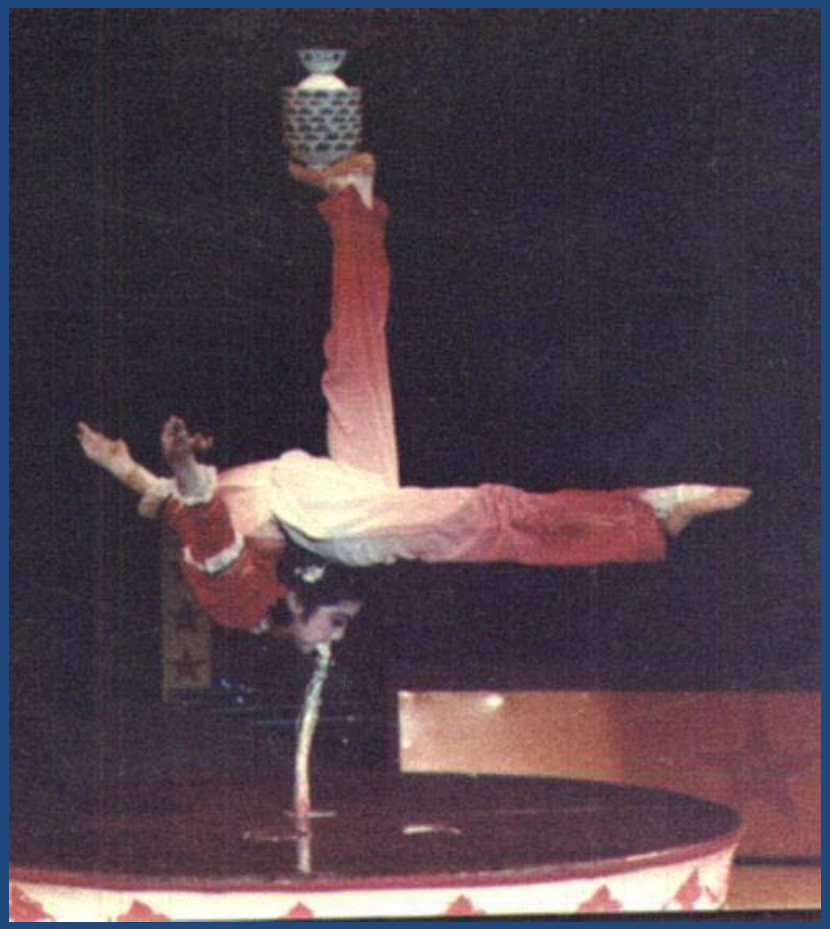


“Balanced” approach



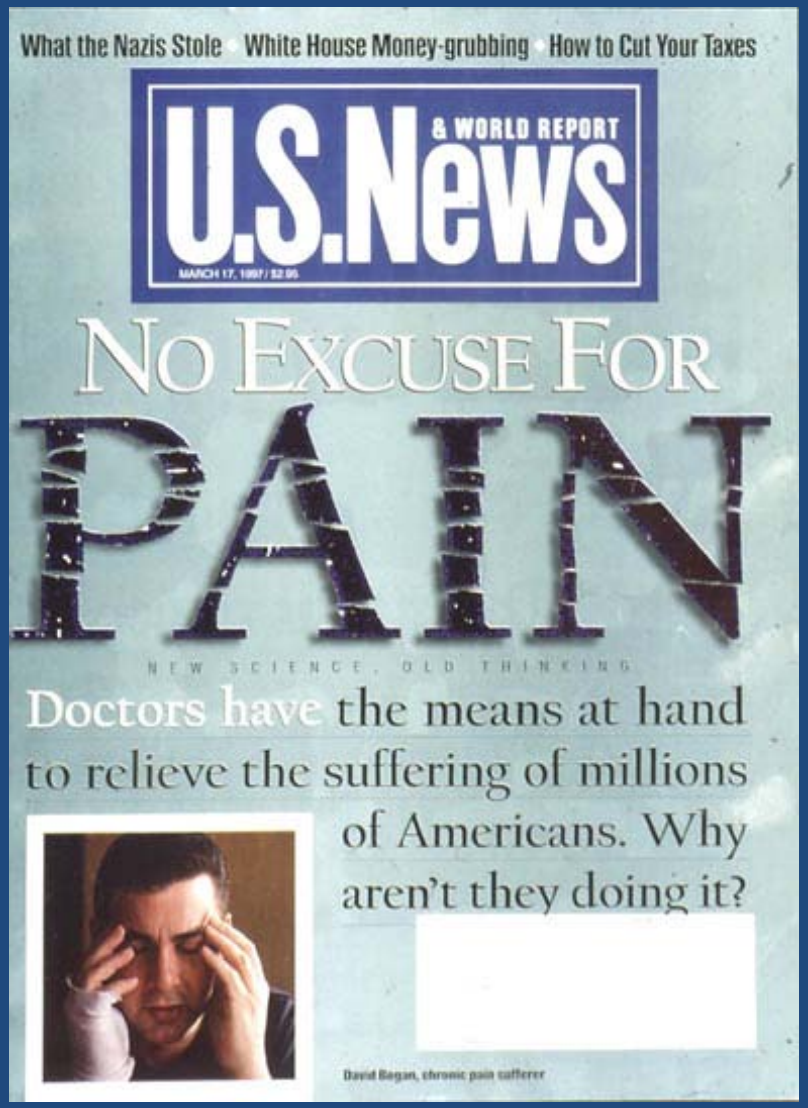
- All guidelines share a common goal
- Promote pain relief and prevent medication abuse
- Recognize opioids are a useful clinical tool and a significant societal problem

“Balanced” approach



- Not that easy to do
- Provide some practical suggestions

Communication Basics



- Ask what they believe
- What is the problem?
- What should be done?
- What do you want me to do?
- What are you willing to do?

Communication Basics

- What you say may not be what is heard
  - Avoid jargon
  - Ask pt. to repeat what you said
- Make sure your actions are consistent with your words
  - Escalation, referrals

Avoid “hot” phrases

There’s nothing wrong with you.	
You shouldn’t have this much pain.	
Accept your pain.	
You’ll have to live with the pain.	
Nothing can be done.	
“degenerative”	

Avoid “hot” phrases

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Nothing can be done.	“No medical solutions” does not mean no solutions.
“degenerative”	Getting older and these are normal changes.

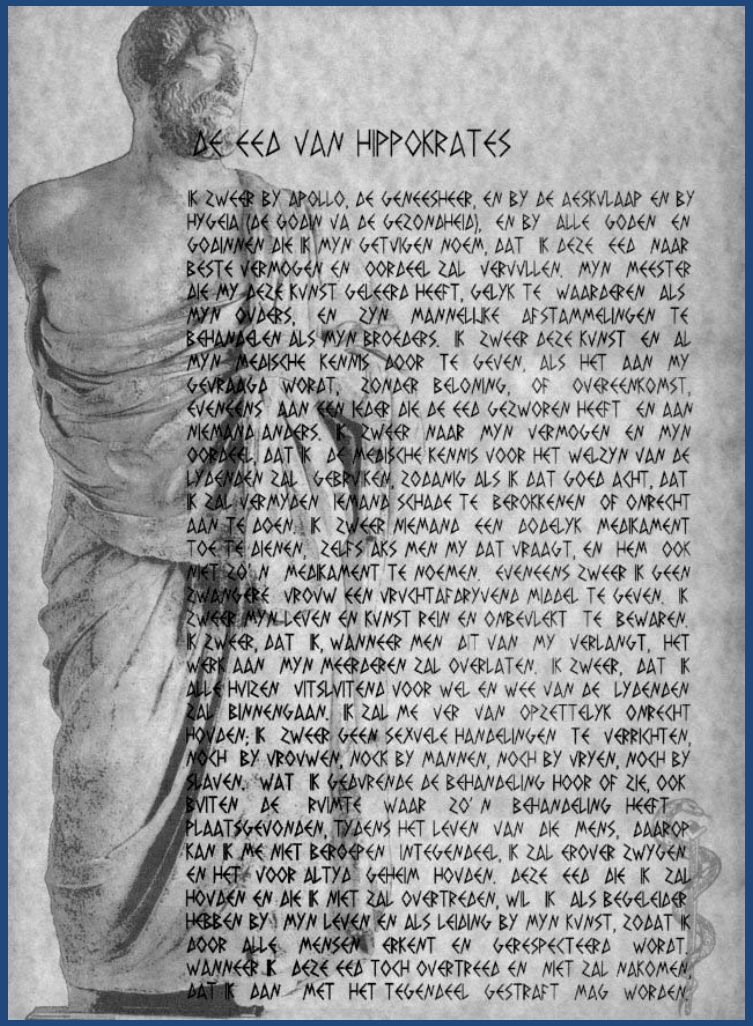
Written Policies

- Clear communication from initial visit
- Allows consistency and fairness over time and across pts.
- Requires an examination of your own model of pain, beliefs about methods, goals and responsibilities
- Guides own behavior in difficult situations

Written Policies

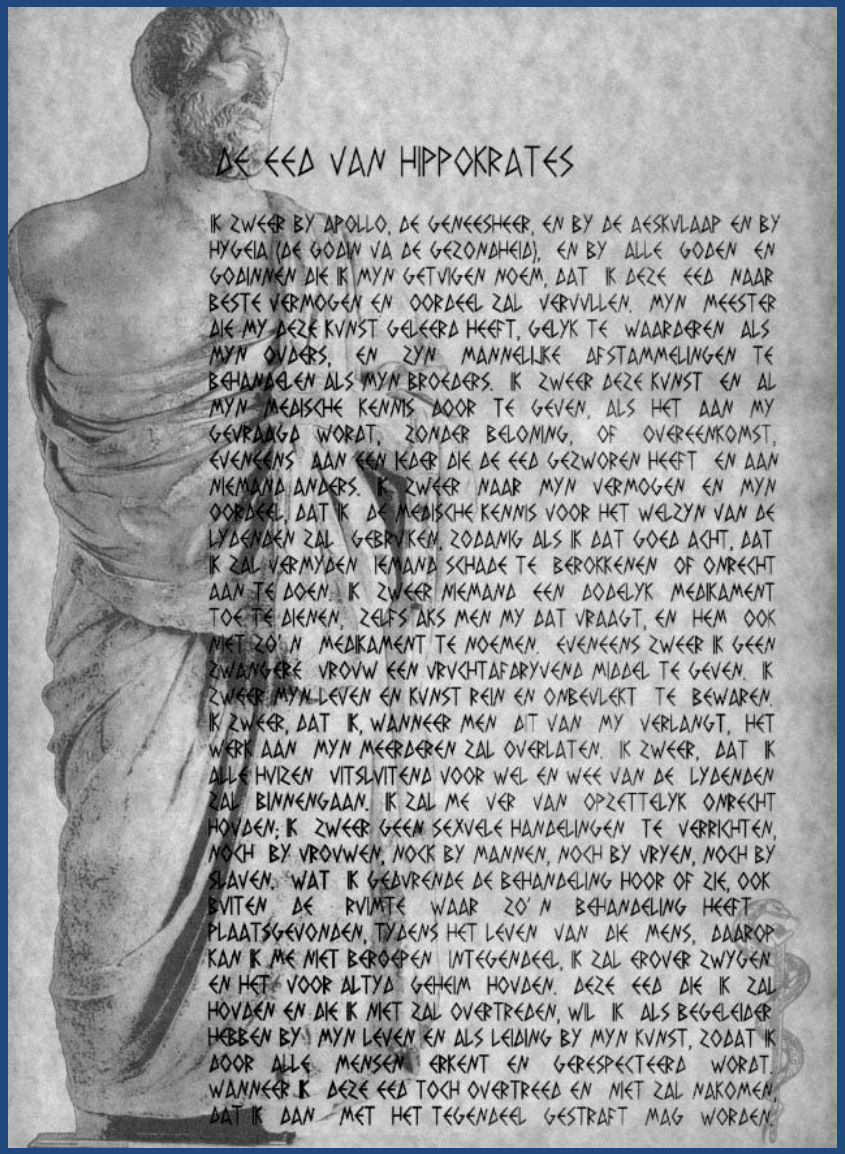
- UDAS
- Early refills/ lost medications
- Self-escalation
- Exacerbations
- Types of medications
- Dose limitations
- Breakthrough medications

Relieve pain but do no harm



- Safety is primary concern
- Initiate opioids in a “trial”
  - Functional benefits justify continued prescription
  - Some people are “non-responders”
- Aberrant behaviors require intervention: CAP program
  - Frequent UDAS, ATC, 1-2 wk refills
- Psychosocial instability requires mental health care

Relieve pain but do no harm



- Pts. do not have a right to opioids. They have a right to good care and appropriate treatment
- In some cases, withdrawing or withholding opioids is ethically mandated

Avoid "opioid sophistication"

"It has time-released pain-killers, so you'll never have another headache."

- Prescribing practices are powerful communications about methods, goals, responsibilities
- Implies that pain is the primary problem, opioids are the answer, and you have the power
- Endless search for the "right" dose or combination of drugs
  - Titrate to effect
  - Opioid rotation
  - Pseudoaddiction

Culture of "Cure"

- Educate early:
  - Shift from a curative model to rehab model
    - Focus on long-term goals
  - Realistic expectations re. short and long-term outcomes of opioids
    - "take the edge off": 30% reduction
  - Develop long-term plan
    - Exacerbation is not a reason to change the plan: "ebb/flow"
  - Acknowledge different medical opinions/strategies
    - Explain your rationale, policies, etc.

Never Argue

- Pushing hard for a decision to self-manage pain will almost always result in patients arguing against change

"I can't because of pain"

- "pain must be relieved first" : responsible for much of the iatrogenic cycle.

- Your patient likely *can* exercise, manage medications responsibly, etc. but *won't* engage in more adaptive behaviors.

"I can't because of pain."

- Explore the reasons why a patient decides to avoid change.
- The goal is to create discrepancy between contradictory statements of long-term goals and the continuation of maladaptive behaviors.
- Help your patients understand how their decisions have short-term benefits but long-term costs.

"Yes...but"

- Instead of direct confrontation, it's useful to "roll with resistance."

- You will encounter less resistance to change by acknowledging that self-management is difficult and by emphasizing autonomy and responsibility.

- You don't need to change the treatment plan because your patient is refusing. It's their right to remain the same. Inform them of the likely consequences of their choices.

- Your job is not to “fix” the pain. Your job is to help the patient make adaptive choices.

Facilitate a Truce

- Pain is the not the "enemy"
- Goal is not to "kill" the pain
- Goal is to assist pt. in returning to a full, satisfying, productive life….even if they hurt.

Helpful Interactions

- Maintain focus on treatment goals other than immediate pain relief
- Maintain focus on patient responsibility for own well-being and the consequences of their choices
- Opioids: Safety ALWAYS trumps urgent pain relief

- Opioids are so often a big part of the problem because they are never a big part of the real, long-term solution