Building a therapeutic alliance with patients with chronic pain

Workshop Faculty

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Learning objectives

• Learn the essential components of a shared decision-making approach to managing chronic pain
• Learn techniques for managing goals and expectations of treatment for chronic pain
• Practice shared decision-making and goal management
• Practice managing conflict in difficult conversations about opioids
Agenda

- Introduction (5 m)
- Presentation: Shared decision-making in the management of chronic pain (10 m)
- Clinical Vignette #1 (15 m)
- Presentation: What to say: Helping primary care providers with difficult conversations (10 m)
- Clinical Vignette #2 (15 m)
- Small group cases and discussion (30)
- Wrap-up (5 m)
Shared decision-making (SDM) in the management of chronic pain
Rationale for a structured approach

“Before you know it, the patient is on a high dose of an opioid, and you are unsure whether you have actually helped them [sic]. What you know is that you have committed yourself to endless negotiations about increasing doses, lost pill bottles, calls from emergency departments, worries that your patient is selling the drugs, and the possibility that one day, your patient will take too many pills, perhaps with alcohol, and overdose.”

Mitchell Katz, MD

Overview

- What is shared decision making?
- What is the evidence?
- Establishing a framework for shared decision making
- Making shared decisions
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Shared decision-making

...a process shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient.
If patients’ and providers’ preferences are incorporated…

- Both more engaged in decision-making process
- Both more invested in successful outcome
- Both more likely to be satisfied with process
- Both more likely to be satisfied with outcome

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SDM in chronic pain treatment: Physician outcomes

- Randomized study of SDM (one-hour training) vs handout
  - 55 internal medicine residents and attending physicians

- At 3-month follow-up, SDM group reported greater:
  - overall satisfaction ($p=0.002$)
  - relationship quality ($p=0.03$)
  - appropriate use of time ($p=0.02$)
  - completion rates of treatment agreements ($p=0.01$)
  - change in care practices ($p=0.01$)

Sullivan, MD et al. JGIM, 2006.
SDM in chronic pain treatment: Patient outcomes

- Randomized study of SDM (single training) vs. handout
  - 67 patients with fibromyalgia
- At 12-month follow-up:
  - Improved quality of physician-patient interaction in SDM group
  - Health-related outcomes not improved in either group

Overview

• What is shared decision making?
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• Making shared decisions
Establish a framework for shared decision-making

• Empathize with your patient, validate pain:
  – “I can see you’ve been through a lot.”

• Partner with your patient:
  – “Together I want to work on developing some strategies to help you manage your pain better.”

• Discuss realistic goals of care:
  – “With pain that’s gone on this long, it’s probably not going to go away entirely.”
  – “Change will take some time.”
Establish a framework for shared decision-making

• Assert the necessity of multi-modal care:
  – “We know that pain affects the mind and the body so we have to work on both.”
  – “We know that the less we use our muscles, over time pain gets worse. We have to work on getting you moving more.”
  – “We know that pain affects your whole life. We can’t make it much better just using pills.”
Establish a framework for shared decision-making

• Promote self-efficacy/optimism:
  – “This pain hasn’t beaten you yet so I know you can make some positive changes.”

• Obtain buy-in:
  – “We’ve talked about a lot and some of these things might be new to you. Give me your honest thoughts about all this. Are you ready to take this on?”
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Decisions that should be shared

• Goals of treatment (C. Nicolaidis)
  – **Specific**
  – **Measurable**
  – **Action-oriented**
  – **Realistic**
  – **Time-bound**

• Type of behavioral therapy

• Medication regimen
During the decision making process

• Be clear, honest, transparent, even-keeled, engaged, non-judgmental

• Offer options, explain pros and cons

• Actively elicit feedback

• Summarize what patient tells you.
  – “What I’m hearing you say is….,”
During the decision making process

- When encountering resistance, refer back to framework, explain rationale:
  - “Based on your goal for ...., my thinking is ...”

- Be open to compromise when possible

- Follow up to assess progress, barriers
Decisions that can’t be shared

- Policies and procedures for prescriptions, refills, and monitoring
- If and when to discontinue a medication when risks or harms outweigh benefits

Approach should still be patient-centered
  - Emphasize risks/benefits to patient
  - Supports your framework and goals of SDM
Take-home points

• Empathize/Validate
• Keep locus of control with the patient
• Set functional goals (SMART)
• Employ SDM
• Elicit buy-in and feedback
• Follow up
Clinical Vignette 1
Vignette 1

• New visit with 48-year-old woman with HTN, depression, neck/arm pain for 3 years following car accident.
• Pain is constant, worse with bending, interferes with sleep, worsening over past year. Has pins & needles pain radiating to both arms.
• PE and imaging consistent with cervical spondylosis with radiculopathy
• Treated with acetaminophen, NSAIDS, PT with minimal success.
• Two ED visits in past couple months, prescribed oxycodone/acetaminophen. This helped, but she ran out.
What to say:
Helping primary care providers with difficult conversations
Why are difficult conversations avoided?

External factors:

• Time pressure
  – Quicker NOT to have the conversation
• Fear of liability
  – Physician “abandonment”
• Financial Pressure
  – Need for patients as revenue source
Why are difficult conversations avoided?

Internal Factors

• Codependence
  – Inappropriate need to gratify the patient and avoid feelings of abandonment

• Confrontation Phobia
  – Provider uncomfortable with conflict.
  – “It’s easier to write than to fight.”

• Countertransference
  – Emotional response to a patient (anger, guilt, fear, pity) that may affect prescribing
  – Often a clue for a patient personality disorder or drug seeking

• Hypertrophied Enabling
  – Tendency to do “anything medically possible” to help
Successful conversations: Prevention

• Shared decision making
  – Agreed upon treatment goals
  – Agreed upon treatment end points

• Discuss practice policies in advance
  – Controlled substance agreements
  – Refill and after-hour coverage policies
  – Urine toxicology testing
  – Normalize processes, minimize stigma
Preserve the therapeutic alliance

• Pain is subjective
  – A patient’s report is the only tool we have to measure pain
  – The pain (of injury, illness, abuse, addiction, withdrawal, depression, etc.) *is real for the patient*
  – It is the duty of physicians to treat suffering
  – It is counterproductive and unjustified to accuse the patient of lying about pain

• Negative diagnostic tests…
  – Do not rule out pain
  – Allow providers to offer reassurance and support
Preserve the therapeutic alliance

• Opioids are only a tool
  – Trusting the report of pain…
    • Does not mean opioids must be prescribed if they are unsafe for that patient
  – No opioids does not mean no treatment
  – Opioids are only one element of a comprehensive pain management plan

• Frame discussions in terms of risks and benefits
  – Side effects, contraindications
  – Judging the treatment option, not the patient
De-escalate conflict

• Remain calm
• Have backup
  – Security on-site
  – Colleague support
• Focus on behaviors and data, not character
  – Avoid labels (e.g., “drug addict”)
• Insist on respectful communication
  – Leave the room if necessary
Overcome confrontation phobia

• A patient with addiction has a stronger relationship with the drug than with you
  – Don’t take it personally!
• Be transparent, consistent, and rational in your approach to prescribing
• Learn how to say “no” and mean it
• Learn how to “turn the tables” on a manipulative patient
“I’m feeling pushed by you to write a prescription that I’ve already told you is not medically indicated. This is concerning to me and we need to talk about your use of alcohol and drugs.”

Adapted From: Am Fam Physician 2000;61:2401-8
Clinical Vignette 2
Vignette 2

• 45 year-old former athlete with chronic low back pain
  – MRI confirmed severe degenerative arthritis
  – Pain not controlled with PT, NSAIDs, Lidoderm, diclofenac gel

• Hydrocodone started after
  – Substance abuse screening (negative)
  – Opioid counseling and review/signature on controlled substance agreement

• Pain persists and worsens, hydrocodone changed to oxycodone (Percocet).
  – Multiple early refill requests, escalating dose requirements
  – Prescription monitoring program shows multiple opioid prescribers
  – UTOX shows no oxycodone but positive for morphine, hydrocodone, and hydromorphone (not prescribed)

• You decide that opioids must be discontinued. You are about to discuss your findings and decision with the patient…
Small group cases and discussion
Thank you for your participation!

Please fill out your evaluation sheets.