



The patient with complex chronic pain and the busy primary care physician

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Disclosures

Disclosure

I have no financial interests or affiliation with any pharmaceutical industry or manufacturer to disclose

Disclaimer

Views expressed are my own

Key points

- Busy physicians
- Patients with chronic non-cancer pain
- The “drugs”

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- Busy physicians
- Patients with chronic non-cancer pain
- The “drugs”
- “Conflict”
- Challenging conversations
- Am I able (and willing)?
- Phrases?

Industry-funded “education” myths

- Opioids are extremely safe and effective for treatment of chronic pain
- Opioid addiction is extremely rare in patients with pain (CR safer than IR)
- Opioid therapy can be easily discontinued
- Because of “opioiphobia,” physicians are allowing patients with pain to suffer needlessly

Efficacy of long-term opioids?

- No study evaluated effects of long-term opioid therapy (>1 year) versus placebo or no opioid therapy for outcomes of pain, function or quality of life for **any** type of painful condition
- Evidence on long-term opioid therapy for chronic pain is very limited but suggests an increased risk of serious harms that appears to be dose-dependent

Opioid prescribing and illicit market filling a vacuum

Fentanyl...the new oxycodone?

"This has been a problem in the making for a decade. The main driver is that we have prescribed too many prescription opioids for too long."

Benedikt Fischer - senior scientist at CAMH

The Current



It is the patient who brings in the CNCP

- Patients we do like
 - Compliant
 - Clear issue
 - Takes care of self
 - Informed
 - Honest
 - Involved in own care
 - Motivated
- Patients we don't like
 - Demanding
 - Unreliable
 - Unmotivated
 - Non-compliant
 - Angry
 - Don't care
 - Lots of issues
 - “Drug seeking”
 - Threatening

Physicians

- Discomfort with uncertainty
- Focus on acute disease model
- Patient-centred care – wants vs. needs?
- Lack of clear policies, procedures and guidelines
- Don't like looking at people in pain
- Poor communication skills and conflict averse

“I need you to fix my pain, doctor”

“To write prescriptions is easy, but to come to an understanding with people is hard.”

—Franz Kafka. A Country Doctor

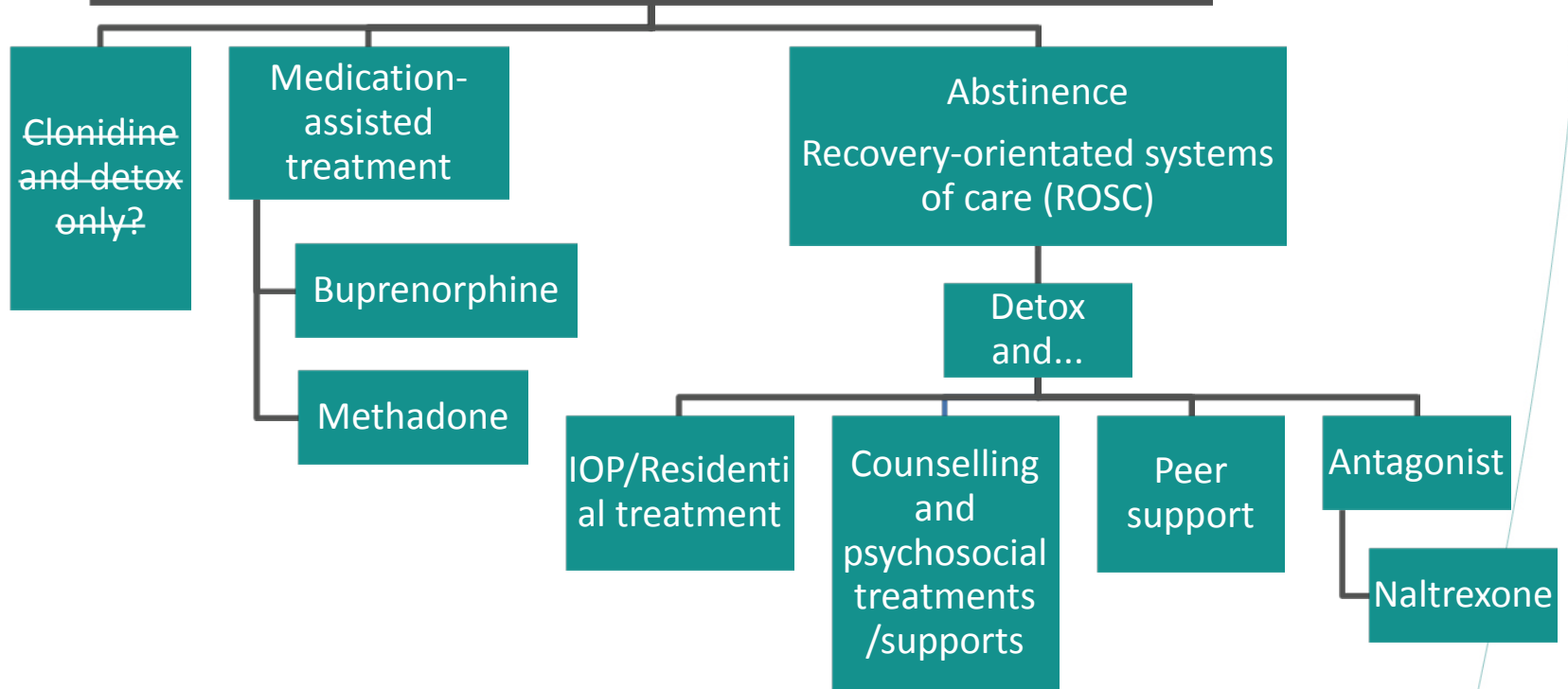


Controlling an opioid epidemic – oversimplified?: A four-pronged approach

A four-pronged approach

- **Prevent** new cases of opioid dependence
- **Tapering** for failed opioid therapy
- **Treatment** for people who are already opioid dependent
- **Supply control** – provincial College and law enforcement efforts to reduce over-prescribing and black-market availability of opioids

Treatment of Opiate Addiction?



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Failed opioid therapy for CNCP but no addiction?

- General taper

1

Prevention of new cases – safe and effective prescribing opioids if prescribing

- Thoughtful patient selection – avoid “adverse selection”
- Care with daily dosing – 50–90 mg MED
- Don’t stock medicine cabinets
- Avoid prescribing opioids in combination (e.g. BZD, Z-drugs, alcohol)
- Use pharmacovigilance – PharmaNet, UDT, pill counts, etc.
- Prescribe lifestyle interventions
- Establish realistic expectations—a “trial”
 - Only one in four patients with CNCP get relief from opioids
 - **2-3/10 decrease in pain is a successful result** – do not keep increasing without benefit
 - **Function must change for prescribing to continue**

Must-have challenging conversations

Involves “conflict”

Interpersonal conflict is an “expressed struggle between at least two interdependent parties who perceive incompatible goals, and interference from the other party in achieving their goals.”

Conflict occurs when perspectives and expectations are misaligned:

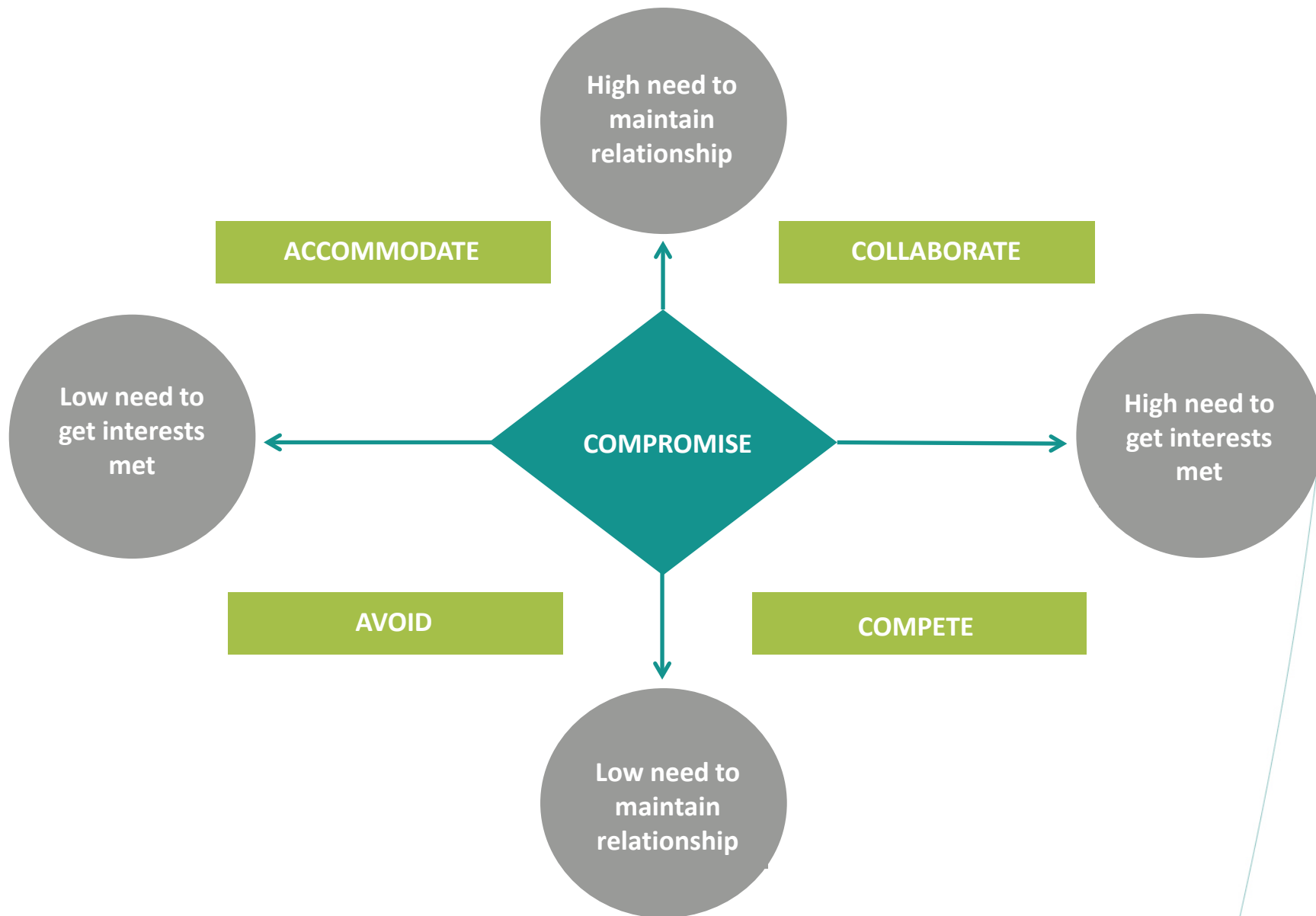
- “Doc, I need you to start me on painkillers”
- “Doc, don’t even think of stopping these painkillers”

What influences conflict?

- The apparent source...“the Issue at hand”
- The parties involved and their needs
- The relationship between the parties including history
- The positions of power
- The time available
- The parties “conflict styles”
- The “words”

How we do conflict?

- **Adversarial**, the extent to which I attempt to satisfy my own concerns
- **Cooperativeness**, the extent to which I attempt to satisfy your concerns



What conflict style do you usually use when dealing with conflict over prescribing?

- Avoiding (“withdrawing”)
- Accommodating (“smoothing”)
- Competing (“forcing”)
- Compromise (“sharing”)
- Collaborating (“problem solving”)

CONTENT

(What we are speaking about)

CONFLICT

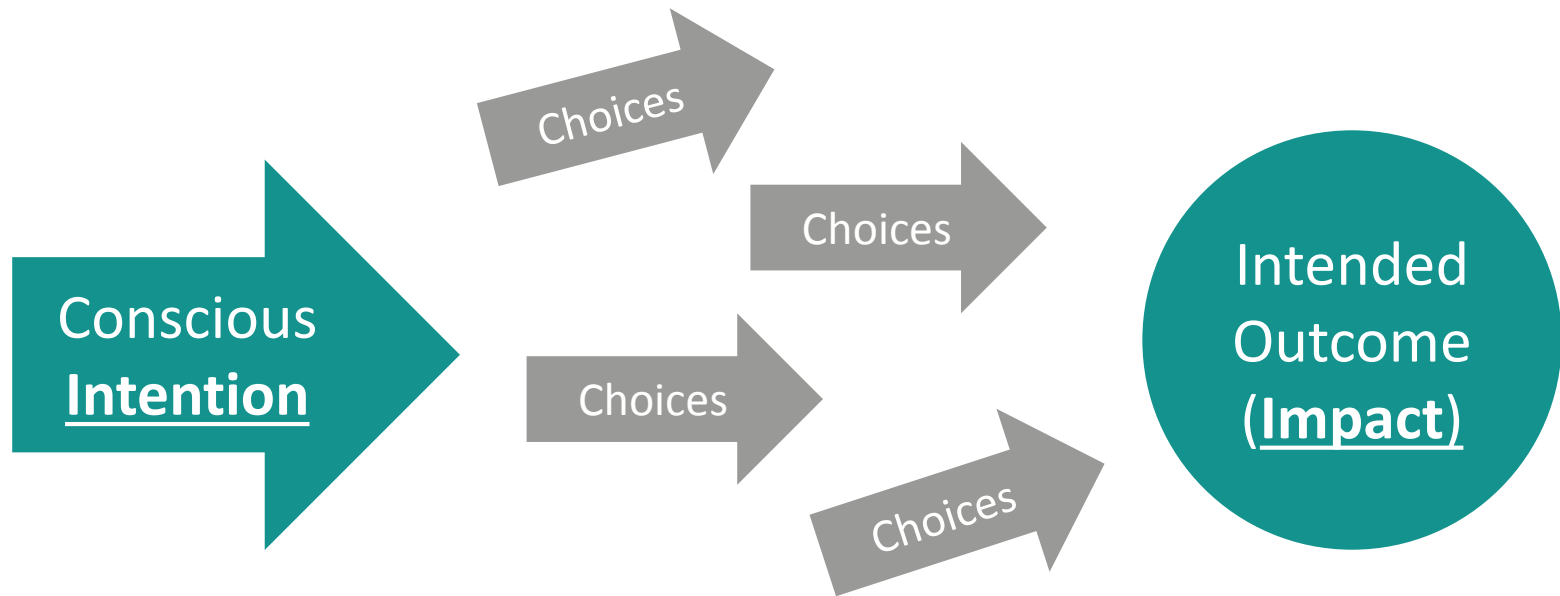
PROCESS

(The way you are speaking to me)

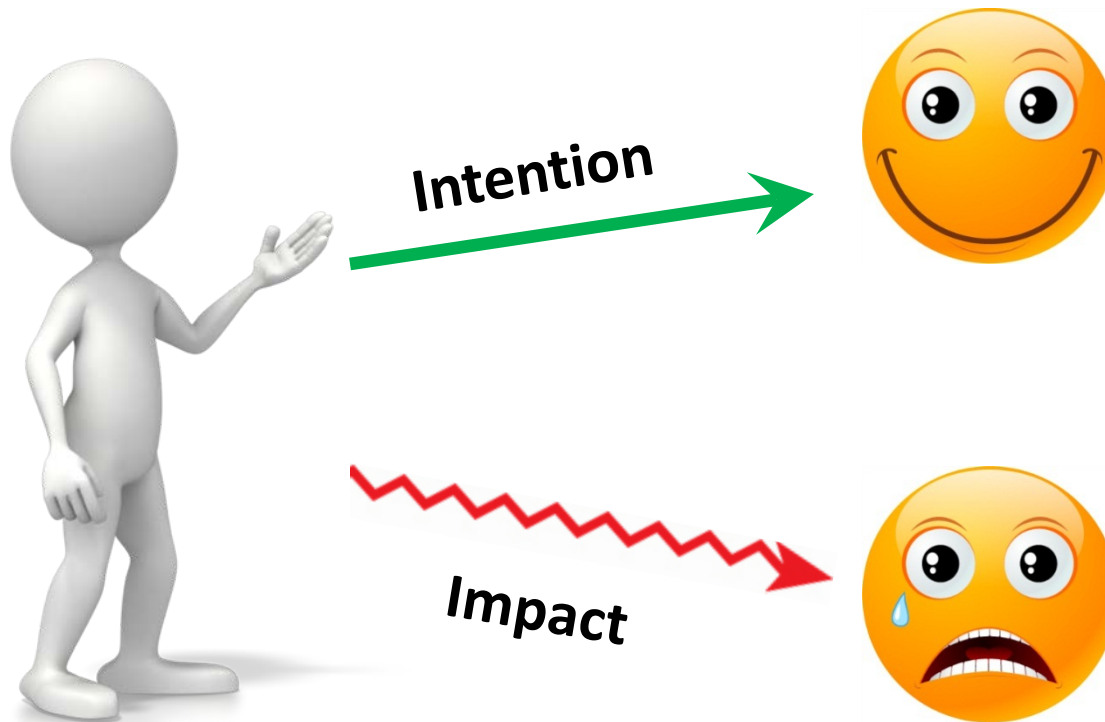
EMOTION

(How I am Feeling about it)

What am I trying to achieve?



Intention and Impact



The “insight” gap

We judge ourselves by our intentions



We judge others by their impact

Challenging conversations planning

- Schedule appropriately
- Not at end of the day when “hangry” and tired
- No interruptions
- Know the facts
- Relevant educational materials
- Emotionally ready

Challenging conversations planning

- What is the purpose of the conversation? (Intention)
- What do I hope to accomplish? (Impact)
- What assumptions am I making about the individuals intentions?
- What I am feeling that is not necessarily their intent.

The conversation

- Talk less, interrupt less
- Listen more...
- Discovery and curiosity
 - How did patient arrive at their perspective?
 - “What would you like to be able to do?”
- Summarize, acknowledge, paraphrase
- Reconcile conflicting views of the seriousness of the diagnosis or seriousness of the treatment

Bridge the gap: clarifying perspective

- **Reflect**
 - On how the patient arrived at their perspective
 - On our own biases/experiences
- **Assess**
 - What can actually be done and what cannot
- **Plan**
 - Negotiate **safe** shared goals – “Your safety is the priority here”

“Assertive” communication

- This is what I am **observing/seeing...**
- This is what I am **thinking...**
- This is what I am **feeling...**
- So **what would work for me is....**

Seeing/thinking/feeling/what would work

- What I am **seeing** is that we have been using these medications for some time, the dosage has increased without you feeling that your pain has really improved and without your function getting better.....
- So what I am **thinking** is that we started this medication as a trial and I can't see that you are a lot further ahead – in fact there has been really no improvement in your pain or functional activities. We have more updated research information now about these medications and their long-term risks and safety profiles associated with the doses you are on.....

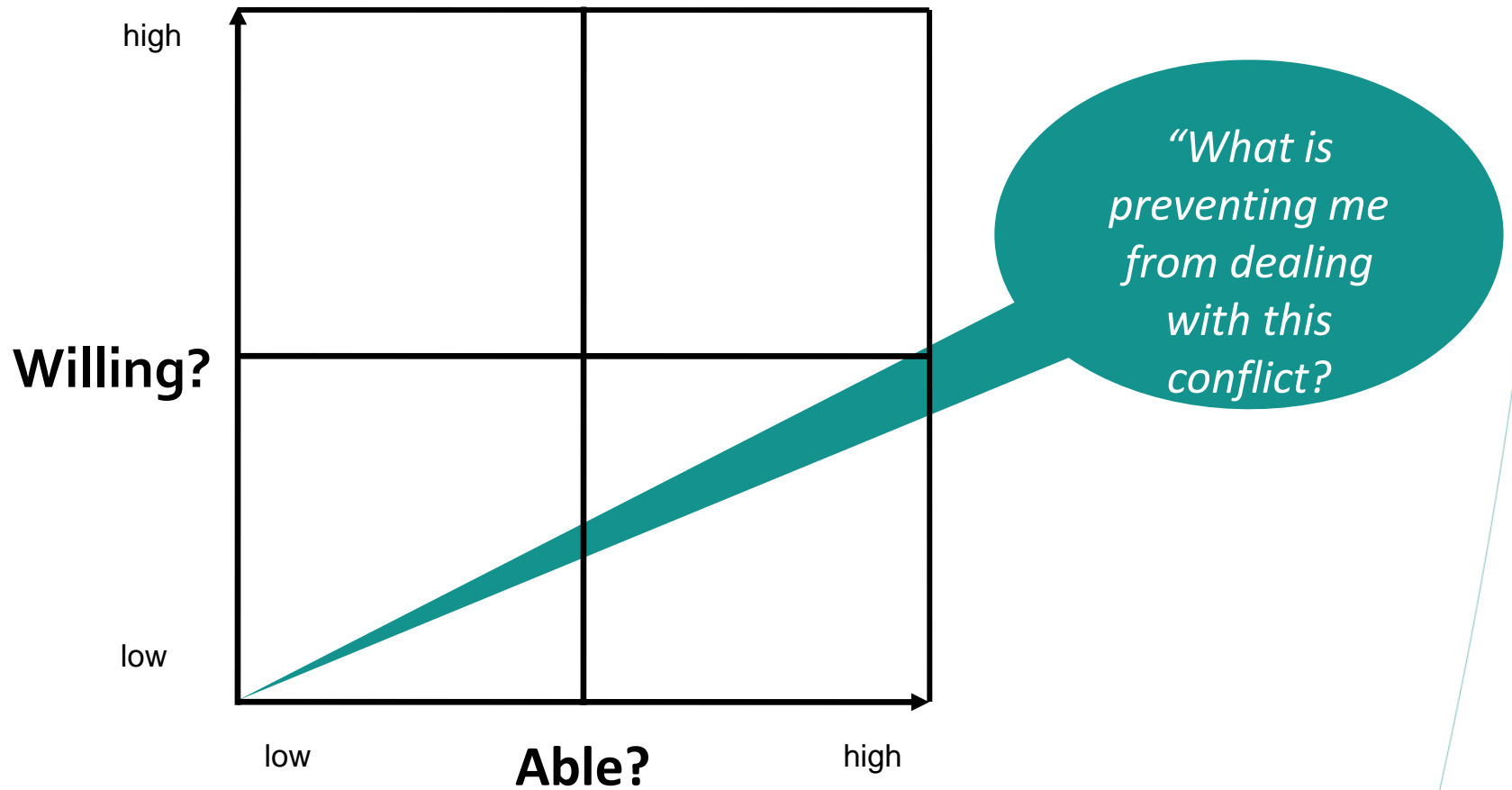
Seeing/thinking/feeling/what would work

- So this is making me **feel** worried and concerned for your safety and your wellbeing. To continue on the path we are on is not safe for you and obviously I cannot risk prescribing something that might not be safe for you. Your well-being is too important for me to do that...
- So **what would work for me** is if we coordinate a very gradual tapering of these medications to more accepted safe dosing and we will approach your pain with additional different strategies.
- **Would you be willing to look at a safer approach to treating your pain?**

Collaborative conflict management – we can

- **Elicit** the patient's perspective
- **Validate** their symptoms
- **Affirm** our commitment to helping
- **Assure** the patient of our concern
- **Offer** other **safer** possibilities
- Give the patient **hope**
- Demonstrate **therapeutic confidence**
- **Engage** the patient in their treatment plan

Challenging conversation I need to have?



Key points

- Busy physicians
- Patients with chronic non-cancer pain
- The “drugs”
- Conflict is normal – collaborative approach
- Challenging conversations – emphasis on safety
- Planning is critical – *seeing / thinking /feeling / what would work for me is...*
- Am I able **and** am I willing?

Thank you

- Questions?
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