Communicating with Patients about Chronic Opioid Use

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DR. JANE LIEBSCHUTZ: I’m happy to be here. One of the things that my talk is not going to do is give you a whole lot of new information. It’s going to draw on skills and things that you already know. I work with Dan at Boston University. I’m going to talk about communicating with patients about chronic opioid use.
I first have a little cartoon here. It says, “We located your chart. It was filed under P for ‘Pain in the butt’.” The goal of my part of the talk here is both to help you manage your patient’s chronic pain, but also to make it less painful for you.
I just want to say some of these slides were developed by colleagues Christina Nicolaidis and Leanne Yanni previously.
If there’s one thing and one thing only that you take away from my 30 minutes here, it’s really shifting your framework from being a policeman, a judge of your patient, to a clinician and doing the things that you know how to do. I was talking to someone in the ladies room earlier and I made this analogy; if you had an overweight, sedentary, smoking diabetic whose A1c was 9 and was on two oral agents, would you consider them a failure or would you be angry at them if you had to go put them on insulin; probably not.

It’s a really different thing, but if you have a patient with chronic pain who’s using up their medications and is having trouble controlling a variety of things, we get very angry and we feel like we have to judge the patient. We have to kick them out. We have to terminate their contract. I want to shift us into the mode that we would do with that sedentary diabetic.
The way you do that is really shifting your frame. It’s not really judging the patient or you’re nice to the patient, I want to give them a chance. It’s really you want to think about the treatment and not the patient as the thing you’re looking at. Often we think, is the patient good or bad. Does the patient deserve pain medicines? Should the patient be punished or rewarded? Should I trust the patient? We really want to shift it, instead of the patient, to think do the treatment benefits outweigh the untoward effects and risks for this patient? You can also have a societal view on that.
That’s what’s maybe a little bit different than the diabetes is that there’s also this diversion, this society piece. People don’t usually get insulin and share it around or sell it, although some of my patients will get drugs and send them to their families in the Dominican Republic, but that being said, there maybe somebody in the DR who needs that insulin.

The general principle, maintain the risk-benefit model. You’re not a police officer. You’re not a judge. This is not an offender. Reassure the patient that you understand the severity of their pain. You want to reflect on patient’s strengths and promote self-efficacy and you want to partner with your patient, so it’s not an adversarial but more of a partnering relationship that you want to develop.
We heard earlier from Jeff and Dan about how you assess factors that affect pain in terms of risk, but you also want to think of the patient. They perhaps have fears around what’s going on and how you may judge them. First and foremost, if you treat patients with pain, they often have a fear that you think their pain is in their head. John, I believe, is going to talk about some mental health and how you work that in together after me. What you want to do is you want to make the patient know that you believe them about their pain. You want to listen to them. You want to show empathy for them. Validate that you think their pain is real.

In the framework of discussing factors that may worsen pain, that’s when you can talk about these other things like mental health or substance abuse; otherwise, if you bring those up first without validating the pain, they’re thinking you’re just thinking they’re an addict. You’re just thinking the pain is in their head.
I actually have a real case of a patient I saw a few weeks ago. He’s a 28-year-old unemployed cleaner. His past medical history is chronic pancreatitis and Type 1 diabetes that has resulted from the pancreatitis. He has chronic abdominal pain. He has intermittent flares of his pain that precipitates emergency department visits. It’s real. He’s had imaging. He had a stent placed in his pancreatic ducts for documented stenosis.
His social history is complicated. He’s Guatemalan. He’s Spanish speaking. He’s here in the U.S. and does not have legal visa to be here beyond his original stay many years ago. He’s unemployed which he attributes to his pain so he has no income. He lives with a cousin who supports him. He has a history of alcoholism which has been in remission. He’s had none since 2008. He sleeps all day. He’s depressed about life and since he became absent in alcohol, he’s become very religious. He reads the Bible all day long. He shows up in the office reading his Bible. He goes to church. He spends his time watching Christian TV programs all night on the television.
In 2007, he had multiple admissions, receiving opioids from different providers, high dose Percocet. He was given MSContin and when I sort of took him over around that time, I tried to change him from just the short-acting to MSContin. I gave him some breakthrough oxycodone and acetaminophen. He was chronically running out of meds. He was having multiple ED visits using high doses of oxycodone. In the summer of 2009 he fell out of control with his medication. I worked with him. I felt that he had a dependence issue. We said let’s think about shifting to suboxone treatment to try to get a handle on this. He really refused because he was quite afraid of the significant pain that he would experience.

So that’s the background. I’ll come back to this case later in the talk.
The points you want to highlight when you talk with your patients about opioids are things we’ve already heard earlier today, which is, opioids are not a perfect treatment for pain. I’m hoping that that’s one of the main points you took away from the earlier talks today. The other thing is the benefit versus risk is a really useful framework.

You can consider using the chemotherapy analogy which is, people know that chemotherapy can make your hair fall out and can make you very, very sick, but because the problem is so severe and cancer and life threatening, you’re willing to take those risks. When you talk to patients about pain, you can say the same thing. This therapy may be causing a lot of risks but the question is, is this problem going to kill you or is the therapy going to cause you a lot of harm? So you want to think about the harm for the therapy versus the harm for not treating with that particular therapy.
You want to talk about the benefits. That’s one of the places I think many of us fall down in treating patients with opioids. We forget to be very realistic with the patients and with ourselves what we can expect and how to monitor. What are the goals of the patient? Many of you, I’m sure if you’re like me, you see a patient. They’ve had pain for 8 years and they come in and say I just want the pain to go away. That’s not very realistic, or I just want to be able to do something I haven’t been able to do in 15 years. That’s probably not realistic. You want to remind the patient that the pain is unlikely to go away completely, particularly pain that has lasted for a long time. The real and most important thing is to manage the problems that the pain causes.

It doesn’t mean, as Dan said earlier, that we don’t want to improve the pain. Of course, we do, but that’s not the only goal. The goal has to be let’s manage maybe the sleep problems that come along with the pain, or let’s manage difficulty working. You were a construction worker. You’ve had pain for 7 years. You may want to talk to a social worker or think about a different line of business that you’ll be able to do.
One thing that we borrowed from our colleagues in other fields is the idea of a smart goal for your patient; and again, sort of this vague goal, I want to be more active or I want to have my pain go away, let’s think about something specific. I want to be able to sleep more than 3 hours at a time. Measurable; you can measure the number of hours that you sleep. Action oriented; it’s a specific action that can be taken. Something that’s realistic; in other words, not saying I’m going to sleep 10 hours but say maybe for three hours at a time. Let’s have a goal that you can sleep 6 hours so you can get in your REM sleep and something that’s time sensitive; something that’s not many years off in the future but something that you can do between now and the next visit.

This has been mentioned earlier that Jeff had brought up. This point that giving them opioid prescription is not the end; it’s a test. You want to then look at the smart goals at the next visit. Does this work? Again, you can think of this like your diabetic. We’re having hypoglycemia at one point and hyperglycemia at another point of the day. Let’s change from LANTUS and lispro to 75/25 and let’s see how it does and we may need to change the dosage. That’s how you think of this in this case.
Slide 14: Communicating with Patients about Chronic Opioid Use

**Discussing Benefits**
- Link continuation of opioids to demonstration of benefit
- Improves patient’s realistic expectations
- Decreases need to prove that pain is terrible
  - “I still have pain, so I still need Vicodin” versus
  - “My meds allow me to do X, so it is worth it to me to keep taking them”

Some of you came up to me and I know a lot of you have patients who are long-term opioids, so a lot of the stuff Jeff talked about earlier and that we’re talking made me think oh, this is at the beginning of prescribing we need to talk about, but no, even if you’ve had a patient on it for a long time and you feel that it’s somewhat out of control or you’re not comfortable with or you want to get a handle on, you can go in and change the way that the dialogue happens, even now. You want to rethink. I’m sure all of you are going to go and see in the next few months when you see your patients on opioid treatments are going to go back and be thinking of the risk benefit framework now that you’ve had this in your mind.

You really want to continue to link ongoing prescription to demonstration of benefit. This both improves the patient’s realistic expectations and also changes something. They don’t need to prove to you that they still have pain to get their medication. A lot of patients may exaggerate their pain because they think that otherwise you’re not really going to listen or you won’t continue to prescribe. It really changes this; I still have 15 out of 10 pains so I still need my Vicodin. No, my pain meds are allowing me to go to the grocery store or going to play with my grandchildren, or keep me at work, so it’s worth it for me to keep taking them. It’s very, very nice when you kind of change that dialogue with your patient.
In terms of discussing risk, you want to set your level of monitoring to match your level of risk. Again, this was talked about quite a bit earlier. A little bit of repetition of what was heard earlier, but when you do it, you want to think about what are the risks; sedation, constipation, physical dependence and addiction. You want to really clarify with the patients the difference between those last two because they may not understand that. You also, obviously, want to talk about dangers of driving and hazardous work.

This is a really important piece. You want to assign responsibility for monitoring signs of harm. You’re going to ask patients about these issues; sedation, constipation, dependence and addiction, when you see them. It’s their job to monitor whether these are going on. You want them to pay attention to those facets.

You want to explain monitoring tools that are used to protect the patient. A lot of patients are worried. They hear about the liver effects of taking statins and so you say, well, listen, we’ll monitor. We’ll check your liver function tests and make sure that you’re not having harm from doing it. This would be the same way. You could say this is something I do in all my patients to make sure things are going well.
Many of you have patients with past substance use history. What you want to do is you want to show admiration for overcoming their addiction, acknowledge that they don’t want to go back there, and then really openly discuss high risk with them. For example, you can use an analogy that your patient might understand. Aspirin causes bleeding in the stomach but it also can prevent strokes and heart attacks. So somebody who I want to give aspirin to, to prevent strokes and heart attacks, I need to keep a close eye or may need to give some other treatment to make sure that doesn’t happen.

You had a substance use history. We know patients like you are more likely to have problems. We need to work together so it doesn’t happen. You want to partner with your patient. They don’t want to become addicted again and they are relieved if they are feeling that they can talk to you about it. You want to leave that so it’s not adversarial but you’re on the same page with them.
Ongoing Use of Opioids

- Assess and document benefits and harms
- To continue opioids:
  - There must be actual functional benefit
  - Benefit must outweigh observed or potential harms
  - You do not have to prove addiction or diversion, only assess risk-benefit ratio

You want to continue to assess benefits and harms from medication of opioids and to continue them you really have to observe a functional benefit. If the patient continues to say, I’m 15 out of 10 pain, or 10 of 10. I’m sitting at home. I’m watching TV all day; that’s a problem. They haven’t identified goals and they haven’t achieved the goals. It may not be helping them. You don’t have to prove that somebody’s addicted or diverting to decide that the benefits are now outweighing the risks and that may also help you away from that adversarial role.
Let’s say you think there is no benefit. You need to reassess what is going on with the pain. Maybe you need to get a consult from a specialist. Is the pain really consistent with regional sympathetic pain syndrome or maybe there’s something else going on, or you want to look at what is the underlying disease. You can consider escalating the dose as a test, but if that test shows no effect, then that means there’s no benefit. If the benefits can outweigh the risks, you have the right to stop the medication. You can use the diabetes. You start another oral agent. The patient really doesn’t want to do insulin. You start a third oral agent. The A1c went from 10 to 9.6; that’s not adequate. You’ve failed the test of that agent and this you could look at the same way.
We all got that part, but what happens when you actually have to talk to the patient with it? It feels that your heart sinks when you see the patient on your schedule. First and foremost, remember that you want to demonstrate compassion for your patient. Your patient is suffering on some level and whether the opioid is the problem, they’re suffering and they see this opioid prescription as potentially helping their suffering, so remember to have compassion towards it.

You’re on the same page with the patient. You’re frustrated. They’re frustrated. There’s no good solution. What are the patient’s strengths? What have they been able to do despite this problem? You want to encourage the various therapies that they may have or that you can refer them to, to cope with the pain, not get rid of the pain. Not that you’re going to abandon the patient, but schedule close follow-ups. This is a patient who needs more support, not less support.
Let’s say you see some aberrant medication behaviors among your patients. There is a differential diagnosis besides addiction. One is miscommunication of expectations; for example, you have a patient who’s given Ambien for sleep and they have Mass Health, they’re only given 10 per month. I have patients who go, well, I ran out after 10 days. I didn’t explain to them Mass Health only pays for 10, you really want to stretch it out to use it through the month, so that’s a miscommunication of expectations.

There is something called pseudo-addiction which I think was touched on this morning, but really is where the patient is having addictive type behaviors trying to get more because their pain is not well controlled. In that case, if you give them more pain meds as a test then that will help them. Addiction, of course, we know about. Diversion; does everybody know what diversion is? It’s illegally or taking the medication and selling it or trading it.

You want the match the action to the most likely cause. This is not a punishment to level of infraction.
This is Part 2 of my case, my actual case. I started to come down on him and say I really think you should do suboxone. I’m very concerned that this has gotten out of control, and he switched to a colleague of mine. She worked with him and refused to prescribe the short-acting medications and only on the MSContin. She also got pregnant so he was anticipating leaving. Also during this time, he has his stent removed.

About a month ago, he came back to me. His labs were all normal except for his A1c which was elevated. His exam was normal. He reports to me that he’s taking MSContin, 180 mg every 18 hours, and he mapped out exactly when. He knew exactly what it was, and he said he was so afraid of running out that he’s so careful not to misuse. I did a pill count. He brought it in and he had exactly the right amount for what he was supposed to do.

He said my pain flares. I want oxycodone for breakthrough pain. He has a legitimate disease; what do you do?
The way I approached it was really this risk-benefit framework. What you want to do is you want to match your action with the patient to what the diagnosis is that you think is going on. Your tolerance of risk, and this is patient high risk, probably everybody in this room should say yes, this is a Red Flag patient, very high risk, but also with very high need for pain meds. If there’s miscommunication, you re-clarify your rules once with your patient. He knew the rules. He got them clarified. If it’s pseudo-addiction, you increase the dose as a test. This is a patient I’m not sure is a pseudo-addiction.

If you think its addiction, then you need to stop the opioids and refer to addiction treatment. You can decide whether you want to bridge or not and I’ll talk about that in a moment. If you’re concerned that a patient is diverting the medication, there’s no obligation to taper. You just stop immediately.
Let’s say you’re concerned that there is actual addiction going on. Actually this was another bathroom question when I was waiting in that long ladies line. What if somebody breaches the contract? Do you give them a second chance?

I don’t know that we’re giving them chances but it’s really a chance for dialogue. You want to explain why the breach of contract raises your concern. It’s clear that the benefits may no longer outweigh the risks. You can also say I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good. Always offer referral to substance abuse treatment and maintain that risk-benefit treatment not judging the patient.
Slide 24: Communicating with Patients about Chronic Opioid Use

Discussing Addiction Tx

- Clarify that patient should get evaluation by expert in addiction treatment
- Reinforce commitment to treat pain, but addiction limits your ability to treat with opioids
- Leave door open for return
- If patient is not committed to addiction treatment,
  - Do not taper meds or bridge opioids

You may want to decide that the patient should get an evaluation by an expert in addiction treatment to kind of help you; again, Jeff and Dan both said pain clinic referrals are sometimes dicey because many of them are procedure oriented, many of them don’t do opioids, and they don’t have the relationship with the patient, but there’s no reason why you can’t work with an addiction provider to give you help. Insist on that with the patient. Say I’m not 100% sure. I need some help from an addiction psychiatrist, or I need help from an addiction colleague who may be more expert than I am in really talking about it.

Reinforce your commitment to treat the pain, but the addiction limits your ability to treat it with this particular modality. Leave the door open for the patient to come back to you. You try to maintain them in treatment. If you’re very concerned about addiction and the patient denies it and they’re not committed, you are not obligated to taper them or bridge their opioids, but you need to document this all very, very clearly. You need to be pretty sure about that.
Avoiding pitfalls and this I think many of you will recognize. Use this framework. The patient is tugging at you, but I really need the opioids, don’t you trust me? I thought you cared about me. If you don’t give this to me, I’ll drink. I’ll use drugs or hurt myself. Patients blackmail you, threaten you. You’re just doing this to save your butt, making you feel guilty. Can’t you just give me enough to find a new doc? Realize if somebody is addicted, they’re going to use whatever they can in their power to try to get that medication from you. It’s probably their addiction talking. Maybe they’re sociopaths, maybe they’re not, but the fact is that they’re going to know how to put the knife in and turn it so it makes you feel bad. Try to continue to keep your risk-benefit framework, your physician framework.
Discuss why breach of contract leads to concern for diversion or addiction.

Leave door open for possibility that you are wrong.

Offer addiction and detox resources.

Discuss your responsibility to society and inability to prescribe when there is any chance of diversion.

Diversion; you think your patient is diverting. This is much harder and much more painful, at least from my point of view, and I’ve had a few experiences with this. In this case you want to discuss why the breach of contract leads you to concern for diversion or possibly addiction. Leave the door open that you’re wrong. Offer addiction and detox resources but also you can discuss your responsibility to society and your inability to prescribe when there’s any chance of diversion. Again, I think having the monitoring program will be incredibly helpful for us because when we get some data that may substantiate the doctor shopping, then I think we’ll feel even stronger that we’re able to do this. It’s very hard to do this unless you have harder evidence than we often have in our offices.
In summary, remember to link the opioid prescribing to the benefits and the functional benefits. All prescriptions should be trials that you need to keep ongoing assessment that there’s benefit from the medication. Give the responsibility to your patient to detect the signs and ask them about it every time. There are some nice tools that were brought up this morning that you can use to assess some of their functional issues. Use that risk-benefit model so that you can stay in a caring mode for the patient and it’s really the treatment that maybe the problem.

[Applause]