Treating the Difficult Pain Patient Population

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Why are Pain Patients Difficult?

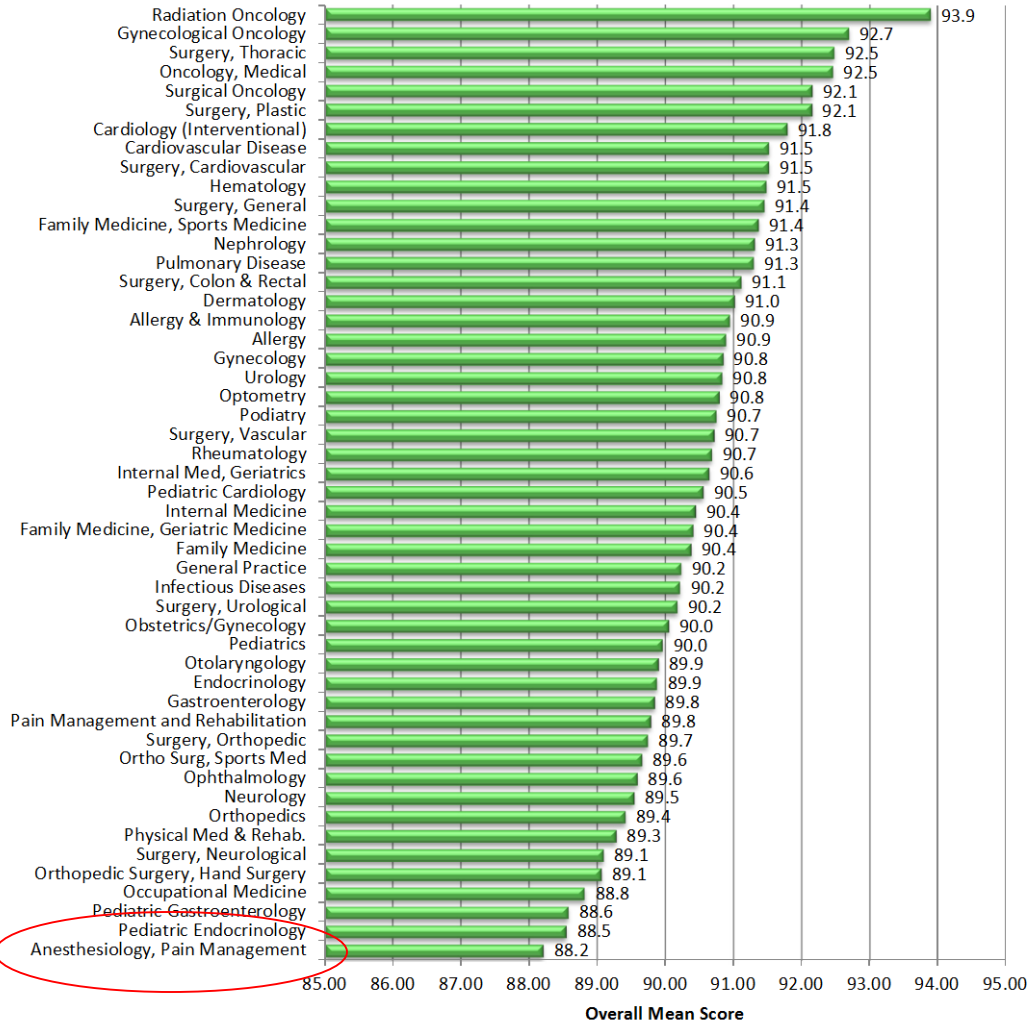
- 10%-60% of patients treated in the allopathic healthcare system exhibit “difficult behaviors”.
- Incidence of difficult patients higher than in other medical specialties
- Depression and anxiety 2-3X more prevalent than general population
- Comordid emotional disturbances
- More likely to have idiosyncratic increase in pain with interventional therapies
- Physicians have inadequate training in psychiatric assessment and treatment

PRESS GANEY

Medical Practice Satisfaction by Specialty

Based on 4,274,639 surveys received from 17,685 sites nationwide between 1/1/2012 - 12/31/2012.

Only includes specialties used by 50+ facilities with 5,000+ patients. Only the "included sample" is included in this



Effects of Chronic Pain on the Patient

Physical Functioning

- Ability to perform activities of daily living
- Sleep disturbances

Psychological Morbidity

- Depression
- Anxiety
- Anger
- Loss of self-esteem

Social Consequences

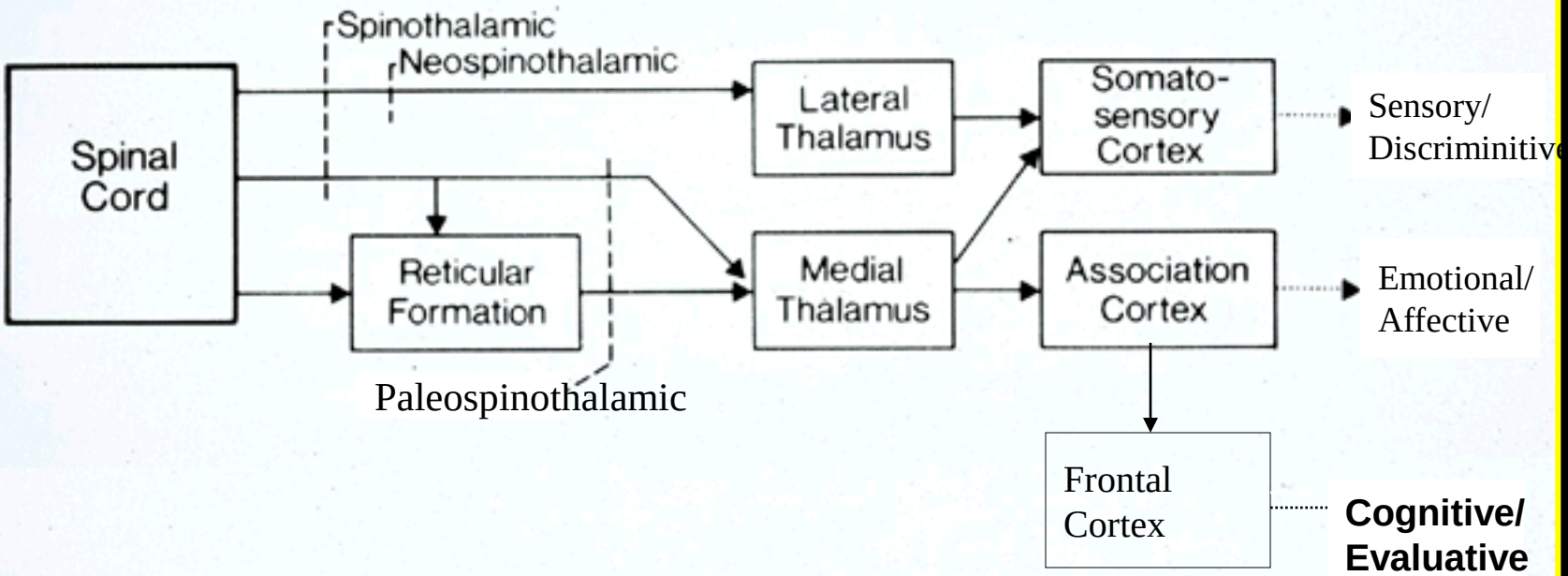
- Relationships with family and friends
- Intimacy/sexual activity
- Social isolation

Societal Consequences

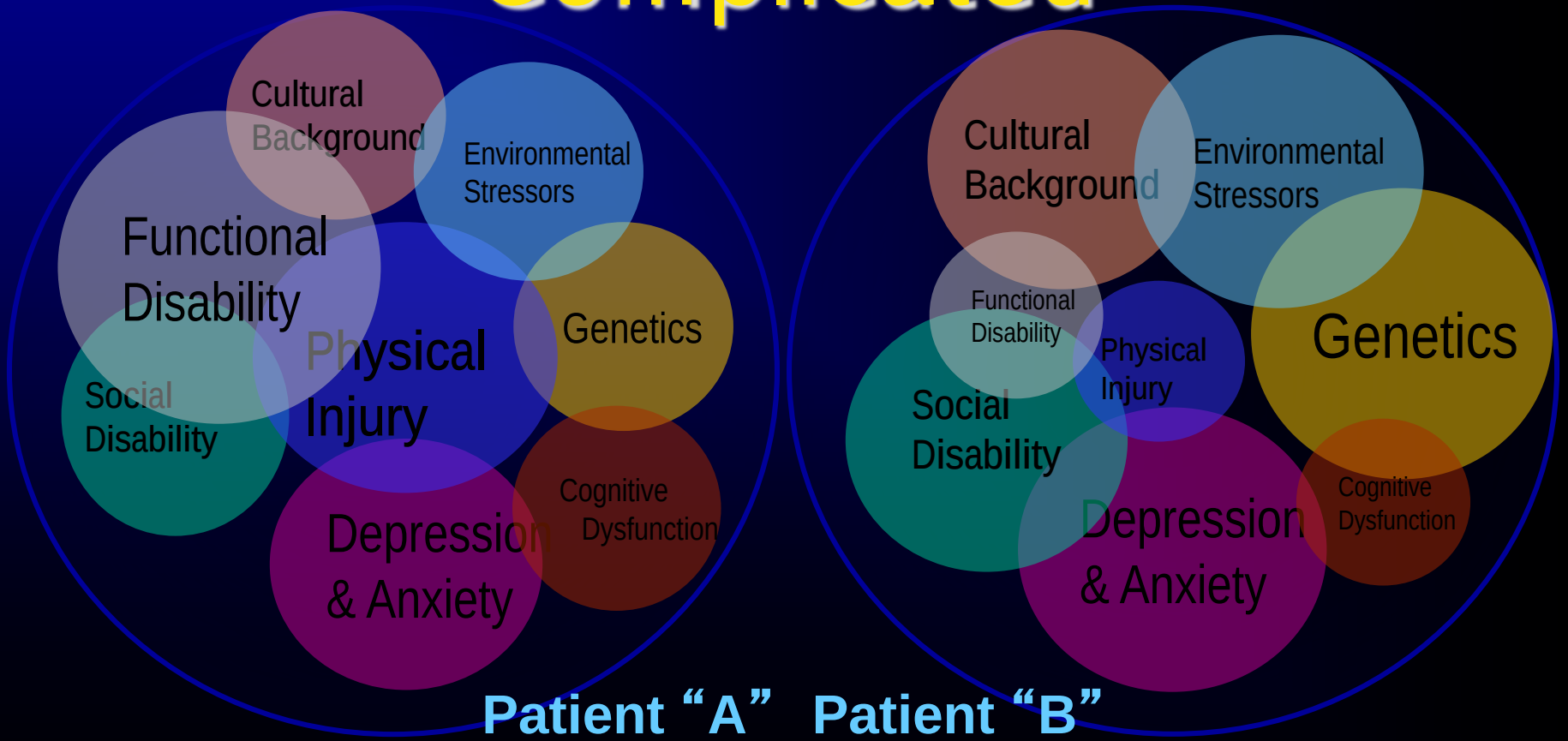
- Healthcare costs
- Disability
- Lost workdays

Galer et al. In: *A Clinical Guide to Neuropathic Pain.* 2000:15-19; Eisendrath. *Neurology.* 1995;45(suppl 9):S26-S34.

The Pain Experience: A Biopsychosocial Perspective



Pain Patients are Complicated



Patient "A" **Patient "B"**

Pain 8/10 **Pain 8/10**

Gatchel RJ. *Am Psychol*. 2004;59:795-805.

Patient Expectations During a Clinical Encounter

- Feel Welcome
- Feel Important and Informed
- Believe their Perspective was understood
- Feel Secure that their needs will be met

Jamison R, The Doctor-Patient Relationship: Dealing with Difficult Clinician-Patient Interactions. In Bonica, pp423, 2010

Who are the Difficult Patients?

- “Normal” difficult patient
- Raise negative feelings from the clinician
- Failure to respond
- Psychosocial stressors
- Comorbid psychological disease
- Socially isolated
- Indigent patient

Patients may have their own *views* of illness and care that may not be in line with the provider's perspectives.

What is a Difficult Patient ?

CONCEPTS OF ILLNESS & CARE

Grove's Difficult Patient Groups

Label	Identifying Featues	Treatment Strategies
Dependent clinger	Escalating need for reassurance	Set limits with realistic expectations
Entitled demanders	Initially present as needy but soon become aggressive and intimidating	Do not react to anger. Acknowledge situation and discuss realistic expectations
Manipulative help-rejectors	Ungrateful, pessimistic about tx outcome	Paradoxically advocate adopting a skeptical attitude toward tx and schedule regular appts.
Self-destructive deniers	Tend to engage in behaviors that thwart attempts to improve condition (smoking, drinking, etc)	Avoid vengeful feelings and punishment but should instead focus on and tx underlying depression

Groves JE. Taking care of the hateful patient. N Engl J Med 1978; 298:883

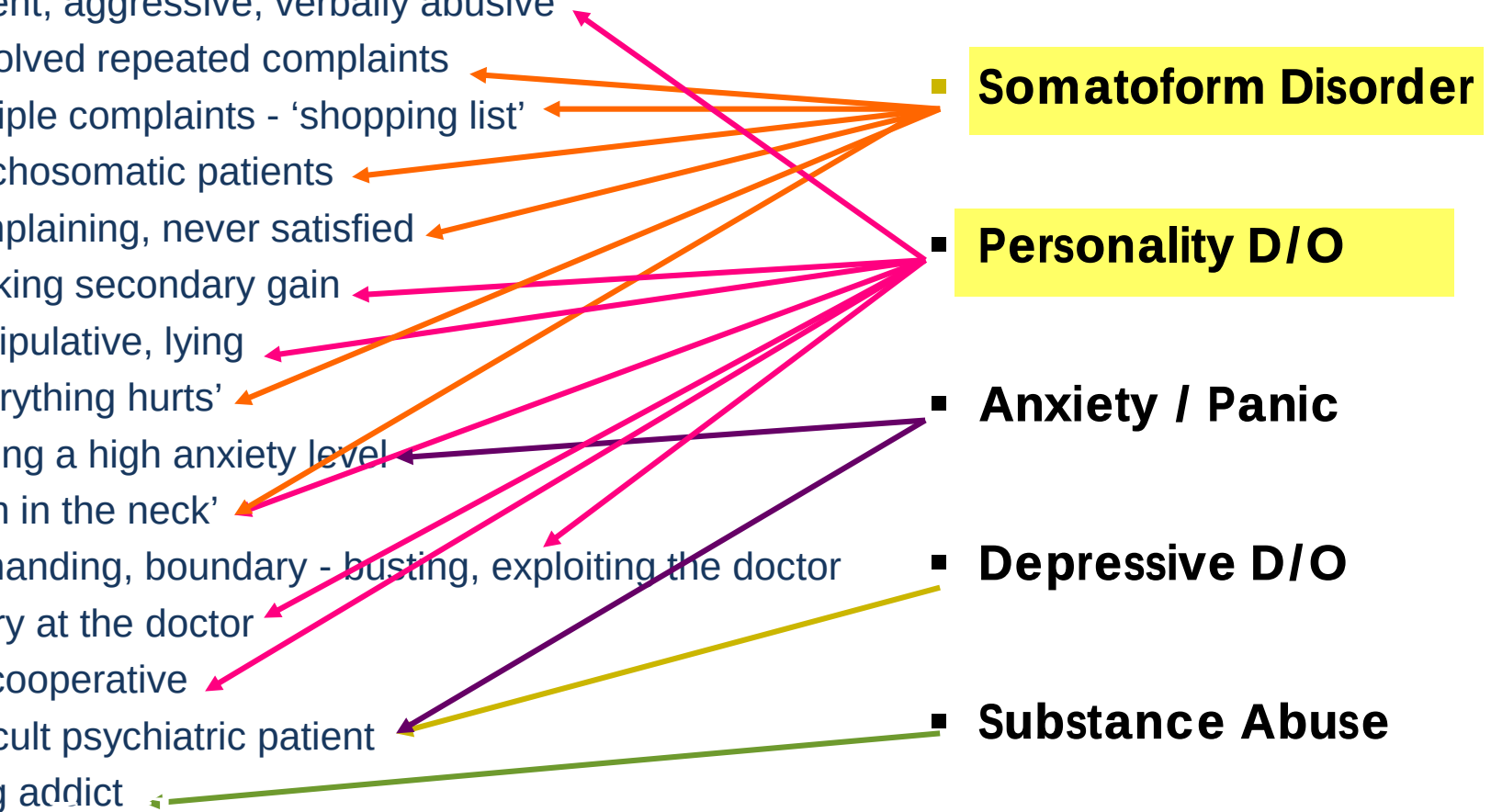
BEHAVIORAL	SOCIAL	PHYSIOLOGICAL
Personality D/O	Trust / Past Exp.	Analgesic Abuse Syndrome
Somatoform D/O	Concepts of Illness	Altered Pain Responses
Bipolar D/O	Concepts of Care	Opioid Metabolism
Anxiety	Fears	
Depression	Stoicism	
Schizophrenia	Family / Friends	Pain Mechanism
Substance Use	Social Stigma	

Causes of Difficult Pain Patients

- Biological
  - Hard to treat syndromes
- Psychological
- Sociological
- Unrealistic Expectations
- Physician characteristics
- Healthcare system related

TABLE 1 ***Types of difficult patients*** *(in descending order of relative frequency)*

1. Violent, aggressive, verbally abusive
2. Unsolved repeated complaints
3. Multiple complaints - 'shopping list'
4. Psychosomatic patients
5. Complaining, never satisfied
6. Seeking secondary gain
7. Manipulative, lying
8. 'Everything hurts'
9. Having a high anxiety level
10. 'Pain in the neck'
11. Demanding, boundary - busting, exploiting the doctor
12. Angry at the doctor
13. Un-cooperative
14. Difficult psychiatric patient
15. Drug addict



What is a "Difficult Patient" ?

Steinmetz D, Tabenkin H. Family Practice 2001; 18: 495-500.

Borderline Personality Disorder

- Pervasive pattern of instability of interpersonal relationships, self-image, and affect with marked impulsivity.
- Most difficult disorder clinicians face
- 18% prevalence
- May amplify the pain or be the sole cause
- See things as “black and white” and easily go from different extremes of emotions

Symptoms of BPD

The symptoms of BPD can occur in a variety of combinations, and individuals with the disorder have many, if not all of the following traits:

- fears of abandonment
- extreme mood swings
- difficulty in relationships
- unstable self-image
- difficulty managing emotions
- impulsive behavior
- self-injuring acts
- suicidal ideation
- transient psychotic episodes

Dealing with the Borderline Personality Disorder Patient

- Early recognition is important
- Medications under the direction of a psychiatrist may help
- Dialectical behavioral therapy (DBT)
  - Teaches them to control and not react to their emotions
- Try managing conservatively as response to treatment can be difficult to assess
- Try to be understanding of emotional extremes and do not react negatively

Affective Disorder

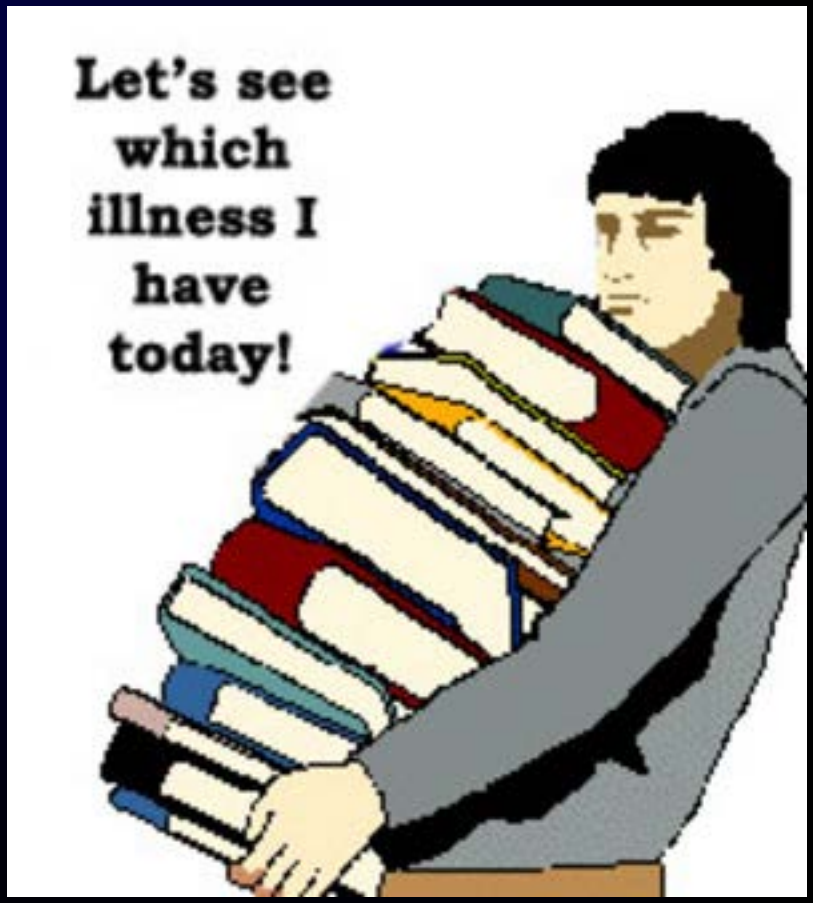
- 30-50% of pain clinic patients have major depression or anxiety disorders
- May emerge in the course of treament, especially if they are not responding
- Results in poor coping, poor motivation
- Tend to blame the physician for lack of response to therapy

Dealing with the Affective Disorder Patient

- A combination of psychotropic medication and psychotherapy most effective
- Embrace a biopsychosocial approach
- Important to:
  - Explore psychosocial history prior to pain problem
  - Use language that they understand
  - Educate on both the physical and emotional aspects of their pain

Somatization

- Self perpetuating somatic symptoms in the absence of organic pathology
- Multitude of unexplained symptoms in the presence of normal results from diagnostic tests and physical examination
- Catastrophize
- High disability and healthcare utilization
- “Sick Role”
- Difficult to diagnose
- Be careful in labeling patients



Dealing with the Somatisizing Patient

- Honest discussion
- Cognitive behavioral therapy
- Antidepressant medication
- Psychiatric consultation
- Very conservative treatment of pain

Hostile Patient

- Common in pain clinic settings
- Yell, become verbally and maybe physically abusive
- Can present a very stressful situation for staff members

Dealing with the Hostile Patient

- Remain calm and collected
- Handle problem in private
- Listen to patient's complaints
- Convey kindness and reassurance
- Try to reach a solution
- Document encounter

– Princeton Insurance. Six steps for dealing with angry patients. www.riskreviewonline.com, 2002

Five A's for Dealing with Hostile Patients

- Acknowledge the problem
- Allow the patient to vent uninterrupted in a private place
- Agree on what the problem is
- Affirm what can be done
- Assure follow-through

– Dealing with Difficult Patients in Your Pain Practice. Wasan AD et al. Reg Anesth and Pain Med. 30:184, 2005

Suicidal Patient

- Suicidal ideation and attempts common among pain patients
- Passive death wish
  - Wish they were dead
- Suicidal intent
  - Actively want to end life
- Suicidal intent with a plan

Suicidal Assessment and Treatment Planning Issues

- Evaluate suicidal intent and lethality
- Establish existence of feasibility of a suicidal plan
- Identify evidence of self-destructive behavior and past suicide attempts
- Attempt to establish an alliance with the patient
- Consider a contract for safety
- Refer to mental health specialist with training in suicidal evaluation and treatment and/or escort to the ER
- Document communication with patient and treatment strategies
  - Dealing with Difficult Patients in Your Pain Practice. Wasan AD et al. Reg Anesth and Pain Med. 30:184, 2005

Substance Abuse Disorder

- 10-16% of patient treated in general practice and 25-40% of hospitalized patients have prior problems related to drugs or alcohol
- Prior history of substance abuse disorder requires careful assessment and monitoring if using opioids

Pain Assessment: Medical History Findings Associated With Substance Use Disorders

- *Medical history:* hepatitis C, HIV, TB, cellulitis, sexually transmitted diseases, elevated liver function tests, etc
- *Social history:* motor vehicle or fire-related accidents, DUIs, domestic violence, criminal history
- *Psychiatric history:* personal history of psychiatric diagnosis, outpatient and/or inpatient treatment, current psychiatric medications

High Risk vs High Worry

High Risk =
Risk of Adverse Medical Effects

- COPD
- Dementia
- BPH
- Unstable gait
- Hazardous environment
- Pre-treatment constipation
- Hepatic insufficiency
- Low blood pressure
- Sleep apnea
- Methadone deaths

High Worry =
Risk of Abuse Behaviors

- History of drug or alcohol abuse
- Criminal history
- Unclear cause of pain
- History of multiple pain clinicians
- Multiple tattoos
- Unstable home environment
- Too ingratiating; too demanding
- “Gut feeling”

Screening Tools To Assess Risk Level for Use of Opioids

- Drug Abuse Screening Test – DAST
  - 20-item questionnaire
- Opioid Risk Tool – ORT
  - 5-item clinical review
- Screener and Opioid Assessment for Patients with Pain – SOAPP
  - 5-, 14-, or longer 24-item questionnaire

Aberrant Drug-taking Behaviors

Major

- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another patient's drugs
- Injecting oral formulation
- Obtaining prescription drugs from nonmedical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurrent prescription losses

Minor

- Aggressive complaining about need for higher doses
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1–2 times
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician

Passik SD et al. *Oncology*. 1998;12(4):517-521,524.
Passik SD et al. *Oncology*. 1998;12(5):729-734,736.

Always Plan for Potential Exit Strategy

- Criteria for tapering emphasized in the initial patient agreement
  - documentation of lack of pain reduction and/or lack of functional improvement
  - documentation of opioid medication or prescription misuse or abuse
  - positive urine screen test for any illegal substance
  - failure to comply with all aspects of treatment program
- Distinguish between abandoning opioid therapy, abandoning pain management, and abandoning patient
- Taper off opioid therapy, with or without specialty assistance

Noncompliance

- Noncompliance can occur with medications, rehab, psychological referral or lifestyle changes
- Causes:
  - Non acceptance of treatment plan
  - Unrealistic expectations
  - Social issues
    - Financial, time, work, etc.
  - Addiction

Noncompliance Management

- Consider modifying treatment plan
  - May coax the patient into acceptance of original plan
- Educating the patient on importance of treatment plan to success
- If patient unwilling to comply, inform them that no further appointment will be made unless they are ready to accept treatment

Noncompliance With Drugs of Dependency

- There should be a low tolerance for noncompliance with drugs of dependency
- Persistent noncompliance should result in drug tapering
  - Achieved with a well defined tapering schedule to avoid withdrawal
  - Patients who cannot comply with a taper should be warned that no further refills will be provided and given locations of detoxification program
  - Carefully document in medical records
  - DO NOT BE HELD HOSTAGE!!

Effect of Litigation on Chronic Pain

- Secondary Gain
- Pain likely to improve once litigation resolves.
- Avoid aggressive invasive therapies if patient in litigation
- Unlikely patient is malingering
  - Stress/anxiety of litigation drives the pain

Marital, Family, Work Dissatisfaction

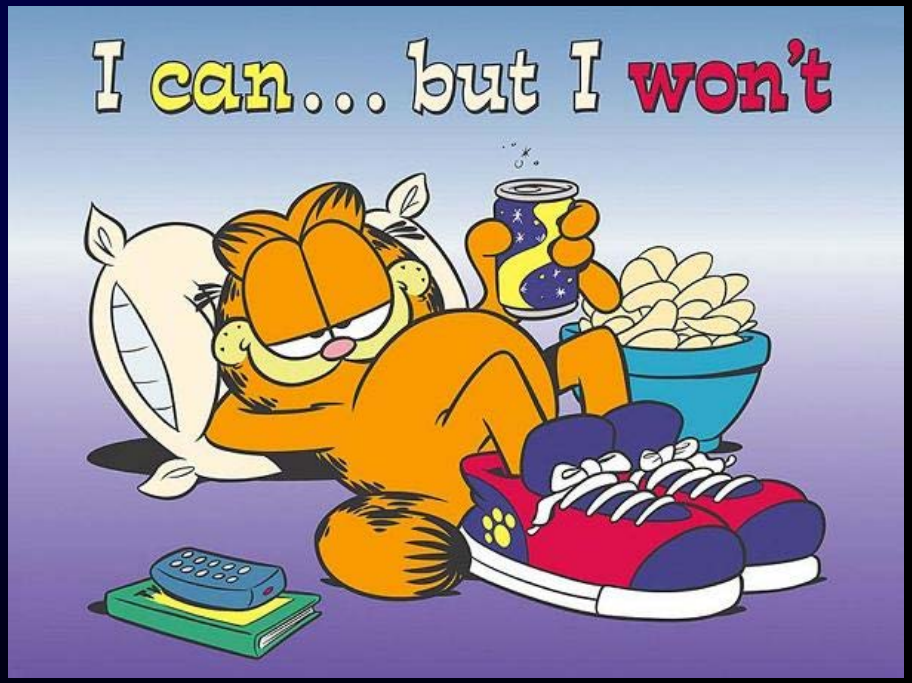
- Social turmoil can lead to increase pain and poor response to therapy
- Beware that these patients may use pain medications (especially opioids and benzos) to treat emotional disturbances
- Work dissatisfaction can lead to secondary gain of disability

Should Pain Physicians Sign Disability Papers?

- Probably not as it is counterproductive to pain treatment
- Pain in and of itself is not a reason for disability
- Reasonable to provide work restrictions and accommodations

Poor Lifestyles

- Pain is more common in patients who do not regularly exercise, eat appropriately and get enough sleep
- Lifestyle changes should be a part of every pain treatment plan
- Compliance with lifestyle changes is just as important as compliance with medical therapies



The Patient Who Wants to be "Fixed"

- These patients usually have unrealistic expectations and do not understand the limitations of modern medicine
- Attempt an honest discussion with the patient and adjust expectations
- Failure to adjust expectations can lead patient down a path of excessive treatment and failure

Physician Factors

- Difficult patients are not always the fault of the patient
- Physicians who are less empathetic are more likely to perceive patients as difficult
- Do not take behavior personally but recognize that it is how patients react to other situations
- Do not let patient behavior drive poor decisions

The 'Silver Lining' :

Older, more experienced doctors:

- Reported fewer difficult Pts.
- Coped better with wide variety of Pts.

What is a Difficult Patient ?

Steinmetz D, Tabenkin H. Family Practice 2001; 18: 495-500.

Components of Every Patient Encounter

- Engage
- Empathize
- Educate
- Enlist
- End

Jamison R, The Doctor-Patient Relationship: Dealing with Difficult Clinician-Patient Interactions. In Bonica, pp423, 2010

Health Care System Factors

- Access
- Delays
- Authorization
- Copays
- Clinic Time
- Phone

Dismissing a Difficult Patient

- Inform the patient why they are being dismissed
  - Face to face and with a formal letter
  - If concern over hostility, only a letter is needed
- 30 days notice is adequate
- Refer to local Medical Society for list of other practitioners they can choose from
- Provide taper schedule for drugs of dependency
- If the patient is a part of a contracted health plan with your group, the group Medical Director will need to terminate

The Difficult Patient with Implantables

- Not as common as these patient undergo more psychological screening before implant and tend to have more of an established strong physician-patient relationship
- If noncompliance or unacceptable behaviors arise, therapy can still be discontinued
  - Easier done with stimulation
  - More challenging with intrathecal therapy

Weaning Intrathecal Therapy

- Scheduled weekly visits with titration down until pump off
- If patient is noncompliant, at next pump refill, turn the pump off and provide oral medications to cover drugs of dependence with a weaning schedule
- Explant of the system has to have the consent of the patient

Interventional Therapies that go Wrong

- Not uncommon for patients to report increase pain after interventional procedures
- In the absence of “red flags”, reassurance is the best remedy along with a short course of analgesics if necessary
- In the case of serious injury, remain level headed and approach the case as you would any patient and do not get defensive
- Do not let threats of litigation intimidate you. Remain calm and manage the patient’s problem as indicated.
- Risk Management may need to be contacted
- Carefully document but do not try and place any blame in the medical record

Summary

- The “difficult pain patient” is often a two-way street and the provider can be just as much at fault
- Understanding the reasons behind the behavior can often defuse the situation
- However, there are times when the line must be drawn with continuing unacceptable behavior. Even when this occurs, rationale approaches are effective in terminating the situation calmly.