My Philosophy in Pain Management

Regarding The California Medical Board's Changing Guidance in Pain Management

In 2001 The California Medical Board required all CA physicians to take 12 hours of continuing medical education on " adequate pain management and appropriate care and treatment of the terminally ill" in order to maintain licensure. The courses I was provided as options emphasized the use of long-acting opioids, with only a small nod to other modalities for the management of pain.

This policy changed incrementally over time, and in 2014 the Medical Board of California reversed itself and published new guidelines which have intimidated physicians into dropping patients with chronic pain from their practices or in forcing abrupt tapers of their pain medications. This has created a local and national problem of pain refugees, that is patients with chronic pain who had been stable and had improved quality of life on their pain medications, who have been cut off of those medications and who as a result are desperate. As the CDC has recently pointed out, these well-intentioned guidelines, which are being enforced as rules rather than guidelines, have placed patients at risk.

Trying to hold to True North in Pain Management While Political Winds are Changing

I opened my private practice here in 2000 and over the years had become increasingly dismayed about the current medical model for care of patients living with chronic pain, about the number of patients who had a single tool, opioids, with which to manage chronic pain, and whose lives were becoming smaller – many were suffering from isolation, depression, and had lost hope of making meaningful contributions to their families and their community. In 2005, I made it mandatory for patients receiving opioids from my practice to attend Healing Groups for people living with chronic pain, in which we teach tools for meditation, cognitive behavioral therapy, the importance of nutrition, movement, and other modalities for managing pain, and so on. See Pain Management. Over the years since, I have treated a large number of patients with painful conditions and helped many of them taper or discontinue opioids, and helped others improve their quality of life, mood, and activity level while maintaining stable doses of medication. I feel it is one of the best things I have done in my career, and it is an approach I have taught other physicians at national conferences (you can find slides from a recent 4-hour workshop here) and at the Family Medicine Residency when I was teaching out of the area from 2008-2013.

Not everyone who comes to me with chronic pain is immediately ready for this approach, however. If patients are overmedicated (which is very apparent when I force them to sit in a darkened room and meditate or listen to me teach for a couple of hours) I will taper immediately until I feel they are at a safer level of medication. Fortunately, however, that is

rare – most have become tolerant to large doses of medication over many years under the care of their previous physicians, and are in no immediate danger if they continue while we start to unwind their issues.

The Rules of Tacks

One of my guiding principles in medicine is Sidney Baker's Rules of Tacks:
1. If you are sitting on a tack, it takes a lot of aspirin to make the pain go away.
2. If you are sitting on two tacks, removing one does not necessarily result in a 50% reduction in symptoms.
The reminder here is, figure out what is causing a problem, which may be more than one thing, and address those causes in order to help a patient. Do not simply pile medicines on top of a problem. As an example, I suffer from migraines. For me, avoiding Bounce drier sheets, dairy, and a few other things allows me to prevent the headaches and to avoid having to take potentially dangerous medications to treat them.

This principle applies to my treatment of patients in chronic pain. In some cases, they have painful conditions, such as neuropathy, which have not been adequately worked up or diagnosed, and my first step is to do the appropriate testing to treat the underlying causes. In some cases, imaging and referral for surgery are needed, and for many of my patients, accessing specialty care can involve long waits and require travel out of the area, which can be a tremendous barrier for people who are in increased pain with even short car rides, who are disabled and without sufficient financial means and so on. For many patients, there is trauma from their childhood or later which needs to be addressed, and for 70 - 80% there is an element of depression/isolation which has developed as a result of having chronic pain. Finally, in some cases, these patients have become so used to relying on their medications as their single crutch that it takes months or even years for us to establish enough trust for them to be willing to begin to safely lower their medications using the other tools I provide. I see this as a long game – we are all on Healing Journeys, and the path does not look the same for every patient.

Narcotic Contract Violations in the State Accusation

I believe all human beings deserve compassionate care, regardless of age, social status, financial resources, political convictions, or medical conditions. I do not think any of us are beyond redemption, and that meeting people where they are is the way to establish trust and move them forward. This has led to me violating "narcotic contracts" and rescuing people who have overused medications. I did not escalate pain medication use for any of these patients to the dosage levels on which they arrived at my practice, but I have worked with them where they are. All are currently at lower doses of medication than when they established care with me, but I have not been tapering them at the rate dictated by an excel spreadsheet, heedless of their response to such a taper, and at times I have increased doses when they had surgery or developed a new painful problem.

As an analogy, when my COPD patients overuse their long-acting beta agonists (also a potentially life-threatening misuse of medication) I do not make them go without until the next month. I struggle with their insurance to get them a new inhaler, review safety precautions, and add other medications, more steroid, anticholinergic, etc. and/or ensure they have a rescue inhaler so that they do not need to overuse the LABA the next month. When they continue smoking despite my advice to stop, I approach them with Motivational Interviewing, not with confrontation and shaming them.

When my diabetics admit to eating donuts or Halloween candy, I ask what they think about their choices, and if there are ways we can support them in making better choices. I do not withhold insulin and tell them to go into a coma so that they will "learn from their mistakes."

I believe this is good medical care, not negligence. My approach to pain medication is similar to these examples, unless I have reason to believe there is acute danger, in which case I will still try to find a strategy, like a caregiver to administer medicines or shorter prescriptions to limit the supply of medications in the home, to prevent them from going into what would be, for many of my elderly and chronically ill pain patients, potentially life-threatening withdrawal.

This does not mean my patients have unlimited "free passes" - I still have a working BullSH*t detector - but I give people the benefit of the doubt, which I believe is what the reviewer found so disturbing.

This is a place for clinical judgment, and I acknowledge mine may be faulty at times, as might any human's. For patients who are out of medications in half the time they should have lasted, I recognize I cannot treat them safely and cannot prescribe unless there is a caregiver who can manage the medications for them, or they may inadvertently overdose. I have discharged patients or transitioned them to suboxone for such behavior. But if they consistently run out 1-3 days early? In these very tolerant patients, that generally reflects waking in desperate pain and taking an extra dose of medication once or twice a week. How many times should we forgive someone for being desperate or not tolerating a taper that was recommended? I believe that is a question for a higher Authority:

"Then came Peter to him, and said, Lord, how oft shall my brother sin against me, and I forgive him? till seven times?
Jesus saith unto him, I say not unto thee, Until seven times: but, Until seventy times seven.
Matthew 18:21-22 King James Version (KJV)"