

On Never Giving Up: Treating Chronic Pain

By Alexander Stone

“I wanted you to see what real courage is, instead of getting the idea that courage is a man with a gun in his hand. It’s when you know you’re licked before you begin but you begin anyway and see it through no matter what” – Atticus Finch, To Kill a Mockingbird

Ms. Dubose’s¹ life was saved by modern healthcare. Three years ago, she collapsed when cleaning her brother’s cabin. She was rushed to a local hospital where a CT scan revealed a left temporal brain hemorrhage with three millimeters of midline shift. She was emergently transferred by helicopter to a tertiary care hospital where neurosurgeons performed a craniotomy, which saved her life. After a month in the intensive care unit, and many months in rehab, she was discharged from the hospital: a success story.

After returning home, Ms. Dubose’s story changed. She started to complain of pain in her groin and behind her ribs. CT scans were unrevealing. Her primary care physician referred her to a chronic pain clinic. Multiple rounds of facet injections in her back and sacroiliac joint injections failed to provide relief. She was placed on daily hydrocodone. Her behavior became more erratic. Multiple neuro- psychiatrists fired her for missing appointments, disruptive behavior, or showing up intoxicated on marijuana. More CT scans and visits to gynecologists and neurologists failed to reveal the cause of her pain. She stopped leaving her house. She became afraid to cook because she worried that she may leave the stove on and started receiving Meals on Wheels. Following a dispute, her brother, who was living with her and taking care of her moved out. She eventually started to call her primary care physician’s office and threatened to hurt herself multiple times each month. These episodes resulted in emergency department visits; each time she was discharged after she recanted her story.

¹ The patient’s name was changed for anonymity. Ms. Dubose was chosen after Ms. Henry Lafayette Dubose, a character from Harper Lee’s *To Kill a Mockingbird*. Ms. Dubose was “the meanest old woman who ever lived” and neighbor to the Finch family. With the aid of Lem and Scout reading aloud books, and an alarm clock, Ms. Dubose weaned herself off of morphine before she passed away. For taking herself off of opioids in the face of death Atticus called her “the bravest person I ever knew”. Lee, H. (1960). *To Kill a Mockingbird*. Philadelphia: Lippincott.

She came to the Pain Treatment Program on Meyer 6 because she had nowhere else to go. The healthcare system was failing Ms. Dubose.

When I met Ms. Dubose, she was agitated. During the interview, she paced around the room, lay down on the floor, and stood on top of her chair. Her thoughts were tangential and grossly disorganized. Her chief complaint was, “the radiation from the cyber knife was leaking from my brain and causing pain in my body”. We initially started her on neuroleptics and lithium. We took her off of all the medications she had that could be causing delirium including her opioids. After a few days, her clinical state did not improve. She started to circulate an online petition promoting opioids for chronic pain and would send emails to president Obama². She said that she was getting ready to sue everyone on the unit.

We went back to the drawing board. We were not satisfied with the explanation that this was who she was after the stroke and were not going to give up on Ms. Dubose. A neurology team had previously seen her and did not recommend an EEG. They explained that following her injury, they would expect abnormal activity and it would not add value to her case. However, subclinical seizures or spike and slow wave stupor was on our differential. We got the EEG, which showed spiking activity around where her injury was.

We started Ms. Dubose on an antiepileptic, and she responded dramatically. Her thoughts became organized, she could sustain a conversation, and her agitation disappeared. She started to become herself again. Though we could not eliminate her pain, we were able to manage it with physical therapy and gabapentin.

Most of the patients in Pain Treatment Program have been given up on by the healthcare system. Their symptoms have been refractory to surgery, injections, and physical therapy. Their work ups have cost many thousands of dollars and often fail to identify a cause or effective treatment. Most importantly, they are unable to live their lives. Their diagnoses do not fit within clean-cut problem lists on an electronic medical record. Despite a lack of evidence, they have

² The petition can be found here <http://www.petition2congress.com/5202/first-do-no-harm-dea-targets-physicians-who-treat-their-patients>

been prescribed and then escalated on doses of opioids³. Their physicians do not do this out of malice, but rather have no other options and want to try to relieve their patients from suffering.⁴

For many patients, the long-term opioids are a dirty Band-Aid; they mask the underlying problems at first, and then exacerbate them. Patients on high doses of opioids become physically dependent on these medications. They are often depressed and not treated for their depression. Some come to the pain treatment program barely functioning⁵. They feel alone because their pain is often not disfiguring and readily apparent to the outside world. When they present to the hospital on their prescribed doses of opioids, other providers do not take them seriously or suspect diversion. Many doctors, exasperated and exhausted have told these patients “I am sorry but I cannot help you anymore” and “there is no magic pill”. The modern healthcare system is not designed to take care of these patients, despite false promises that opioids are effective and that a mark of a good hospital is that it can accurately measure and eliminate pain⁶.

I am convinced that the pain treatment program is only possible on a psychiatric ward. Good psychiatric care is inefficient by the metrics of the modern healthcare system. There are no tests to send to confirm diagnoses. People need time to get well and it is impossible to rush the

³ There is **no** evidence to support the use of long-term opioids for chronic non-cancer pain. Political forces and pharmaceutical companies drove the adoption of practice. The majority of the studies that show effectiveness of opioids for chronic pain are less than 12 weeks, and there are no studies for treatment of opioids for a year or more. The observational studies of long-term opioids for non-cancer pain do not show effectiveness but rather make clear the high risks of chronic opioid treatment. The CDC has recently published a comprehensive review and are critical of the practice of providing long term opioids for non-cancer pain patients. Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *Jama*, 315(15), 1624. doi:10.1001/jama.2016.1464

⁴ Some of the rationale for expanding use for opioids in the late 1990s stemmed from concern for physicians undertreating pain. These were based on studies of racial disparities for acute pain following long bone fractures in the emergency department and not chronic non-cancer pain. See; Kolodny, A., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction. *Annu. Rev. Public Health Annual Review of Public Health*, 36(1), 559-574. doi:10.1146/annurev-publhealth-031914-122957 and Wailoo, K. (2014). *Pain: A Political History*.

⁵ In the 1950's lobotomies were used for chronic pain patients as a way of taking them off of chronic morphine treatment. Raz, M. (2009). The Painless Brain: Lobotomy, Psychiatry, and the Treatment of Chronic Pain and Terminal Illness. *Perspectives in Biology and Medicine*, 52(4), 555-565. doi:10.1353/pbm.0.0121

⁶ By this I am referring to the “pain as the 5th vital sign campaign”. This was announced in the late 1990s by the American Pain Association and adopted by the Veterans Affairs and the Joint Commission. Pain is a symptom, not a sign, and I do not believe it can be accurately captured on a 1-10 scale. Currently patients are being asked to rate how their pain was treated in hospital satisfaction surveys, which encourages more aggressive pain treatment. While it is important to always think about patient's pain, the 5th vital sign campaign encourages unrealistic pain treatment goals like a pain score of 0 following surgery.

process. As a result, psychiatrists push back on the pressures to shorten hospital length of stays⁷. Therapeutic relationships are cultivated, and healthcare consumers are transformed into patients once again. When a treatment does not work, instead of being discouraged, another therapy is tried. The patients, who have been suffering alone, find support in the group therapies. They are weaned off of opioids and benzodiazepines, which is a painful process, but the team expertly manages their symptoms⁸. The nursing staff attends to these patients that have many needs without judgment or frustration. Even when things seemed dark, the team maintained a therapeutic optimism, something that many of these patients have not experienced in years⁹. I will always remember how the attending physician encouraged the patients every day and told them on rounds “I will get you better”. It is something these patients were unable to get anywhere else despite the exhaustive work ups and treatments.

I have learned many things in medical school: from the Krebs cycle in the first year, to taking histories and formulating differential diagnoses in the third year. However, my time on Meyer 6 and Ms. Dubose, taught me that the most courageous thing a doctor can do is to never give up on a patient.

⁷ To quote the attending on service with me, “if we have money to bomb the middle east, we have money to treat this patient for another week”

⁸ While the physical signs of opioid withdrawal (runny nose diarrhea, muscle aches) are well taught in medical school there is no substitute to witnessing the mental anguish opioid withdrawal causes first hand. The dysphoria is striking. On the first day of treatment, I saw multiple patients who were previously reasonable become completely engulfed with rage as their home medications wore off while orders were being placed.

⁹ More often they hear “there is nothing more I can offer”