PROVIDING COMPASSIONATE CARE FOR PERSONS WITH SUD AND CHRONIC PAIN: HOW TO ADDRESS ETHICAL DILEMMAS

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WHAT WE WILL LEARN TODAY:

• How to provide compassionate ethical care when treating chronic pain patients with SUD
• Ethical Dilemmas treating chronic pain patients with SUD
• Best Practices to treating chronic pain patients with SUD

We will also talk about:

• Definition of chronic pain and the scope of this issue
• Patient Autonomy
• Quality of Life Enhancement
• Pain management as a human rights issue
• Barriers to pain management
Real-Life Stories
HOW CAN YOU RELATE TO CHRONIC PAIN????

WRITE IT IN THE CHAT BOX
Defining Chronic Pain and Identifying the Scope of Chronic Pain Issues

Pain can be defined as physical suffering or discomfort caused by illness or injury.

*****Pain is subjective and may not always be corroborated by objective data.

Chronic pain can be defined as pain that is moderate or severe, lasting 6 months or more, requiring long-term management.
Defining Chronic Pain and Identifying the Scope of Chronic Pain Issues.

The American Academy of Pain Medicine reports in 2018 100 million adults had chronic pain.

Goal of pain management: Maximize functionality while providing pain relief.

Common Dilemma: Although pain greatly impacts SUD patients it is often undertreated due to concerns related to SUD/the opioid epidemic.
**Common Dilemma:** Patients pain is often discounted and not believed since it cannot be seen.

Important that we as clinicians, pastors, physicians, addiction therapists, peer support, other professionals become *educated* on chronic pain to better help our patients and *dispel myths*.

Pain is acute or chronic

- **Acute** – pain related to trauma, sudden onset, resolves with healing of injury.

- **Chronic** – persists for weeks, months or longer and usually has an underlying cause.
Pain Impact on Health & Functioning

* Stress, Anxiety, Depression, Sleeplessness, relationships, quality of life, physical/mental health, mobility, independence, ability to work and cycle of more pain.
A Voice of a Chronic Pain Sufferer

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Every single day I struggle beyond my own strength.

I battle my own body, my emotions, and other people’s judgement.

My pain level changes from moment to moment, and I have no control over that.

I do my best to walk in the shoes I have.

Please accept me for who I am and not for who you want me to be.
EFFECTIVE PAIN MANAGEMENT:

Effective CNCP management in patients with or in recovery from SUDs must address both conditions simultaneously. (Trafton, Oliva, Horst, Minkel, & Humphreys, 2004).

Effective Pain Management is a Human Right (entitlement and freedom all human beings hold), applies to persons with SUD.

AMA states, physicians have an obligation to relieve pain and suffering.
Pain Management as a Human Right

International statements articulating pain management as a human right:

The Declaration of Montreal (2011)

“and recognizing the inherent dignity of all persons and that the withholding of pain treatment is profoundly wrong, leading to unnecessary suffering that is harmful, we declare that the following human rights must be recognized throughout the world”:

*“Article 1: The right of all people to have access to pain management without discrimination.
*“Article 2: The right of all people to have acknowledgment of their pain and to be informed about how it can be assessed and managed.
*Article 3: The right of all people in pain to have access to appropriate assessment and treatment of the pain by adequately trained health professionals.”
BARRIERS TO PAIN MANAGEMENT:

Despite prevalence of pain and its impact on patient functioning there is still concerns with undertreatment and unnecessary patient suffering due to barriers to pain management:

Barriers:

- Lack of training of health care providers
- Not acknowledging patient pain
- Racial biases/implicit biases
- Inadequate access to health care
- Opioid crisis restricts legitimate access to opioids
- Inadequate pain control
- Globally – disparity in access to opioids
The Right to Access to Pain Management

What is your ethical responsibility to clients regarding pain management?

According to the World Health Assembly:

It is an ethical duty of health care professionals to alleviate pain and suffering

The right to pain management as a human right is part of the states obligations to ensure “health services are available, accessible, acceptable and of good quality” for all people including persons with a SUD

Under human rights law we want to apply harm reduction strategies (Medication Assisted Programs) to protect and promote the health of substance users.

Danger of a highly regulatory response to the opioid crisis, persons who may truly need the medication, may not be able to obtain.

Clinicians should be trained in pain management and substance use to dispel myths and help provide the best ethical care to patients.
Exhibit 3-1 Algorithm for Managing Chronic Pain in Patients With SUD

Evaluation sufficient to confirm:
- Diagnosis of chronic pain (pain does not result from a health-threatening or correctable pathology)
- Functional impairment
- Psychological comorbidity

Active addiction
- Start addiction treatment
- Defer opioids/analgesia (Patient already on opioids should have trial of opioid weaning. Opioids may be continued only if the patient immediately initiates SUD treatment.)
- Analgesic determined by pain physiology
- Implement non-pharmacologic treatment

In recovery
- Without medication
- On agonist therapy

Without medication
- Non-opioid analgesics as determined by pain physiology
- Concurrent
  - Nonpharmacologic pain treatments
  - Reconditioning as determined by functional impairment
  - Treatment of psychiatric/sleep comorbidities

On agonist therapy
- Continue agonist; may increase dose as required for analgesia

Successful outcome
- Inadequate benefit

Initiate opioid trial if risk is warranted
- Relapse
  - Wean opioid
  - Continue other therapies
- Failure
  - Continue strategy
  - Monitor for demonstration of continued benefit
- Success
**Cross Addiction**

Persons with chronic pain and SUD are increased risk for cross addiction to any medications that act on the brain as a reinforcing agent. (Edlund, Sullivan, Steffick, Harris, & Wells, 2007).

**The Cycle of Pain**

Seeking pain relief, having relief occur, experiencing pain again

If using medication or substances – may provide relief, tolerance develops, take more for relief, develop a physical dependence, increased pain when the substance is not present, may also experience withdrawal symptoms, ingest more of the substance.

**Physical dependence** – body requires a specific dose of a particular drug such as a prescription opioid to prevent withdrawal symptoms. Do not necessarily develop a SUD. The patient may experience some euphoria, yet has control over their use.

**Addiction** – compulsive behavior that manifests as cravings, inability to control use, continued use of the drug despite consequences,
Elements of a Comprehensive Patient Assessment

Element: Pain and Coping

• Location, character (e.g., shooting or stinging, continuous or intermittent)
• Pain types (i.e., nociceptive, neuropathic, mixed)
• Lowest and highest extent of pain in a typical day, on a 0-to-10 scale
• Usual pain in a typical day, on a 0-to-10 scale
• When and how the pain started
• Exacerbating factors (e.g., exertion/activity, food consumption, elimination, stress, medical issues)
• Palliating factors (e.g., heat, cold, stretching, rest, medications, complementary and alternative treatments)
• Prior evaluations to determine the source of pain
• Response to previous pain treatments, including complementary and alternative treatments and interventional treatments
• Goals and expectations for pain relief

Mental Status: Medication focused • Somatic preoccupation • Mood • Suicidal ideation and behavior • Cognition (e.g., attentional capacity, memory)
Elements of a Comprehensive Patient Assessment

**Element: Collateral Information:** • Findings of other clinicians, prior and current • Family concerns, beliefs, and observations • Pharmacist concerns, where relevant • Data from State electronic prescription monitoring programs, if available • Medical records, including psychiatric and substance use disorders (SUDs) treatment records

**Function:** Effect of pain on: • Activities of daily living/ability to care for oneself • Sleep • Mood • Work/household responsibilities • Sex • Socialization and support systems • Recreation • Goals and expectations for restored function

**Contingencies:** • Family support of wellness versus illness behavior • Vocational incentives and disincentives • Financial incentives and disincentives • Insurance/legal incentives and disincentives • Environmental and social resources for wellness

**Physical Exam:** Relevant associated signs of pain disorder • Signs of substance abuse (e.g., track marks, hepatomegaly, residua of skin infections, nasal and oropharyngeal pathology)
Elements of a Comprehensive Patient Assessment (continued):

**SUD history and Risk for Addiction:** • Current use of substances, including tobacco, alcohol, over-the-counter medications, prescription medications, and illicit drugs (confirmed by toxicology) • Focus on opioids to the exclusion of other treatments • Adverse consequences of use (e.g., functional impairment; legal, social, financial, family, work, medical problems) • Age at first use • Treatment history, including attendance at mutual-help groups • Periods of abstinence • Strength of recovery support network (e.g., sponsor, sober support network, mutual-help meetings) • Family history of SUD • History of physical, sexual, or emotional abuse or trauma

**Co occurring Disorders:** • Psychological conditions (e.g., depression, anxiety, post-traumatic stress disorder [PTSD], somatoform disorders) • Medical conditions (e.g., hepatic, renal, cardiovascular, metabolic) • Cognitive impairments (e.g., dementia, delirium, intoxication, traumatic brain injury)
“Caregivers are obligated to understand the complexities of their patients’ lives, their network of relationships, and their anguish in order to truly care for them. If you’re equipped to walk alongside the person who is suffering, you’ll experience a profound sense of purpose and meaning. This is why people go into healthcare. Compassion is the answer.”

The Schwartz Center for Compassionate Healthcare, Beth Lown, MD, Medical Dir.
QUOTES ON COMPASSION

“If you want others to be happy, practice compassion. If you want to be happy, practice compassion”. Dalai Lama

“Love and compassion are necessities, not luxuries. Without them humanity cannot survive”. Dalai Lama

“The purpose of human life is to serve, and to show compassion and the will to help others”. Albert Schweitzer

“As I get older, the more I stay focused on the acceptance of myself and others, and choose compassion over judgment and curiosity over fear”. Tracee Ellis Ross

“Our sorrow and wounds are healed only when we touch them with compassion”. Jack Kornfield
WHAT DOES YOUR EVERYDAY LANGUAGE SAY ABOUT YOUR PATIENTS?? DOES IT STIGMATIZE INDIVIDUALS WITH CHRONIC PAIN AND SUD.

DOES YOUR CLINIC USE TERMS SUCH AS:

- FREQUENT FLYER
- DRUG SEEKING
- OTHER:

REPEATED EXPOSURE TO PATIENTS SUFFERING WITH CHRONIC PAIN AND SUD CAN REINFORCE NEGATIVE EMOTIONS AND CREATE COGNITIVE BIASES TOWARDS PUNITIVE JUDGMENTS VERSUS COMPASSION.

IS IT POSSIBLE TO REPLACE LANGUAGE WITH TERMS SUCH AS COMFORT SEEKING VERSUS DRUG SEEKING?

SHIFT FROM JUDGMENT TO COMPASSION

 PROVIDER ATTITUDES, ASSUMPTIONS, STIGMA’S, IMPLICIT STEREOTYPES, HAVE AN IMPACT ON PATIENT CARE.
Clinicians should be aware of their implicit bias when working with chronic patients having SUD.

Unconscious bias have an impact on the medical care our patients receive.

**Implicit Bias:** Attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner.

Recognize where implicit bias may exist  
Be aware of unconscious decision making and the consequences  
Own your own stuff  
Expose yourself to people and experiences outside of your normal circle  
Take the implicit bias test - Harvard’s Project Implicit
Ask yourself????

Who are your 3 best friends – implicit bias and stereotypes continue through lack of contact with others outside of the group you are comfortable with

Do you automatically exclude certain neighborhoods as places you might live or send your kids to school?

A landmark study found that once a neighborhood reaches a “tipping point” of minorities, whites left. Racially tolerant whites had a higher tipping point.

Do you only date a certain type??
Ethical Duty to reduce Patient suffering (not alleviate pain)

**Patient Suffering** – once we understand it we can take action
**Inherent Suffering** (comes with the diagnosis and treatment)
**Avoidable suffering** (suffering we as caregivers can provoke or make worse due to dysfunctional systems) – waiting, unsafe environment, lack of empathy, not connecting with patient/family, not working as a team, repetitive questioning, labeling “our patient”, etc.

**Caregiver Suffering** – stress of the job, complex patients

**Answer to Suffering**
Remember why we got into this field – we are here to help our patients heal

**Roots of Suffering in Healthcare**

Healthcare no longer emphasizes the reduction of suffering
Society does not prioritize personal connections
Provider education change the way we train providers (online and simulated)
Performance reviews not based on client experiences.
Best Practices:

**Quantifying Suffering**

*Engagement survey* asking about patient and caregiver suffering
Ask about pain management, degree to which your emotional needs were addressed, responsiveness of staff, cleanliness of environment, do you feel safe at the clinic.
Patient and family give detailed responses on unmet needs – which causes suffering.
Best Practices:

**Compassionate Connected Care**

Acknowledge a patient’s suffering – be empathetic and provide compassionate responses; validate patient concerns to get to the root of their issues.

**Body Language Makes a Difference:**

Eye contact, body position, elbow bump.

**Reduce uncertainty and anxiety to show understanding for patient suffering**

use reassuring phrases, check in frequently in a purposeful way to check on their pain/concerns.

**Coordinate Care:** Show concern for patient when they go home to help them have a successful recovery program. Follow up call/referrals.
Best Practices:

Compassionate Connected Care (continued)

***Loss of Autonomy increases suffering:

Give the client a voice and allow options

Compassionate Care goes beyond the medical diagnosis:

See the client as more than a person in recovery with chronic pain. Find a way to connect and not see the person as client #2222. Do you have any personal touches or anything you do to provide care for the client/family.
Best Practices:

Compassionate Connected Caregiver

56 second conversation to connect with your client

Offer choices

Talk with clients about their pain

Frequent sessions/connections to demonstrate empathy, compassion and a desire to serve.

Critical thinking is key

Cultivate your resistance so your compassion tank is not empty—need to survive the inherent suffering in healthcare and provide compassionate connected care—utilize mindfulness, positive thinking, care for self,
Best Practices:

How to integrate compassion into your practice:

- Compassionate connected teams mitigate suffering
- Improve team huddle
- Compassion Huddle
- Hope Huddle
- Interdisciplinary Rounds
- Shift Reports
- Provide seamless team-based care
Ways for chronic pain patients with SUD to reduce suffering:

Goal to Restore/Enhance

• Mobility
• Interaction
• Independence
• Validation
• Love
Ways for chronic pain patients with SUD to reduce suffering:

• Be your own advocate
• Body Maintenance/Exercise
• Identify and set boundaries
• Analyze your resource spending
• Manage concentration and cognitive abilities
• Alternative therapies – Acupuncture, aromatherapy, chiropractor, hypnosis, etc.
• Support groups
• Retrain your nervous system
• Mindfulness and meditation
• Mental Health care
• Finding calm in the storm
• Reframing harmful thoughts
• Ignite creativity – dance, music, at therapy, knitting – meaning comes from creativity
Ways to reduce suffering:

- Spirituality
- Medicine of Movement
- Let your food be medicine
- Recharge, get mental health help, research your pain
- Gain treatment perspective
- Build a “pain free village” – connect with others going through the same thing
- Build a conventional and complementary provider network
- Manage your pain at work, home and while traveling
- Acceptance – accept your new reality, accept that you are a new person, accept the good, let the rest go.
- Stay connected to your spouse/partner
- Build a network of friends and family
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QUESTIONS/FEEDBACK