Its good to talk

TALKING WITH PATIENTS WHO HAVE CHRONIC PAIN

In this session

- We will look at how to identify patients with chronic primary pain
- We will look at time resources and some challenges and solutions
- How to prepare ourselves to speak with these difficult, demanding and rewarding patients
- How to create a framework or model from which to help the patient understand chronic (and functional) pain

How long have you got Doc?

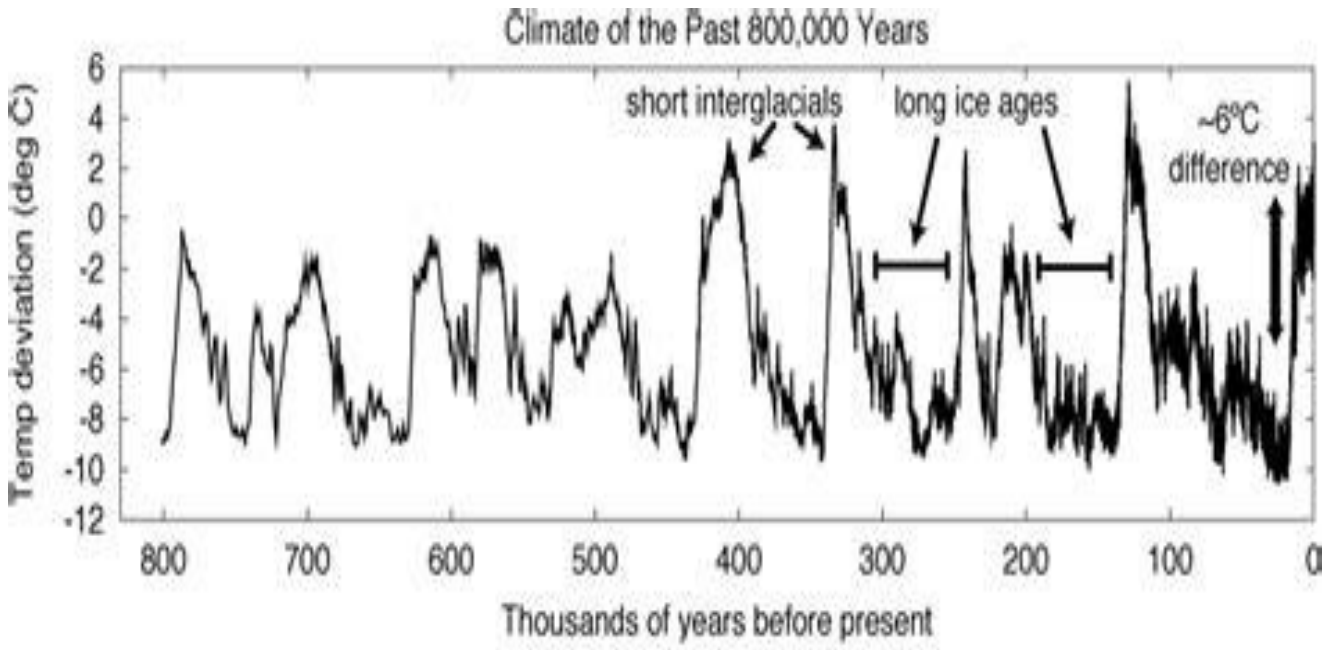
- How long does it take to unpack a problem like chronic pain?
- Compare this with the time for a prescription or specialist referral
- But then think about the time that chronic pain patients take – with duty doc calls in distress, with complex decisions and discussions about their opiates, with high levels of consulting
- (In Aviemore patients with chronic pain used to consult around 15 times per year – that's nearly four hours of your time – every year)
- Imagine if your plumber limited every visit to 15 minutes – what would happen to your heating system?

The good news

- Strategic investments of time seem to pay off
- In a series of high consulting patients with chronic pain in Aviemore – a structured programme involving an hour of GP time resulted in a 30 percent reduction in the number of consultations per year – enough to pay your investment back in 6 months
- Consider a strategic investment of time in talking – negotiate this with partners. We all buy washing machines!
- When can I fit this in – how can I negotiate with colleagues
- Make this the last patient of the day?

When to communicate ?

- Patients with chronic pain cycle through different periods of stress/distress and calmness.
- A phone call to the duty doc is usually a time of greatest distress – the patient is “ triggered”, activated, anxious or “ hot”. Emotions will be driving their thinking. You will achieve little perspective change.
- Dialogue with patients when they are at the calmest/coolest. Booked appts with a doctor who has continuity with them



To summarise – when to talk

Reduce/stop duty doc calls about analgesia – do some brief holding work

“ I can hear you are distressed and really want to help you move on with this”

“ I can give you an appointment in 10 days time when we will really have time to do this justice and set things on the right path. In the meantime would it be OK to (use gentle stretching, have hot baths, practice your relaxation techniques, use the existing pain relief we have in place)

Make protected longer, routine appointments with a consistent GP, when the patient is calmer

Preparing yourself – the right headspace
Its not their patient's fault

- Patients with chronic pain can have already frustrated us, been unreasonable or demanding (cos our system does not meet their need or we have created unrealistic expectations)

The causes of chronic pain (see Fink's work) as we best understand them include:

1. **Predisposing factors - Genetics, upbringing/trauma**
2. **Precipitating factors -Surgery, infection**
3. **Potentiating factors – Cultural, family factors, inappropriate treatment**

The great majority of these are not within the patients control – they have happened to them

Chronic pain, very largely, **is not the patient's fault**

I just need better painkillers doc – I cant stand this

- Acknowledge the distress
- Explain the possible effects of more opiates – temporary relief, longer term harm and loss of effect
- Keep calm
- Use “ in your best interest” and avoid “ I am not prepared to…..” etc
- Make a time when you can “ do this justice”
- Explain what the patient can do meantime

Have realistic expectations

- Chronic pain is not curable – but you may be able to help the patient understand their condition and learn some skills for dealing with it
- Acceptance of this by both parties is a key part of coping/recovery with chronic pain
- *I really started to move forward when I realised I would not get rid of this pain*
- My experience is that 30 percent of patients can be substantially helped 30 – 40 percent somewhat helped and 30 -40 percent will not engage or report no help

Have I got the right patient 1?

If your patient has an unclear diagnosis, outstanding scans or consultant opinions. Clarify these issues before you start – but it does not always have to be either/or

Someone has to be brave enough to draw a line under the investigations – that's you!

Screen for depression and treating this

What is chronic primary pain?

Chronic Primary Pain – ICD 11

Pain lasting for more than 3 – 6 months

Multisite pain

High levels of emotional distress and/social dysfunction

And not better explained by another diagnosis

Chronic Pain and Chronic Primary Pain

Chronic pain : 68 year old woman with OA hip who can no longer play golf and is waiting for a ortho assessment and is fed up with this

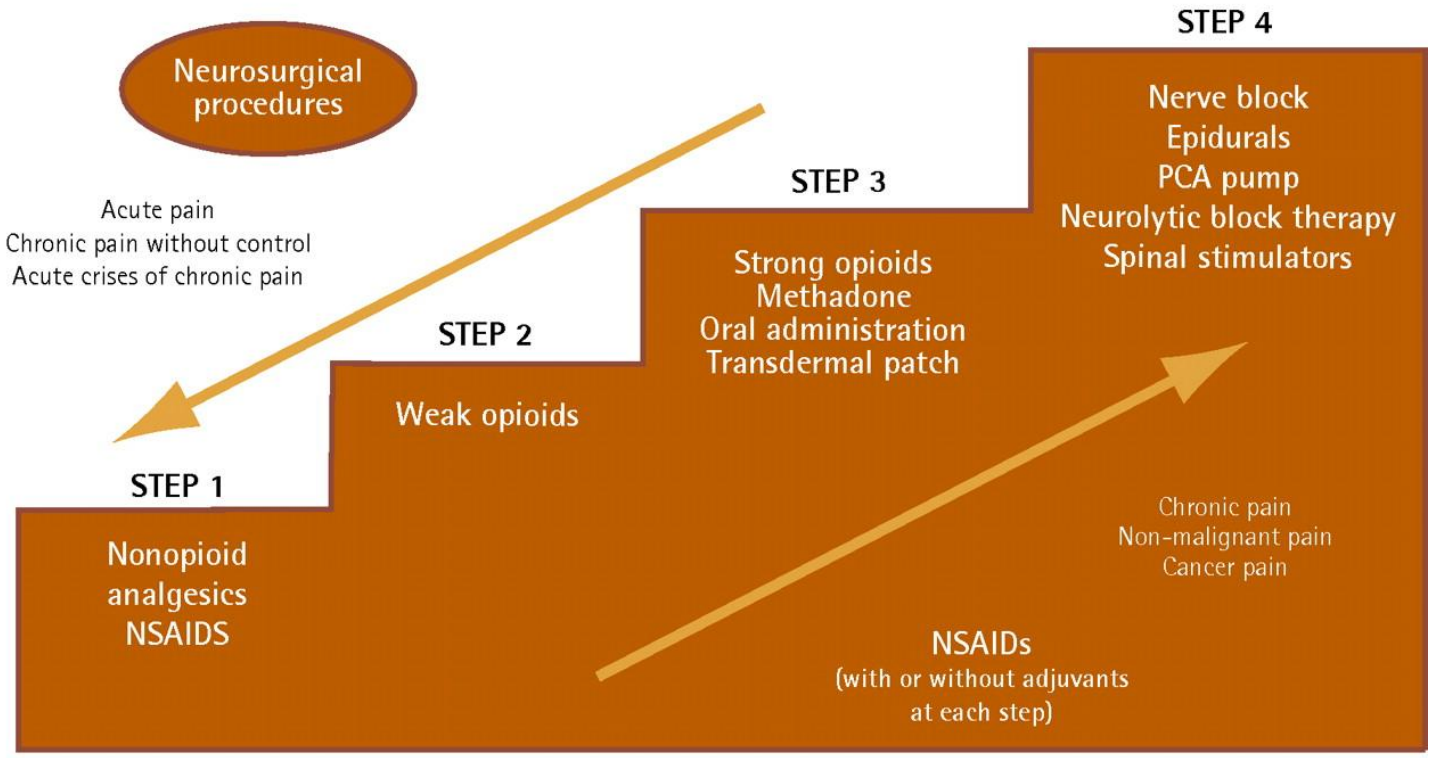
Treat with physio, analgesia, injection, joint replacement, monitor mood

Chronic Primary Pain: 47 year old woman with abdominal and pelvic pain, whose CT and scope findings are negative, who had had to give up work as a secretary and who struggles pain and exhaustion to do housework because of pain

Treat with a holistic approach – information about chronic pain, acceptance of condition, uncovering and challenging unhelpful thinking and behaviour, appropriate activity plan, living a meaningful life with the condition, monitor and treat mood, avoidance of medical harm

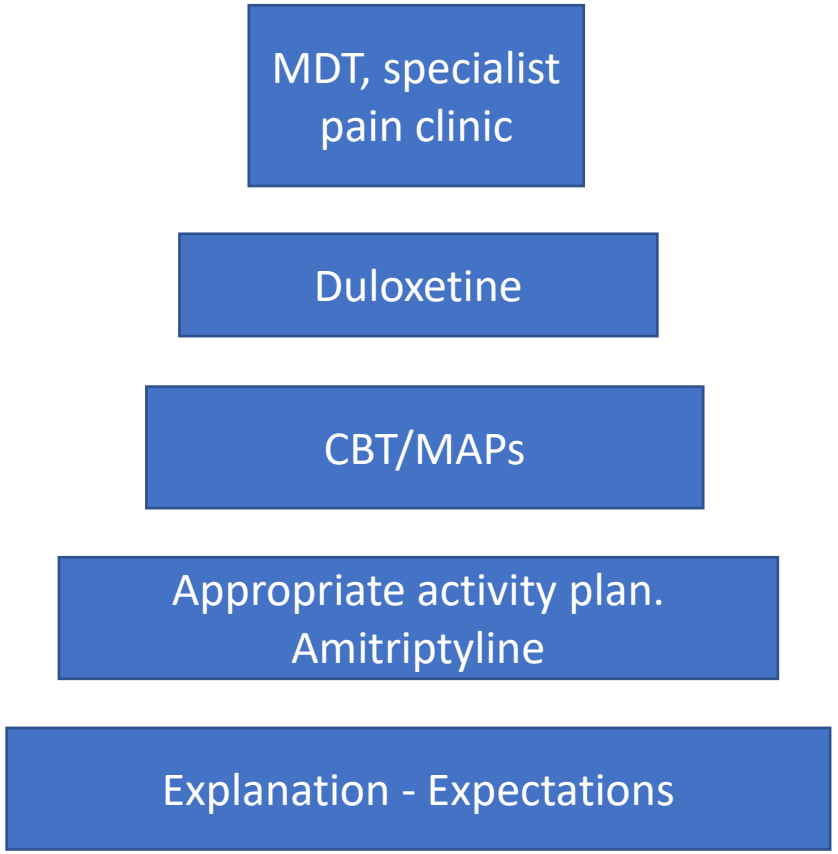
Right for trauma and surgical pain

Figure 2. New adaptation of the analgesic ladder



NSAID—nonsteroidal anti-inflammatory drug, PCA—patient-controlled analgesia.

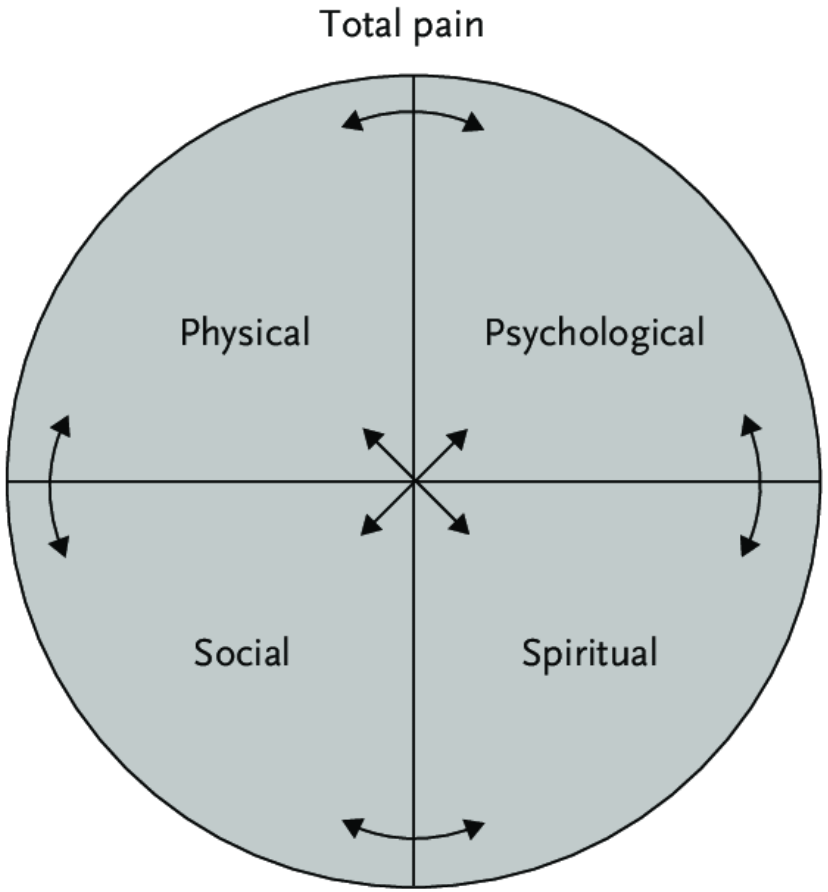
Right for Chronic Primary pain



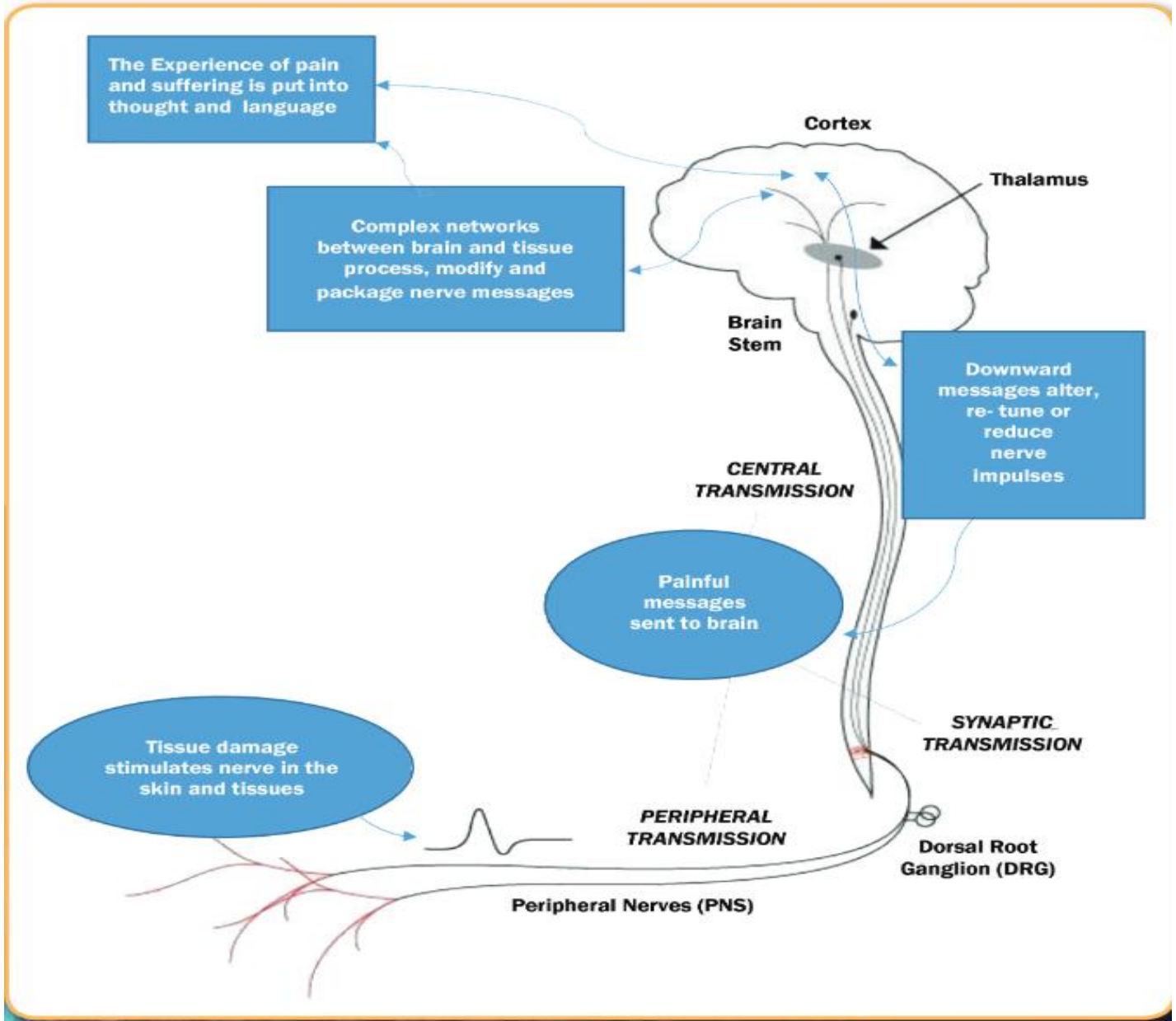
Create a drug free zone

“ We have spent a lot of time trying medication, but most of the science now points to other treatments as most effective. Lets put those aside for today so we can concentrate on some possibly more powerful approaches”

Get your holism glasses on!



The “body-mind person”



You are saying this all in my mind doc!

You might respond with

- *The body and mind are parts of the same whole – which are connected through an immensely complicated network of nerves and hormones – so when things go wrong it always effect the body AND mind – they are part of the same person.*

- *Or - the body and mind are always in constant conversation - sending each other messages. This conversation has often gone wrong in patients with chronic pain.*

Model for talking with patients – talking about cause and effect. Non linear causality

- **“ Upward causality**
- *Damage in a limb sends signals to the brain - downward causality*

Downward causality

The brain processes these impulses - and sends signals back to tissues – through the GABA system/Hormones etc

- **Complex causality**

In a complex system – the weather, society, the person there are multiple pathways and systems interacting in unexpected ways

Complex causality

- The brain-body self is immensely complex - so a picture of a close friend who has recently died can send impulses to our lacrimal gland and make us cry
- Or shame about a relationship might cause pelvic pain
- Or worry about hurting our back may make us very stiff when moving around
- Or surgery, despite a good technical outcome can cause ongoing pain – eg post cholecystectomy syndrome

Three analogies that work – The Gong Why pain persists

The motorway – Functional pain
Why the tests are negative

The Sprinkler – turning on soothing GABA pathways

- The brain produces soothing downward messages - a bit like a sprinkler system damping down a fire. This sprinkler system tends to be turned off in patients with chronic pain – but the work you will be doing will help turn it back on!

Listen to the “suffering narrative”

Why do you think this pain has happened to you?

What do you think this pain means?

What do you tell yourself when things get really bad ?

Write these down in the notes to come back to – these are clues to which issues to address, and may contain negative thinking

Talking with patients with chronic pain – the first ten minutes

- The first minutes:
- Let the patient speak for several minutes
- Ask when it started, what was happening around that time?
- What does the patient think might have triggered or contributed to the pain
- Show your acceptance and belief in the patients experience – no matter how odd it might seem
- Make an accurate record – including the suffering narrative

How can I get more help?

https://aviemoremedical.co.uk/chronic-pain/