Approaching the chronic pain patient: learning from 33 years in the field

by Patricia Livingston OC MD FRCPC MEd

Chronic pain affects nearly 8 million Canadians[1]. Patients are often stigmatized by partners, co-workers, and healthcare practitioners[2]. Physicians may view appointments for pain with dread, as these visits require extra time and pain education in medical schools is insufficient. For such a common problem, a median of only 20 hours of pain content is offered in Canadian medical school curricula[3].

As a practitioner of chronic pain management, I have developed an approach that has resulted in both alleviating patient distress and making my practice truly rewarding. There are few things more satisfying than helping someone who is suffering to a place in life where they are happy, healthy, and able to function. The purpose of this article is to share learning and perspectives from 33 years in the field.

The greatest challenge to comprehensive pain management is time. Patients arrive at their first appointment often feeling discouraged and unheard by prior healthcare professionals. Listening may be the single most important aspect of the initial visit. Time spent in listening to patients early on, and establishing rapport, pays huge dividends subsequently. Patients who trust their practitioner has their best interests at heart, will be willing to make the hard changes: smoking cessation, regular exercise, healthy diet, and meaningful engagement with the world.

Assessment

Start with open-ended questions and then listen. Some patients may need a bit of probing but allowing them a generous amount of time early on usually ends up being the most efficient and productive way to conduct the interview. There is always the concern that open-ended questions will let the patient dominate the interview and take the conversation in unfruitful directions. Additionally, some patients want to unleash their frustrations with the medical system on a receptive ear. Avoid these pitfalls by using graded assertiveness to maintain control of the interview. If the interview is becoming unproductive, intervene promptly. Allow your questions to become more specific as the interview progresses. Summarizing the findings back to patients clarifies understanding and reinforces that they are being heard.

We are privileged in medicine to know our patients and learn about their lives. Details about the social history, functional status, hobbies, and interests are especially relevant. Atul Gawande, in his book *Better*[4], recommends that we, "ask an unscripted question". This does not provide medical information but enhances our job and the patient's experience, building rapport.

During the interview, jot down ideas, as they arise, about the management plan. For example, if a patient is as smoker, jot down "smoking cessation". These ideas come up during the interview and are often hard to recall at the end.

For the physical exam, refrain from putting patient through unnecessary suffering that will not change understanding of the issues or influence the management plan. Palpation of tender areas should be with as little pressure as needed to gain necessary information. Start lightly and go deeper, only if necessary.

After completion of the history and physical, and review of imaging results and previous consultations, develop a working diagnosis of the potential etiology and factors that influence the pain. Patients who are used to being dismissed, are greatly relieved to receive this information. When possible, they appreciate seeing photos or skeleton models to explain the problem.

Plan

The most effective pain management plans are multi-dimensional and tailored to the individual. My broad goal is to help patients have the best quality of life possible with as few medications as possible. Many patients are frequently overmedicated and tend to feel better and more clear-headed when medications are reduced to the most essential.

A written prescription holds gravitas. I provide patients with a legible written list of their treatment program, much of which will require active management strategies by them. This list must be tailored to the patient's situation, feasible, and obtainable. There is little point in asking an elderly person who lives in a rural setting to make frequent trips to the city for treatment. Seek buy-in and negotiate with the patient to get agreement to follow this plan. People are more willing to stick to a plan that has been designed for their circumstances, abilities, and interests. Record the plan and follow up with the patient at their next visit to reinforce compliance.

Exercise

Inevitably, people are hesitant to exercise for fear of aggravating the pain. They may also have a limited view of options. Exercise should be gentle with some cardiovascular component. The best options for patients with pain include swimming or aquafit, Qi gong, yoga, cycling (stationary or on a level rail trail), walking, and core strengthening. Ideally, exercise suggestions should be those that the patient enjoys and will be possible given their physical limitations. Encourage a variety of activities. A physiotherapist may help with tailored corrective stretching and strengthening program.

Mind-body

Patients often benefit from mindfulness practice. They may experience solace in forest walks, listening to the sounds of nature and leaving technology behind.

Hobbies

In this busy world where everything is purposeful, people can discover great joy in hobbies. Many people enjoy gardening, which can be simple container gardening for people with physical limitations. Hobbies may include crafts, reading or learning another language. Music and art are valuable for pain reduction[5]. Sometimes people need to hear from a physician that these activities are important.

Education

If possible, refer the patient for pain education at a group program. If patients are willing, they may find books such as *Explain Pain*[6] to be valuable.

Diet

Nutrition is increasingly recognized as relevant to pain. There are strong links between diet and systemic inflammation that contributes to persistent pain[7]. Patients with pain are well served by adopting an anti-inflammatory diet high in fruits, vegetables, whole grains, nuts, and beans and low in gluten, sugar, red meat, and processed foods. Diet is especially important for patients with migraines, as certain foods are common triggers.

Smoking

In addition to numerous known harmful effects of tobacco, smoking also perpetuates pain[8]. Patients respond well to motivational interviewing and providing supportive resources for cessation.

Medications

The approach to medications for pain should be to use those that are of clear benefit and to avoid overmedication. Opioids are rarely appropriate for chronic non-malignant pain. Prolonged use of NSAIDS increases the risk of complications. Low dose tricyclic anti-depressants and gabapentinoids may be helpful, especially in neuropathic pain. There are many side effects with pregabalin; I prefer to use this medication very selectively, if at all. The literature is still mixed (and evolving) on cannabinoids, but patients often report benefit with fewer side effects than with many prescription medications. If this treatment is selected, the oral route is preferable to inhaled.

Procedures

Simple procedures, such trigger point injections, can be managed by most physicians. Specialist interventional procedures may be beneficial but difficult to access. Other than complex nerve blocks, the rest of the suggestions in this article can be implemented by non-specialist physicians and nurse practitioners.

Follow-up

Setting reasonable expectations for follow-up avoids patients calling in crisis. Patients who have follow-up visits scheduled, or at least know when they should return, are reassured and less likely to require emergency care.

Patients will surprise you with what they are willing to do. I have had people stop smoking after 60 years, non-swimmers taking adult swimming classes, and patients returning to full-time work after decades on disability. Others are just looking for a quick fix and no amount of patience and rapport on your part will change their views. For people who are genuinely stuck, it is still worth making a concerted effort to hear their concerns, try to bond and give them an opportunity to surprise you. If patients are still completely unwilling to partake in active pain management strategies, the best plan is to offer what is reasonable but not to succumb to pressure. In such cases, clearly outline what you will and will not do and stick to that. Relief cannot always be found, especially for patients who are unwilling to follow through on active pain management strategies.

The greatest barrier to this approach is time. It is always faster to write a prescription for medication, but not necessarily in the patient's best interest. Investing time in the beginning saves time later. In addition, the ideas presented here improve general health, in addition to relieving pain. Patients are enormously grateful when their suffering is reduced; it is truly satisfying to see them move from barely surviving to thriving.

Dr Patricia Livingston is an associate professor of anesthesia and pain medicine physician. She was recently awarded the Order of Canada for her humanitarian work in international medical education.

Figure 1: Summary of pain assessment

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