The Death of Pain Medicine: What will Pain Medicine look like in the Next Few Decades?

ICOO 2018

Daniel B. Carr, MD

Disclosures

- No recent commercial interests
- Mass DPH: PDMP Council, DFC
- Mass Governor's medical education task force (represented Tufts)
- Mass BC/BS (opioid policy), AAPM, IPRCC, ACTTION/IMMPACT
- Wife: NEHI, SHC boards

2

Today's Talk (1 of 3)

- History of MPCs
- Working definitions
- Unanswered questions about MPCs
- Current tensions, trends
  - Human rights dimension of access to pain assessment and treatment
  - Deploying MPC resources for AP Rx
  - Cautious optimism: opioid crisis, other trends (e.g., ACOs) may reverse long-term decline in coverage for MPCs

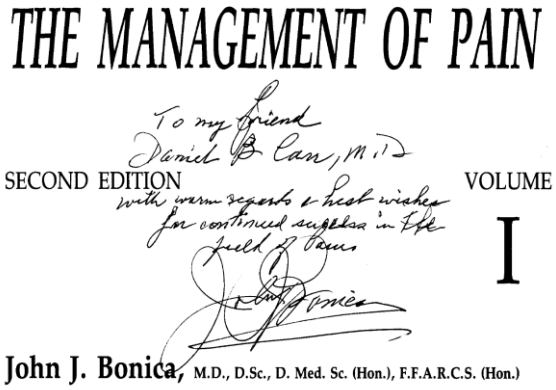
3

Worldwide Disability (Lancet, Economist 2015)

Pain: 2018 View

- Multilevel, multidimensional disease
  - High prevalence and global burden
  - New interest in acute → chronic transition
  - BUT: lagging evidence base c/w other diseases
- Access to management is a human right
  - We didn't say "zero pain"
- Public health/ population health problem
  - "Disease = pathology + host + environment"
  - Disparities, inequities, social justice
  - Prevention models: 1º, 2º, 3º
  - Unanticipated consequences (opioids)

5



John Bonica (1917-1994)

- Many patients with chronic pain have conflicts that center around obtaining medications, failure in obtaining relief, and obtaining certification of the sick role.
- The physician who is unaware of the psychosocial dimensions of chronic pain will fail to identify the vulnerable patients… become frustrated and wonder whether the patient is a drug addict or the psychological symptoms are the cause rather than the effect of the pain.

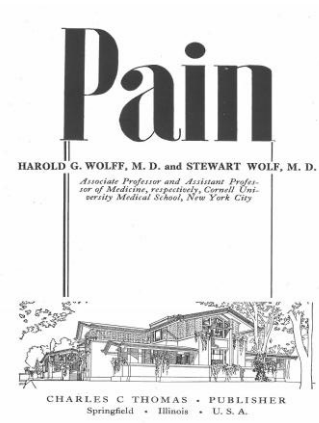
7

Stigma, Marginalization (IOM)

- It has been hell. First, you have to find someone who believes you. [#135]
- Doctors don't recognize pain they cannot see or diagnose as a specific issue. [#314]
- The stigma is one of the biggest barriers. I have been treated like a lowlife by medical people when I disclose that I have chronic pain and use opioids for it. [#383]

8

O'Brien et al
EFIC 2017



The most rational therapy for pain involves, not the use of analgesics or mutilating surgical procedures, but the interruption of the mechanism which produces pain. Analgesics are administered only when the latter cannot be satisfactorily accomplished. For the proper choice of analgesics it is important to obtain, if possible, some estimate of how long the painful condition is likely to persist. Addiction to morphine has frequently followed its prolonged use for the relief of chronic pains. It is also important to estimate, if possible, how much of the patient's discomfort is due to the perception of pain from noxious stimuli and how much may represent over-reaction to minor disturbances at the end-organ. Complaints of the latter type are common and are often treated more appropriately with reassurance and emotional support from the physician and attention to the individual's personality and life situation than with analgesic drugs or other palliative measures.

THE ANESTHESIOLOGIST AND THERAPEUTIC NERVE BLOCK: TECHNICIAN OR PHYSICIAN *†

(WITH EMPHASIS ON THE PROBLEMS OF PAIN RELIEF)

LEROY D. VANDAM, M.D., AND JAMES E. ECKENHOFF, M.D.
Philadelphia, Pennsylvania

Received for publication October 16, 1953

WITHIN the past ten years, many reports have appeared in medical journals proposing the organization of "pain clinics" by anesthesiologists. During this period almost every gathering of anesthesiologists has listened to one or more papers describing the role of the anesthesiologist in the treatment of pain. The result of such written and spoken reports has led many newly trained anesthesiologists to believe that they were in the position to treat satisfactorily a variety of painful syndromes. It is noteworthy, however, that few of these papers have described in detail the actual accomplishments or indicate the proportion of patients who have obtained significant relief from pain by nerve blocking procedures.

DISCUSSION

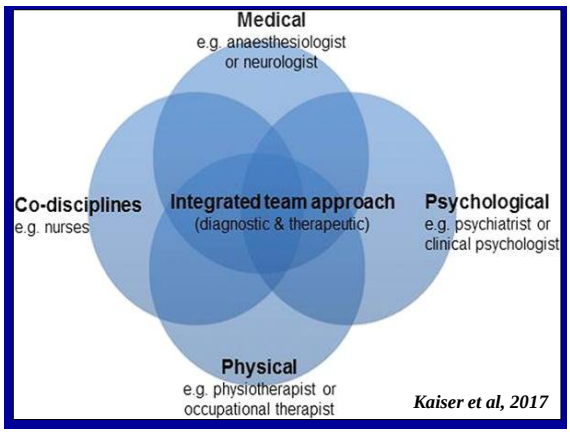
From the foregoing account of experiences with pain and allied syndromes, it is apparent that success was achieved primarily in those patients suffering from acute somatic pain or pain associated with autonomic nervous imbalance. When pain was of long standing, whether or not it was related to organic disease, too often success was not achieved. We never believed that all pain would respond to injection, but neither were we prepared for the number of total failures or the high incidence of insignificant improvement. It often appeared that the procedure was a technical exercise rather than contributing anything to knowledge of pain or its relief. Although others have written and spoken optimistically about the value of "pain clinics," a close examination of their experience reveals that they too met many of the same obstacles and failures.

psychiatrists, orthopedists, neurosurgeons and internists have often given valuable suggestions which have altered treatment. It is impossible to treat satisfactorily large numbers of patients with chronic complaints without frequent advice from others. It would be better to form a group representing the specialities of anesthesiology, medicine, psychiatry, neurosurgery and radiology to study and discuss the treatment of the patient with intractable pain. By such a gathering of minds, treatment of the patient could be improved, and knowledge of pain increased. This has already been done by others.

Multidisciplinary Pain Center (IASP, 1990)

- Organization of health care professionals and basic scientists; includes research, teaching and patient care related to acute and chronic pain.
- Largest, most complex of pain Rx facilities; ideally, within a medical school or teaching hospital. If no research/ teaching: MP ***"Clinic".***
- Clinical director supervises a wide array of health care specialists such as physicians, psychologists, nurses, physical therapists, occupational therapists, vocational counselors, social workers and other specialized health care providers.

14



Kaiser et al, 2017

MPCs: IP Pain Team Members (Am Pain Soc 2010)

- Patient
- Family
- Physicians
  - anesthesia, rehab/ phys med, addiction…
- Nurses
- Psychologists
- Physical therapists
- Occupational therapists
- Recreational therapists
- Vocational counselors
- Pharmacists
- Nutritionist/ dieticians
- Social workers
- Support staff
- Volunteers
- Others

16

Attributes of a Well-Functioning Interdiscip Pain Team (APS 2010)

- Shared philosophy, mission, objectives
- Working together for common, agreed upon goals
- Integrated, interdependent approach
- Mutual respect and open communication
  - often in a team meeting format
- Frequent effective, direct, clear, and reciprocal intra- and extra-team (PCP, referrers) communication
- QI efforts ongoing, responsibility of all on the team
- Collaborative approach to care, education, QI, research
- Deliver evidence-based multimodal treatments

17

Unanswered Questions on IMPT (Kaiser et al, 2017)

- Multi- *vs* unimodal (minimum # modalities)
- Compare different multimodal approaches
- Proof-of-concept trials of new Rx concepts
- Subgroup analyses (e.g., predictive)
- Cost-benefit ratio *vs* waitlist or other Rx
- Identify barriers to IMPT implementation
- Observation of long-term outcomes

18

THANK YOU