A Balancing Act

Nicole appeared on my primary care schedule the first week of every month. She was 29 years old when she began seeing me for management of migraine headaches, uncontrolled type 1 diabetes, chronic renal insufficiency, and major depression. She was unemployed, was without stable housing, and was a single mother of 3 children. She had been prescribed low-dose oxycodone 6 years prior to use only for severe refractory headaches. Over the years, we slowly increased her daily dose as she reported uncontrolled migraine pain. I told her numerous times that I thought opioids were inappropriate treatment for migraines, but alternative approaches to pain management were ineffective. At nearly every visit, she requested an increase in the number of pain pills she was prescribed and believed that I was not listening and did not care about her when I was reluctant to increase her dose. I was frustrated by my inability to effectively treat her headaches and believed that our time together would be better spent addressing her other medical issues. Although I wanted to treat her pain, I was worried that I was complicit in the development of an opioid addiction. This was not the kind of medicine I wanted to practice.

Past attempts to wean Nicole off opioids ended in crisis. She went to the emergency department and received a short course of higher-dose opioids and discharge instructions to follow up with her primary care provider for ongoing pain management. At the next visit, we were back to square one. Based on our practice guidelines, she was at high risk for misuse of her pain medication and the indication for long-term opioid treatment was poor. Was a prescription for oxycodone the price I paid to keep her in care? It seemed as if we had negotiated an unspoken understanding over time: She would cooperate with her medical care if I continued to treat her pain with opioids. I feared that weaning her off the medications would cause her to abandon treatment for depression, diabetes, and kidney disease. The only thing I could say with certainty was that without regular medical care, her overall health was at significant risk for deterioration.

There is no objective decision aid, instrument, or measure that can help me balance the benefits of prescribing opioids to treat pain with the risks I worried about, including tolerance, physiologic dependence, diversion, and overdose. In Nicole’s case, and for many other patients like her, I struggle with these issues without adequate guidance. I have seen seasoned primary care providers leave their practices due in large part to burnout related to narcotic prescribing and a lack of support. I have seen residents turn away from primary care after one too many contentious interactions with patients demanding these medications. How can we provide care to patients with chronic pain and continue to engage them in care for their other medical problems? How can we compassionately provide what we believe is appropriate medical care without alienating or abandoning them?

Most of us in primary care have little to no training in appropriate opioid prescribing, management of opioid dependence, and effective communication strategies for these complex patients. First, teaching primary care providers these critical skills is an essential step toward improving the care of patients receiving opioids for chronic pain, as well as the job satisfaction of the physicians caring for them. Second, primary care providers need additional support in caring for these patients. At the community health center where I practice, we developed a monthly case conference during which primary care providers, nurses, medical assistants, front desk staff, and a psychologist meet to develop care plans for the most challenging cases of chronic pain. These meetings have effectively provided support and helped the team to strategize about these difficult situations. Finally, appropriate referral resources for complicated pain management and addiction cases are critically needed. A multidisciplinary approach, including care from psychiatrists, addiction specialists, pain consultants, and primary care physicians, has the best chance of providing holistic, compassionate, and medically appropriate care to these patients. This care needs to be provided in an atmosphere free of stigma and judgment. Unfortunately, these resources are rarely available to the patients and providers who need them most and were not available to me in Nicole’s case.

I want to compassionately and effectively treat the chronic pain of patients like Nicole, continue to engage them in care, and, most important, avoid unintentional harm to themselves, their families, and their communities. I want to provide comprehensive care, including pain management and treatment of opioid dependence, to my patients while still having time to care for their other medical conditions. I want to go home at night without wondering if my patients will have a fatal overdose, if their children will gain access to the medication, or if they will divert these drugs into the community. Most of all, I don’t want to see my colleagues burned out and leaving primary care because of a lack of support in their care for patients with chronic pain. As a medical community, we urgently need to turn our attention toward this ubiquitous and growing crisis.

Nicole left the room after 20 minutes of negotiation about her oxycodone dosing and little attention paid to her diabetes. I was left drained and defeated, feeling unsupported and inadequate in my ability to manage her pain without leading to opioid abuse or dependence. I believed that I was failing this patient and scores of others like her that I see each week in my primary care clinic. I hope to have more resources in the future to manage her
pain and other medical problems. In the meantime, I see a shift in my own practice, as well as in the providers working around me. I think very carefully before giving a patient a new prescription for opioids, even for an intended short course, knowing the real risks associated with ongoing dependence on these medications.

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Note: Patient name and some details of the case have been changed to protect confidentiality.

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