Doing the Math

Category: Stories
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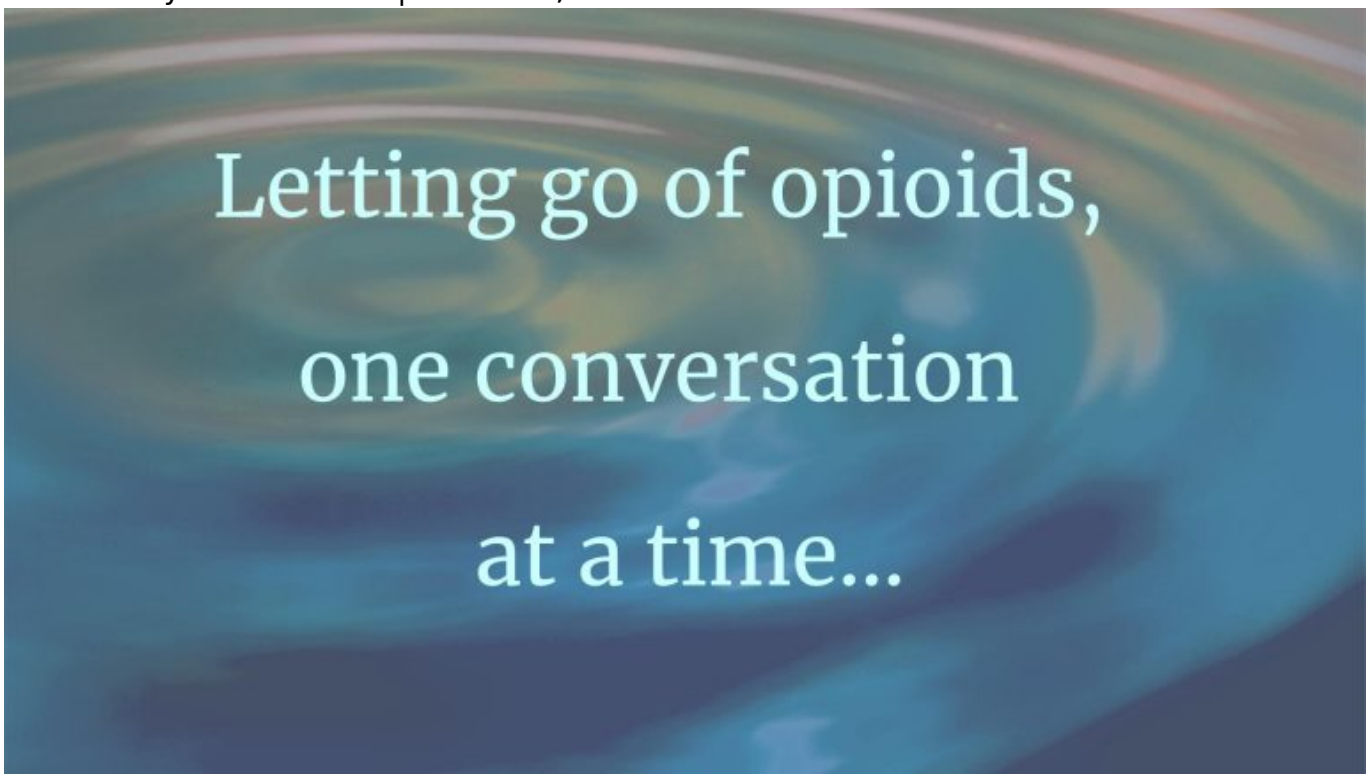

“I can’t do it—I’ll die!”

Veronica is in tears.

I’m a family physician, working in a pain-management clinic in the Bronx. As Veronica’s doctor, I’ve asked her to see me to discuss coming off her opioid medications. It’s part of a clinic-wide initiative to reassess using these medications long-term with patients who have chronic pain.

Veronica’s story resembles that of many patients. Years ago, she was in a car accident, after which she suffered persistent back pain. She consulted a doctor, who started her on opioids.

About two years ago, I inherited her as my patient. She had been taking oxycodone 10 mg three times a day for years—not a particularly high dose, but still one that could pose long-term health risks.

Of course, Veronica is much more than just a user of opioid medications: She is the fifty-something mother of five adult children. She’s also the proud owner of two dogs—and, to my delight, a turtle whom she loves to let wander around the house, and whom I ask after almost as frequently as I do her children. Despite her chronic pain, she gets exercise by taking walks around the neighborhood. She tries diligently to improve her health, which I admire in her.

On good days, she jokes with me and asks questions. On bad days, her pain is

all she can think about. The only source of even partial relief is her oxycodone.

I'm dreading this conversation.

As a pain-management physician, I'm torn by a constant inner struggle over the rights and wrongs of chronic opioid therapy. It presents a thorny dilemma.

The more we research opioid drugs, the stronger the evidence about the harmful effects of their chronic use. Besides their dangerous side effects, opioids create what is called "hyperalgesia": When a person's cells are chronically exposed to opioids, they make more opioid receptors; paradoxically, this leads to a false sensation of pain when there shouldn't be any and perpetuates the chronic-pain cycle.

I've seen this repeatedly in our clinic. About half of our patients receive an opioid prescription, yet none seem to get "better." Many require more and more opioids just to tolerate their pain—and some admit that they buy additional pain medicines on the street.

I fear that if I keep prescribing opioids for these patients, one of them will someday die of an overdose. It hasn't happened yet, but I've heard too many stories for me to be naïve.

Just as importantly, the more I work as a pain-management physician, the more I see that these medications don't just kill pain; *they change patient's personalities.* I've seen patients become volatile, withdrawn and hostile in their efforts to obtain opioids for their pain. And the media runs stories about patients who commit suicide after their opioids are "taken away."

So although I'm reluctant to prescribe these personality-altering psychiatric drugs, I've seen the statistics: I worry that if I stop prescribing opioids, the psychological ramifications might drive a patient like Veronica to suicide.

Anxiety about these patients keeps me awake at night.

It has seemed to me that, like many other well-intentioned doctors, I've become part of the problem. Instead of encouraging other, healthier coping mechanisms, I'm allowing my patients to continue the cycle. It's just not good medicine.

About two years ago, in response to concerns like these, our clinic administration decided to do as many other pain clinics are doing and start weaning our patients off opioids.

Since then, I've had conversations with dozens of patients about their opioids. It seems what they fear most is that their doctor will pull the rug out from under them and either wean them too quickly or just refuse to prescribe opioids altogether.

I've come to believe that for most patients, what's most frightening is not

the pain itself but the *fear* of potential pain—the fear of losing their sense of control over their medications, and therefore over their pain. Which brings me back to this conversation with Veronica.

Taking 10-mg pills three times a day adds up to ninety pills per month. I start by suggesting a typical tapering-down strategy:

“How would you feel about bringing that down to seventy-five pills per month?”

That works out to about a 15 percent decrease. To me, this feels appropriate: Most doctors will reduce dosage somewhere between 10-25 percent per month.

“That’s too fast!” she exclaims, panicked. “My pain will be terrible!”

“Okay, Veronica,” I say. “My suggestion was to decrease by about fifteen pills per month. But what I can do is give you the power to choose: If you like the idea of still being able to take medication three times a day, I could give you ninety pills, and decrease the dose in each pill from 10 to 7.5 mg.”

She pauses to think.

“Yes, yes, that sounds much better to me. That’s the way I want to do it.”

The second *she* gets to make the choice, I feel something shift in our conversation. She speaks more calmly, holding her head higher, and she looks me in the eye instead of down at the floor.

Let’s do the math: The second option means cutting her dose by a full 25 percent—much faster than the 15 percent that I originally offered. Ethically, she has the right to understand that.

But when I point this out, Veronica holds fast to her preference. Clearly, in her mind, the freedom to make the choice put her back in the driver’s seat. Giving her the power of choice, of control, took away the fear.

In medicine, we call this “shared decision-making.” It’s become more and more a part of medical training—the idea that although doctors know medicine, our patients know themselves, and what they need, far better than we do.

Amazingly, as Veronica stands and prepares to leave, she hugs me. Her posture is more upright, her expression brighter.

“Doc, I think I can do this.”

Postscript:

Veronica’s math was fuzzy, but her calculations about her own body were absolutely right: She has broken the pain cycle. She has now been off of opioids for several months. Her cells no longer crave them—and her pain is actually better. She plays with her grandkids in the yard. She plays with her turtle while doing back stretches on the living-room floor.

I wish I could say that every patient’s story ends as successfully. Sadly, many don’t. Initiating these conversations has strained my relationship with many of my patients. Some have even “fired” me.

I still struggle to strike a balance between controlling people’s suffering and trying to keep them safe. However, stories like Veronica’s have taught me that these conversations *can* be had—and had well—to the patient’s ultimate benefit. We *can* move forward in addressing the opioid crisis, one careful conversation at a time.