LETTER TO THE EDITOR

Pain Management – A Locum Perspective

To the Editor,

Like many of my colleagues, I started getting burnt out a couple years ago. I had a stable job, good staff and I worked for a company I respected. But there was something missing. I no longer had that spark and drive. I knew I needed to make a change. First, I cut down my hours. That helped initially, but a few months later, I needed more. So, much to the surprise of everyone (including myself), I made the decision to quit. I put my house on the market and joined the locum circuit.

My first locum job was in New Zealand. What a glorious place to have a working holiday. Though the pay wasn't ideal, work-life balance was just what I needed. Patients appreciated and respected what I had to offer, paperwork was minimal and I started feeling like the doctor I went to medical school to be. I also made some lifelong friends, traveled around New Zealand in between assignments and felt refreshed.

I moved back to the US after a year where I landed a locum job in rural America. Soon after starting, I realized that one of my primary roles was managing chronic pain patients. I'm trained in family medicine and though I have managed patients with pain my entire career, I never had a substantial pain management load. Seeing 5+ pain patients daily in addition to the more routine family medicine visits, I quickly felt overwhelmed.

So, I had to learn fast. What should I do when a patient comes in for their opioid prescription? The easy option was to prescribe them what they wanted and what they were used to. Not ask too many questions. Not get too involved in the decision making. After all, I'd be leaving in a few months. Why rock the boat?

My conscience wouldn't allow me to do this. Though there were patients that I felt were legitimately on appropriate medications, the majority were taking substantial opioid pain medication for chronic, non-cancer pain. Unfortunately, many of these patients were also on other controlled medications (recreational marijuana, benzodiazepines, sleep agents). To my surprise, they did not seem aware that combining these medications was a concern.

I embarked on an endeavor to help these patients wean down on their medications. I knew I wouldn't get patients completely off their medications in the few months I was there. But I thought if I decreased their daily intake, it would help them know that they can survive with less medication and hopefully, their next provider would have a similar philosophy.

Some patients were open to these changes. Of course, some took to a more comprehensive plan better than others. But ~50% of patients agreed to work with me and did pretty well. Many also allowed me to incorporate Osteopathic Manipulation into their regimen in an attempt to ease their pain.

Another 25% tolerated the changes made but after a month or so, wanted to go back to their previous regimen. Depending on the situation, sometimes I agreed. Other times, I offered alternatives and pushed them to continue working on decreasing their opioid burden. These interactions were tedious and took a lot of effort.

The last 25% staunchly refused to make any changes. There were threats of switching to a different doctor. I was being unfair. "Why change what is working well?" Patients said I was forcing them back to meth. They had to increase their marijuana use to compensate for me taking away their medication. "I'm calling my lawyer." Even threats of suicide. It was very emotional.

For a few patients, their medication needed to be stopped abruptly. The inconsistent urine drug screen, the patient that kept having her medication stolen, an overdose. There was one young man that crushed and injected his oxycodone, ultimately resulting in osteomyelitis of the spine. That was a tricky one. He was legitimately in pain from his spine infection. But I stood firm and required that he travel 1.5 hours to the nearest Pain Management Specialist. They wouldn't fill his medications, in part because he had marijuana in his system. The choices patients make have real consequences.

These patients were foisted on me, a conservative prescriber, for their pain management needs. As I muddled through, I gained confidence. At first, I probably gave in a little easier. But when I started seeing how some of my patients were thriving with less medication, I realized that I should follow my instincts and strive ahead, even with the resistance that was ever present.

Toward the end of my 4.5 month assignment, though few and far between, patients told me they appreciate my care. They appreciated the time I took with them, asking questions no-one had before and coming up with a comprehensive plan. I hope there are others that never got around to thanking me. I think there are.

I learned some valuable lessons about pain management. These were not lessons I wanted to learn. But I did the job I felt compelled to do and learned how to handle a diverse clientele, all in some kind of pain, but with varied agendas. I was better able to determine which patients would be open to alternatives. Which ones would follow my advice. Which ones might do just as well with non-opioid options. Who would be open to OMT. I learned pain management isn't quite as daunting as it had seemed at first.

As a locum, I don't have the luxury of continuity. I don't know if the next provider will have the same philosophy as me. She might agree with some patients and put them right back on the medications they were on before. But I trust she will appreciate my efforts. I've learned that it's OK to be uncomfortable with overmedicated patients while advocating for non-addictive and ultimately safer options. In light of the opioid crisis we find ourselves in, I challenge the next provider to continue bringing healthy balance into the lives of these patients. They deserve it.

Katrine Bengaard, DO
Family Physician
Kotzebue, Alaska