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VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Welcome back to Central Line. I'm Adam Striker, your editor and host. We're joined today by Dr. Dave Dickerson, Vice-Chair of ASA's Pain Committee, Clinical Associate Professor at University of Chicago and Section Chief of Pain Medicine at NorthShore Health Systems. Dr. Dickerson. Welcome.

DR. DAVID DICKERSON:

Thanks for having me, Dr. Striker.

DR. STRIKER:

Well, as you know, September is Pain Awareness Month and we're pleased you could join us, uh, to talk about pain management and somewhat how it relates to the current pandemic and let's start there. How has the COVID-19 pandemic impacted the practice of pain management?

DR. DICKERSON:

Well, all of our lives have become significantly more complex and pain care has always been traditionally complex as well. It's really a complexity that's amplified, uh, due to the new rules of engagement that our patients and our clinical groups have to really acknowledge, uh, and implement to make sure that patients are safe as, as they seek their comfort from us. Pain is pretty complex as well in and of itself, it's typically, requires an individualized approach and, uh, it's a very bio psychosocial phenomenon with, you know, requiring sometimes multiple touch points of treatment, multiple therapies, often times not delivered by the same clinical group. Um, and then the

overlay of, of stress, uh, in our communities right now on top of, of this, uh, has also further contributed to, to the challenge at hand.

DR. STRIKER:

Well, let's single out this stress topic. Because we're all under stress with the current pandemic everything that's going on, but specifically as it relates to pain, can you talk a little bit about the relationship between stress and pain?

DR. DICKERSON:

So we experience pain in, in many parts of our brain including our limbic system, where are memories and emotions are stored and processed. So changes in limbic function, uh, can impact how we're going to experience pain in, in a given moment or, or, over a lifetime. That's why stress reduction techniques are, are very powerful and effective. That's also why increases in stress can lead to an increased pain experience. Um, and pain, remember, cannot only, isn't just like the feeling of a hot poker, but it can also be our feelings, um, so it can, has an emotional layer, and that's really that, that limbic system component.

Anecdotally speaking, we are seeing flare-ups as people are undergoing the stresses of, of all of our changes in our lives and we're seeing patients, perhaps experiencing more pain than they were at baseline. And that's probably multifactorial, but it, it's really an overlay that we have to be conscientious of. And while those of us in this specialty recognize pain as a, a bio psychosocial disease or psychosocial biologic disease, the psychosocial ramifications of a pandemic are definitely, um, creating this interesting challenge and intersection for us as our patients are coming to us with new symptoms or exacerbation or even failure to respond to their current treatments.

DR. STRIKER:

Well, how have practices adjusted? I'm mainly focused on what creative solutions have physicians and other providers come up with to ensure that, uh, pain patients are getting appropriate care through this crisis?

DR. DICKERSON:

So, I think our advances really are honed in on both the efficacy of our treatments which are challenged again by the ability to, to be face-to-face with our patients. But then also on the safety of our treatments and the safety of the management we may be providing in the more remote fashion. All this is also happening as we've undergone significant

staffing changes as some clinics, uh, have had to either shut down, downsize their, uh, staffing or putting people onto, onto furlough as the clinic was not able to be open. And then how you close down, reopen and, and in between, uh, continue to provide access for your patients and their needs.

Some of the creative solutions are, well the creative solutions have really been many, but um, we really have to continue to try to leverage the concept of comprehensive pain care approach because the complexity of pain has, has not changed, if, if anything, it's got worse. And so, uh, we really have to make sure that that access to care is not just uh, over phone calls or for uh, prescriptions, but also, um, actual care and reassessment. Uh, and I think that practices have adjusted in finding ways to, to really change the way we, we did business where typically it was primarily face-to-face. Uh, we've now really moved towards making sure patients can have virtual engagement with us, but really making sure that we maintain the meaningful value that patients get from, from working with us.

DR. STRIKER:

Do you think these restructured approaches benefit the patients in any way?

DR. DICKERSON:

Well, I, I think the primary restructuring we, we're seeing is really a, a massive shift towards the uh, towards these virtual engagements through, uh, telemedicine platforms and initially I think until telemedicine was, was immediately available, we were seeking out any and every way to be able to let our patients to know we were still there for them, including outreach phone calls and, and things like that just to make sure that patients knew that they weren't on their own all of a sudden, and in a, in a battle against their pain, that they really had a, a team helping them with.

Uh, telemedicine has, has really been one of the, like I said, main restructuring and it, it does have significant benefits. Uh, you know, significantly bolstering access, uh, in a time where people don't want to leave their house, uh, sicker patients who maybe are doing well and, uh, but just are at risk for, uh, viral transmission or contracting COVID, um have the ability to check in with us, let us know they're doing well, let us know about new symptoms or let us know that, that they're thinking about us, which has happened in several of these interactions.

So, there are those benefits and then also we finding that through telemedicine, we're getting access to some of our colleagues that we collaborate with, uh, for patients that maybe were, would have considered that drive too far before. And so we're actually

perhaps continuing to progress on how we scale up the assessments of our patients conditions by leveraging this increased access via telemedicine and, and that's been, that's been exciting to, uh, get to hear the opinions of our colleagues who perhaps were out of reach, uh, to these patients that now they have, they can get to because of the telemedicine platforms that we've uh, we've all worked to establish.

DR. STRIKER:

The upsides of telehealth I think are fairly apparent from what you're saying. I imagine there's a downside, too.

DR. DICKERSON:

Well, in, in, in pain care, you know, there, there really is only so much that we can do from afar, uh, especially when you consider that some of our most high impact therapies do require potentially a face-to-face interaction. Also changing a treatment plan where you're not able to have to the, the patient in front of you and able to, you know, engage with you in that personal fashion where you can conduct a physical examination to really appreciate whether or not the sensitivity to light, touch, or whatever form of nerve dysfunction you had identified last year, uh, was really, really starting to uh, abate. You have to direct patients to uh, conduct, you know, specific neuro exams, which sometimes is just not possible including important things to most of our practices like examining reflexes and, and uh, things that really are part of more neuromuscular examination.

Um, that said though, uh, it's been fun to see how patients, uh, start to take our tricks for tracking their own symptoms or the severity of their symptoms as you've shown them what you're looking for looking at (sic) signs and things like that, or some, some of the other provocative maneuvers that we're now walking them through doing, uh, through the telemedicine portal.

But the downside is also that we, we really lose some of the, I think the transfer of, of empathy and care that is hard to generate and over, over an internet connection and, and being able to be with our patients in an office sometimes as is therapeutic in and of itself. So they know another human is, is there for them and uh, sees what they're going through and is continued to, is able affirm their commitment to, to their treatment. So our ability to offset hopelessness or, or inspire our patients to, uh, continue to be motivated and, and getting through this and getting through their painful days is something that I can telehealth at, at time challenges. And then again, interventional pain, uh, medicine can be so impactful for patients on their, on their outcomes and quality of life. It's something that we've really had to sort of think about getting creative with that and, and

it may be using telehealth as a portal for us to really start to triage who, who needs to come for a face-to-face visit.

DR. STRIKER:

Many of us have heard the phrase necessity is the mother of all invention. And although this didn't invent telehealth, this situation, it certainly brought it to the forefront and, and I think accelerated a lot of healthcare organizations embracing and utilization of it. Like with anything, there's pros and cons that we just talked about on the lion's share, when it's all said and done, as we move through the COVID crisis and beyond, how do you see telehealth playing a role going forward?

DR. DICKERSON:

Well, I think it'll really continue to have a role, um, and I hope that the alignment of patients, payers and providers will continue to make that decision together and that payers will continue to, to make sure that it's, it's as supported as face-to-face encounters as long as providers are making it meaningful for patients. That access to a specialist that may not exist in a specific community can be granted with telehealth. And I think that's very important because while we talk about going and getting a second, traveling for a second opinion, some people are unable to get, actually get an adequate first opinion in their communities and telehealth creates a, a gateway for that. Um, I think it will be a continued part of our pain care delivery model and hopefully for all of our care delivery, but I think that it's, it's all about how we understand what the threshold is for escalating or pivoting into face-to-face care.

Um, I do think that, uh, we, we have to make sure that as we understand what reimbursement looks like, uh, making sure it is commensurate, because the efforts actually for telehealth in my opinion are much more significant, uh, of a burden on the physician in that uh, the open, the close, the medication reconciliation, all of the, the education where you might have handed some of that off to a, a team in the office, your MA's, your nurses, it's, it's uh, It's really all on you. And after a day of that, it's a whole it's a whole, um, different feeling. Uh, you, you the kind of leave it all out there, uh, on the field as you, as you've gone patient-to-patient in the virtual environment and maybe never left your office, uh, but really tried to make sure the patients know that you're still there for them. (Sic) again, I think you, we really have to be all in, to, to help them feel like they're getting the value of the experience. Cuz I do think the leveraging the relationship and the care relationship in pain is, is a very important part of the therapy.

DR. STRIKER:

Has this allowed for you to see patient out-of-state?

DR. DICKERSON:

Yes, so it does. I think different payers will have different restrictions as to how those networks cross state lines. But typically we we're in a tri-state area and we have patients that, um, we've solved for that for face-to-face and with telehealth, the, the same rules have applied. Uh, but it is payer specific and it's good to know that, you know, network restrictions still apply, uh, and so we try to respect those and we try to make sure that we understand, uh, what that looks like. And the nice thing is in, in a tri-state area, that's not been a problem.

But I think as we think about further and further reaches, you know, are we actually, uh, one of my family members needed a second opinion for a complex neuromuscular disorder and, uh she was able to connect, uh, with, when we were down there visiting, with a, a group of specialists, uh, multiple states away, that we knew, that I had connections to, uh to have them weigh in for a second opinion and having that personal experience, uh, you know, I, I can see myself advocating for making sure that even if you're skipping a couple states, uh, that we create some sort of pathway to get patient access when, when patients, uh, desire that, need it. And perhaps at the end of the day, it will lead to a patient's spending less, having a smaller carbon footprint to enhance their care or enhance their knowledge of their disease.

DR. STRIKER:

Yeah, and, you know, as we've used telehealth in the pre-anesthesia testing clinic, we found that it's certainly advantageous to a lot of families to not have to bring in, you know, for pediatrics certainly, but, but throughout the anesthesia the world, if you don't have to bring your family in to physically see someone beforehand and understanding that they're probably going to be plenty of situations where you have to get tests and see other specialists, but if you can filter out some of those visits that are inconveniencing to the families, we've found that it's actually, you know, quite helpful in that regard and it's been well-received on the patient side. I don't know if you've heard any feedback from your patients or colleagues in that regard, like do the patients on, on the whole see this as a helpful thing? Or do they see it really still as a hindrance because you don't have that physical connection?

DR. DICKERSON:

Yeah, I think that's what's interesting. It's like most things in, and how we deliver care. It's, it's not really one-size-fits-all and it is a, just another aspect of how we, you know,

engage in shared decision-making. And some of my patients really are committed to using telehealth whenever possible but listening when we need them to come in. And, we've, we've heard lots of positive feedback. Um, many patients, um, have expressed that the convenience factor, especially if they're in a stable care pathway and they, they're doing well, that this has been a very valuable thing for them in that they've not had to, um, find someone to cover their job because they, they're going to have a three-hour experience waiting and waiting room, seeing the physician, traveling to and from. But now they can actually, uh, check into the virtual waiting room and in about 30 minutes to 60 minutes be said and done, and still be in the same place where they need to be for their next meeting. Uh, and I think that's been, uh, one of the things we've heard from a lot, a lot of our patients is they really appreciate the convenience and that we've set this up.

And then I have other patients that they really, after a couple of telehealth visits are, are longing uh, to, you know, come back in and, and have that face-to-face visit because, uh, and some of them believe, and rightly so, that when they're with us, we may pick up on something different as we watch them walk or as we have the ability to, uh, to spend time with them in person. Um, and I think it's all about, again, trying to meet the patient where they are and figure out what it is that they need at that time. So, uh, again, one-size-fits-all probably is not the way to go. If all of my patients wanted to be telehealth right now, uh, like we had for a, a significant period of time I would say probably not for everybody would be my preference in that some people we really do need to see, see, them, track them, uh, in terms of their physical examination.

But then also create some oversight because there are a lot of behavioral aspects of pain that can be unhealthy and we might not be able to detect how our patients are doing, uh, over the virtual portal or telehealth platform. And seeing them in the office and getting to spend time with them and seeing that maybe there's a little more psychomotor agitation, maybe they don't look well, maybe they look disheveled. Uh, the ability to get ready to leave the house and be with us is a, um, aspect of daily living that maybe is a little bit less apparent, uh, when we're talking to someone sitting in their kitchen, maybe still in their pajamas, because they're at home and it is 10 in the morning and that's something I think we all enjoy sometimes.

DR. STRIKER:

Well, surely not everything has changed and there are still traditional solutions to pain management that I'm sure still being used. Do you mind talking about some of those?

DR. DICKERSON:

Absolutely, so I, I think that as a pain specialists, we've really, uh, like I said, have had to lean on the rest of our team for creative solutions. An the team can include neurologists, pain psychologists, physical therapists, and really watching what they've done to, um, continue to engage their patients and provide their therapies. Uh, so it's been, it's been great to see that some of the stress reduction, uh, tools that our patients are using that might be app based, or might be more guided through uh, a telehealth platform from those therapists has been, uh, it's been great to hear patients coming in saying that they're uh, still able to engage of those therapies. Um, as well, it's been great to see that the physical therapy groups we've been working with have been practicing with the CDC guidelines in mind for how to reduce viral transmission uh, screening their patients and then making sure that patients that are at risk, uh, perhaps have less in-person interaction.

The traditional solutions like med management, uh, you know, still highly available from us and lots of states have worked to enact a, you know, guidelines in terms of how patients that are on chronic opioid therapy can continue to, and should continue to, receive their, their treatment even through uh, virtual visits as a way to continue to maintain a therapy amount of the patient safety. Um, and so we are, we are seeing that traditional solutions are still highly accessible, uh, it's just that the way that we're creating those is really just not conventional, uh, and it's a, it's a work in progress as we see what works, uh, and as we see the viral numbers go up and down in the various regions and the, the need to move into different phases of precaution.

DR. STRIKER:

Well, let's talk a little bit about opioids given the current climate. How has COVID had an impact on opioid use and/or overdoses?

DR. DICKERSON:

So there's clearly, uh, an unfortunate phenomenon behaviorally occurring at a, from a public health standpoint right now in that what we've asked people to do to reduce viral transmission is isolate themselves and stay-at-home. Unfortunately that can be a very dangerous scenario for people who use drugs or for people have substance use disorders, and they may not have a social group within which they're, uh they're using substances and the margin for, uh, injury changes. And, and the ability to have someone there that can identify that an overdose maybe impending, uh, is, is really challenged or for someone else to say, uh, you know, I think I think something's going on here that's not very healthy for you. So that isolation really creates a significant, uh, challenge, uh, for people who perhaps are dealing with addiction issues and we've seen overdose deaths, uh, increase since the beginning of the pandemic due to what we

believe is this isolation, changes to drug supply chains, and the way that drugs are procured by people who use drugs. Um, and then we're also seeing that overtime the deaths from fentanyl and, uh, fentanyl analogues, those overdose deaths are increasing.

Um, there's many different things that are contributing to that including, when we talk about access to pain care, access to addiction treatment also has undergone similar impact and it already was challenged by the availability of those services prior to the COVID pandemic. And so we're, unfortunately seeing that, uh, opioid related injury is increased. You know, this is at a time where prior to the pandemic we were seeing opioid prescribership going down and we really have had a hard time teasing, out at this point, it seems that this is more illicit, uh, fentanyl and fentanyl analog related, uh, up uptick, and uh, we have to see the, the rates of prescribership to see whether or not opioids are perhaps being, uh, leveraged more at this time.

What we're seeing is that, in our practice, uh, patients on opioids who they are having more pain, it's a, it's a solution that they've had at home to self-manage and, um, even if they're using those responsibly with the stress overlay and the lack of access to the other treatments that have helped them like going in a warm pool, or making it to their physical therapy appointments, or getting massages, without those tools, they're having less tools in the toolbox. And the opioids are still there for them if that is a part of their regiment. And so we've seen patients asking for um, increases in the, the strength or the number of tablets that they could take of an opioid that they've been taking, and we've been really conscious and conscientious as a pain group to not let opioids become a crutch at this time because the risks of opioid therapy, and that risk benefit ratio really hasn't changed. Um, unfortunately, the access to other kinds of care have changed, and we, like I said, have to be creative and make sure we're not heading backwards or over leveraging, uh, higher risk treatments.

DR. STRIKER:

That's such a unique challenge to you and your colleagues that manage chronic pain having to tow that line with opioids. It's a valuable tool. But, but obviously a tool that can be easily misused and in this situation as you pointed out some of the other therapies may not be available to some of your patients and trying to parse out which patients may need more and which may be less. I have to, it just seems like a daunting task. Is that true?

DR. DICKERSON:

Yeah, so I think that that's the whole idea, and that's, you know, we sort of started talking about the individualized patient experienced and their assessments are individualized, and so we can still use our screening tools to look, look at how patients are utilizing these therapies. And we, and these are validated tools that allow us to, uh, really assess whether not a patient's risk of misuse has increased in this time. And so using those tools, even if over, over a virtual consultation and tracking those can be very helpful to understand whether or not maybe there's something else going on. Um, and oftentimes, there's a lot of reasons for people to feel sad or angry or frustrated right now and that intersects with how people are able to self soothe, or uh, feel pain relief or engage in a treatment plan, be motivated.

Uh, and so those screening tools are helpful that also using screening tools that uh, really start to ask is there a mood disorder that's beginning to develop for this patient? Uh, and we should all be worrying about possible major depressive disorder or even an adjustment disorder to changes in livelihood from, uh, the way the economy has shifted in in terms of changes in workforce and, and employment, uh, and the way that even just the way that the government has offset some of that and how that's been a dynamic landscape. We really should worry about untreated depression and how that can make patients more treatment refractory, especially since patients with chronic pain have the higher risk of depression and anxiety. And so screening these patients with not only risk tools for are they using their opioids appropriately, or misusing potentially, um, but also uh, screening them for depression, which maybe is not a standard part of the common pain practice, uh, but it is something that is widely available and validated and may be a highly influential intervention in someone's morbidity and mortality.

Um, so it's been interesting to, really again, move into the watching the psychosocial, watching patients change in terms of, uh, their behavior in this time. And, and I know that as providers we're seeing some of those changes in ourselves as we take on more and more stress and, and try to adapt to the new normal which, uh, seems every months to be, um, different than the last name normal.

DR. STRIKER:

Well, let's talk about challenges. What are the main problems patients and physicians are coping with in regard to pain management right now?

DR. DICKERSON:

So I think we have a couple areas of, of cognitive dissonance that we're, we're trying to settle out here uh, or, or just conflicts of goals. But, uh, as anesthesiologists that's, that's what we do. We're, we're usually faced with having to pick the lesser of two, uh, issues

and, and then, uh, monitoring to see whether or not that was that was the right choice. Uh, so I think that we see that in a couple domains. One, asking patients to leave their house, uh, risking exposure using PPE, uh, to protect ourselves and to protect patients and their families, to be able to deliver interventional pain care. Um, we really have to understand that that's not a risk-free approach but it really calls into question are we offering a high-impact therapy? Um, patients who've been on chronic treatment plans that have been responders in terms of reduction in disability and pain with our interventions, those patients are established as being responders and should perhaps have access and I think you have a margin of benefit there.

But patients who are exploring new therapies, we really have to look at the evidence in supporting those. And being able to recognize that, uh, there is treatment failure with everything that we do, but the likelihood of treatment success and improving someone's ADLs is something that we have to balance. Activities of daily living, or, or they're reducing their disability is something we really have to, have to think about.

And then maybe even thinking about different therapeutics have different risk benefit margins in regards to maybe even reducing susceptibility to COVID transmission, uh, in certain patient populations. So the use of steroids which can be immunosuppressive, uh, there's been a lot of cognitive dissonance there in that I've had patients sending me articles about, uh, thanking me for giving them a dexamethasone injection because they just read the World Health Organization is promoting dexamethasone as being a treatment for, uh, COVID-19. And so there's interesting overlaps here where the, the drugs are the same but the clinical indication in context is, is perhaps not. Um, but to patients, um, telling them that a steroid dose might be bad for them when that's being promoted for the treatment of COVID is another area of cognitive dissonance that we have to work through and perhaps leverage evidence that's not directly related to this virus or the injection you're going to do, but talking about immunosuppression and steroids. And that's a part of an informed consent discussion that we have with many of our patients.

When I, when I think about the need to provide these treatments interventionally, it really does come down to, again, an individualized assessment but asking also, uh, what's the impact of this treatment and also, is it a treatment that could, that I'm offering, that might make it so this patient has no need to come see me in person for several months or maybe even till next year? And that then has a whole other layer of benefit that we, um, that we should be contemplating as we think about the risks of, of face-to-face care.

DR. STRIKER:

You know, I hadn't thought about that before you're saying that could be a disadvantage too. You don't want to withhold treatment, but do you weigh those risks benefits if you say alright, I'm going to administer an interventional treatment to a patient. They may not come back, but I'm actually worried about this patient not coming back for a significant period of time. And if I do this, I may be putting him at risk for other coexisting diseases that we just discussed.

DR. DICKERSON:

Yeah, so I think that's, that actually opens up a whole discussion of proactive engagement post-procedure. It's like doing preoperative nerve blocks and going to the break room and, and telling everyone that your blocks work a hundred percent of time and everyone uh, laughs because they know you've never gone to the PACU. Um, it's all about how you actually follow your outcomes. And it's a, it's a broad discussion of, of that awareness and recognizing that when you're doing interventional pain care a, a patient might go away for a year for many different reasons and what's your level of engagement with that patient during or not during a pandemic to find out, uh, did what you did help them, and what is their total health, uh, 3, 6 and 12 months after that?

Uh, and then, yet, I think that you can create a framework for, for, uh, that vigilance of care, um, and, or you could just assume that every intervention you've ever done for every patient that never showed up again, is that they got better, which I am, uh, highly confident, that's not the case.

DR. STRIKER:

Well, how do we balance the risks so we can change people's lives for the better while keeping them safe?

DR. DICKERSON:

Well, the good news about most of the treatments, if not all of them that we provide, with the exception of maybe intrathecal pump placement, uh, is that most of the care we provide doesn't require hospitalization and it's typically a, a, brief care episode that's often, if not always, ambulatory. Uh, most of our treatments have minimal if any complications, uh, and even our most invasive are, are still low risk procedures. Um, and I do think that these are things that, uh, coupled with COVID screening for patients coming in, do create a balanced approach to being able to get some of these game-changing therapies to patients.

There's also the risks of not treating the pain, uh, as well and, and, and sort of continue to manage in maybe a more remote or conservative fashion, and that's the path to go down but asking at what threshold do you escalate and share some of the tools that, that you have that you spent a career, uh, learning, uh, post training, uh, as well as in, in your in your fellowships. And so there's really an ethical conversation here of, of deciding whether or not to provide these treatments and we have to ask ourselves. I think the idea of the central pain care, uh, and talking about threats to life and limb, uh, which is a question we've all been asked across procedural medicine arenas during the pandemic the idea of putting a time as to when people will be at risk is, is a real challenge cuz it's different for everybody.

But the only thing about the risks of despair related injury or, um, self-harm from persistent untreated pain, I would say that our position as pain specialists and advocates should be that pain care is as essential as the treatment of mood disorders during this time. And we need to mobilize all of our efforts and again in a balanced ethical approach give people access and be willing to advocate that patients have access to that even during a shutdown if we're noticing certain facets of that patient's pain im, impacting a certain facets of their life. And that's something that really requires ongoing engagement, especially if the patient says, you know what, I hear your recommendation, but I'm really concerned about coming in right now. And then the next time you talk to them two weeks later or four weeks later, their mood is worse and they have self-harm feelings at that point. Uh, at that point, the question is, is it time for an intervention? Probably not. You might have now moved into a space where you need to be leveraging a whole different set of treatments. And if you had perhaps been able to work with the patient to find a safe way to deliver that care of pain was really, uh, one of the determinants in li, in causing their disability and they're low quality of life, uh, an opportunity may have been lost there and now you're pivoting for managing the mood disorder and managing perhaps suicidal ideation, whereas the threshold for pain management was earlier.

So I do think it's, it's an interesting ethical consideration and I think that everyone in this field really needs to be thinking about how we advocate for patients and, and recognize that uncontrolled pain is uh, something that can, can lead to, uh, significant mortality.

DR. STRIKER:

Well, let's, um, stay on that a little bit, at the importance of patients getting access to this care. How has insurance coverage changed, if at all, and um, and does it vary by system or carrier?

DR. DICKERSON:

What we've noticed we are really facing a continued even pre-pandemic, you know since 2016 CDC guidelines, that have really identified the, the lack of evidence for chronic opioid therapy and, and while establishing the significant risks. We're seeing that the partnership of our insurance providers has unfortunately moved in a, in a separate direction that seems to be driven more towards cost savings, and the ASA, the AMA, uh, AAPM, many organizations have come together to really make sure we're leveraging an evidence basis and support of comprehensive pain care including interventional treatments.

Uh, and we're seeing the access to care be really driven by, uh, cost decision by some of the payers and, and some policies continue to not provide access for their beneficiaries, some private insurances, to things that have Level 1 evidence supporting their role in the treatment of complex treatment-refractory pain syndromes. And having done dozens of peer-to-peers, uh, in the last month during the pandemic where we've identified treatments that have a high likelihood of success for patients and being told by other physicians in peer-to-peers that the policy just does not provide coverage for that treatment for this patient despite the fact that they are opioid dependent or the fact that they have risks of, uh, that keep them from being able to be on other therapies, uh, is really unfortunate and it is a major focus for advocates as well as the ASA Pain Committee. And we really are going to be pushing to establish additional oversight of the companies that feel that that's a care decision that they want to make, uh, because we feel it is putting patients at risk and it's also a perhaps a expression of, of bad faith.

So we really need our patient partners to also advocate for continued expansion of non-opioid therapies and interventional treatments, especially ones that have an evidence-basis for them, and while the evidence basis may not be Level I for some of these treatments, we may have retrospective studies, K Series, that's more than we have for opioid therapy which continues to be covered by almost all insurers despite the opioid epidemic.

And so it's very disheartening that here with the pandemic and with the need to deliver high-impact treatment in a timely fashion, there is still an indirect over-leveraging or suggestion that because opioids are cheap, they still remain in the algorithm while some of these other treatments uh, are, um, not available to patients who would benefit.

DR. STRIKER:

Unfortunately, this is a, a battle that we've all fought for a long time and it probably, unfortunately, is going to continue for some time. But are, is there anything that any anesthesiologists that are listening can, can do today to help in that regard with chronic pain management?

DR. DICKERSON:

Absolutely. So, so I think that working with your state, uh, association or organization is incredibly important as many of these policies are, are driven at a state level. Um, working with, uh, your representatives, uh, to the House and Senate to share with them individual stories in which, uh, even things like arduous pre-authorization processes are slowing down patients' ability to get these the, this care, is incredibly important. These issues are connected into the opioid epidemic in the ongoing opioid overdose epidemic and it is something that without our bringing that to the attention of, of these folks is, is not going to help.

The other aspect connect with, uh, the ASA's, uh, Washington office through the Pain Committee. If you do see something that's related to a practice that is, uh, perhaps not patient-centered or doesn't promote the best evidence and Pain Care, uh, we really want to engage with individuals seeing this happening and again, like I said, create oversight and let those, uh, let our partners in the insurance industry know that, uh, we will hold them to a standard that permits access to safe and effective pain care.

DR. STRIKER:

Well stated. And it's nice to know, you know, we're all trying the amidst of all the issues going on, especially this year. You know, we're all trying to figure out how do we, how can we help such big issues? But what you just laid out are some really nice specific targets to focus on for, for many of us within the field that a lot of us who have expertise on and can weigh in on with our, with our local representatives and our society. So, so I think it's, it's important to, to remember that there are little battles we can win even though you're in this sea of chaos, if you will.

DR. DICKERSON:

Absolutely. I think that often times, what we notice is something that we don't think is right because we're clinicians and it, it might be more of a personal encounter with how pain care is being provided or denied. And it might not even be related to uh, uh, something we've seen in our own clinical practice but is coming, uh, at a very personal level and when we have, you know, 76 million Americans with some sort of daily pain of significance that impacts their activity, that might be where we're going to encounter this more so than, uh, as we deliver, uh, anesthesia care. Uh, and so recognizing that, taking a little bit of extra time to document what happened in terms of a denial of care or in, in terms of the even a gap in in how care is being delivered by a, by a system or group, we all can grow together and it's not just a insurance company area that needs to improve.

Improvement really is something that, um, we all should be engaged in and interestingly enough, we are more likely to, to see it or just a likely to see it on a personal level with friends and family, uh, in these times. And it's probably good that we, uh, we apply our insight and judgment there as well. And then, uh, and then lean into our, our ability to advocate with a such a powerful organization like, like ASA and, and it is really impressive to see the lead that this organization has taken, uh, consistently to bring other groups together and leverage a, a very strong voice in, in terms of making sure pain care is becoming better and better with each year.

DR. STRIKER:

No, absolutely. Well let's end this on, on a bit of a bright note. Tell us what's exciting in pain management right now?

DR. DICKERSON:

So I think that we're seeing a entry into the field of some of the most talented residents, uh, in their classes going into pain medicine. It's, is a self-selecting field that may drive some people away and into other areas of, of anesthesia sub-specialization, but we are seeing a ongoing uptick in just excellence in terms of the fellows that are coming in and, and want to become pain specialists. I think that's a reflection of their recognizing it's a challenging field that can be hard, uh, but rewarding and that it really does lead itself to lifelong learning. So that's in, incredibly exciting is to see the future in the field is really being built on a talented, exceptional group.

Additionally, I think those individuals as well as all of us who've been practicing are incredibly motivated by the treatments that are emerging that we have available cuz we can, in my opinion, provide people with quality of life that didn't have before and, and with a rate that perhaps we weren't able to employ before in that a lot of the therapies that we've had for several decades have continued to advance and develop into treatments that are less and less invasive, more and more effective, and with, uh, with a safety margin that really makes it much more palatable for patients to even consider these treatments. That, that really applies to some very specific therapies, and in a time like a pandemic where you want to limit the number of treatments you, or the visits you might have with a patient, that safety and efficacy allows us to perhaps push the envelope in a way to give patients something that allows them to, on a personal level, live through these moments, uh, in a way that they, they might not have been able to without our care.

Uh, specifically, you know, some of the treatments that just are so exciting for me, are, are the ability to treat spinal stenosis and mechanical compression of the canal's

contents that results in pain with, with standing and walking, and to be able to do that in a 20 to 30 minute procedure that uh, under image guidance either bolsters, uh, a segment that has had degeneration and creates more space with a, a tiny spacer, that's, that's placed uh, just under a small incision with image guidance, or by removing through a tiny tube little pieces of ligament that might be encroaching onto the canal.

And with both of these procedures having Level 1 evidence, an option that doesn't require steroids, uh, and also, uh, doesn't require hospital admission, has minimal restrictions afterwards, uh, these are really great options that, uh, really unlike an open spine surgery that might require admission or a hospital stay, really perhaps have a role, uh, during a pandemic for effectively treating patients with a high rate of success and, and nice margin of safety, uh, with both of those treatments having very low, complication risks.

Effectively, the ability to give people that function it, it's really powerful and it, and it comes at a time too where anesthesiologists are entering into a space of becoming so much more, you know, just on the covers of, of major magazines honoring the work that we're doing in intensive care units and, uh, emergency departments and operating rooms, uh, managing, uh, the complex physiology and pathophysiology of COVID infections, or just managing other routine care in the area of this epidemic, it's amazing to see the, the many areas that we're impacting our population's health.

Uh, and the way that patients are expressing their gratitude for that as we meet them in telemedicine visits and they check in to see how we're doing, I think is a reflection of a partnership between our specialty and our communities that is, uh, perhaps reaching a pinnacle, uh, and it's exciting to be there especially when those things give us strength as we keep trying to, uh, go on in our own ways, with our own families trying to, uh, get through these very interesting times.

DR. STRIKER:

Absolutely. Well said. Let's leave it there. Uh, Dr. Dickerson, thank you so much for joining us and for this insightful conversation. And hopefully we've been able to highlight, uh, the importance of pain management, but particularly chronic pain management, and this role that anesthesiologists play, and so thanks again for joining us.

DR. DICKERSON:

Thank you very much.

DR. STRIKER:

Well, this is Adam Striker, thanking everyone for joining us on another episode of Central Line. Please join us again next time. Thanks.

(MUSIC)

VOICEOVER:

September is Pain Awareness Month. Unfortunately, pain is the most common cause of disability in the US today. Pain personally affects one in three people and causes more disability than cancer and heart disease combined. Untreated pain can be even more debilitating during times such as the COVID-19 pandemic. If you have patients with pain that won't go away help, them find relief with the tips found at asahq.org/pain.

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