

PROBLEM *Solving*

James Patrick Murphy, MD



As a physician, one of my greatest joys is when I meet a new patient. To become so trusted by someone that they would share their most intimate thoughts and fears is a profound privilege. My routine is that I welcome, ask questions, listen, examine, review data, assess, and then engage in problem solving. But, sometimes my patients' problems are too difficult for me to solve. Last week, my new patient broke down in front of me, because I had unmasked his vulnerability and, in doing so, I had unmasked my own.

I'm an experienced pain medicine specialist. I pride myself on being open to a wide array of *multimodal* therapies. I am also an addiction medicine specialist, so I strive to be adept at assessing patients and prescribing medications including opioids, rationally, appropriately and safely. My new patient, "John" (not his real name, and the details have been edited to preserve privacy), was in his 40s, married with children, and had a full-time factory job with benefits.

He had chronic pain from a serious injury 15 years ago. He also had a secret. He went to a methadone clinic.

Understandably, this made me think John was in treatment for an opioid addiction. But that was not the case. John had chronic severe pain that was treated, somewhat, by his daily dose of methadone. About 10 years ago, John had stormed out of his doctor's office because he felt the endless drug screens, prescribing contracts and pill counts required by his doctor were insulting. After all, John had never abused drugs. All he did was get himself injured on the job and then sought legitimate medical care. But by cutting ties with his doctor, John had also cut off his supply of the medication that allowed him to function.

In desperation, John started going to a methadone clinic, thinking it would be temporary until he could find another doctor to take over prescribing his pain medicine. But something happened. Due to the hype surrounding the "opioid crisis," the legal pendulum began to swing away from the legitimacy of chronic opioid therapy for pain. Laws were passed. Doctors were arrested. Clinics were

closed. And many prescribers became terrified of treating pain with opioids. As a result, patients like John were left with few options. In other words, John was trapped. In his case, this captivity had gone on for over 10 years.

But his independence day had come. John found his way to my office. After about 45 minutes of evaluation, I gave him the good news: he was not addicted after all. John was not craving or compulsively using or overusing his medications. John was using the methadone he received in two-week supplies to treat his pain. He did not have a primary, chronic disease of brain reward, motivation, memory and related circuitry. In reality, he had developed *physical dependence* on methadone, as would anyone who had taken opioids for more than a few years, regardless of the reason.

Better yet, John didn't have to go to the methadone clinic any longer. He could come to see me and be prescribed methadone pills that are strictly for pain, instead of the little bottles of liquid methadone issued to him every two weeks from the clinic. Oh happy day! This was great news!

So why did John begin to tremble and tear up when I told him?

John declined my offer to take over his methadone, even though it would be covered by his insurance and dispensed in monthly supplies from a pharmacy of his choice convenient to where he lives. He thanked me for the news, and he agreed that he was not addicted. But he looked deflated, defeated.

He told me he couldn't risk it. It had taken him years to jump through the hoops at the methadone clinic - the daily visits that eventually became weekly and then monthly, the requisite number of "clean drug screens," the mandatory counseling sessions, and finally earning the privilege of actually taking home two-week supplies of the liquid medication. John's life had become manageable, even if it was in captivity.


John did not take me up on my offer because he was satisfied with being labeled an "addict" in order to get some measure of effective pain relief. He turned me down because he could not accept the risk that I might not be able to prescribe for him chronically. He could not risk that I would eventually be closed down or that I might stop treating pain. He could not risk having to start all over at the methadone clinic with daily visits. His job, his lifeblood, his ability to provide for his family, might not survive another reboot at the methadone clinic.

So, instead of a new beginning, potentially better pain relief and successful tapering of methadone, I gave John the steroid injection he had come to me for in the first place. That does not change the fact that transitioning his medication management to my care was entirely appropriate. John does not belong in a methadone clinic. He is not an addict. But he is a prisoner.

Later that evening, during a phone conversation with my colleague, Dr. Wayne Tuckson, I vented my frustration about this suffering patient, who had come to me seeking comfort, but left my office probably more despondent. I certainly hadn't solved his problem. And as I told Wayne the story, I began to realize that my patient and I had more in common than I originally thought.

I had called Wayne trying to garner a unified response to help patients suddenly left without pain care, through no fault of their own, due to DEA raids on their pain clinics - a growing unintended consequence to our current response-to-the-opioid-crisis world. And as I talked with Wayne, I began to see reflected in my own patient's dilemma, the precarious footing upon which I also stood. I could not solve my patient's problem, because my patient was not confident I could solve my own.

He could not be sure that my practice, my profession, my life's calling, would survive in the wake of the pendulum's swing. In the end, my patient chose the safe harbor of his fraudulent methadone clinic over my offer of legitimate pain care, albeit on turbulent seas.

That experience with my new patient, no less a privilege despite the foreboding outcome, has left me thinking, "Where will I find a safe harbor?" 

James Patrick Murphy, MD specializes in Pain Medicine and Addiction Medicine, is a past-president of the Greater Louisville Medical Society, and is president-elect of the Kentucky Society of Addiction Medicine.




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