Nation’s leading pain specialist visits CHC

By Scott Whipple, special correspondent

Bennet Davis M.D. was in Middletown recently to meet with Community Health Center and its Weitzman Institute. Medical Director of Project ECHO Pain, Dr. Davis and his colleagues founded the Integrative Pain Center of Arizona (IPCAZ) in 2002. Dr. Davis, board-certified in anesthesiology and pain medicine, holds an appointment as adjunct associate professor at the University of Arizona College of Pharmacy in Tucson. As its Pain Fellowship Director, he trains family practice residents and primary care physicians.

Dr. Davis did his undergraduate work at Stanford University, and received his medical degree from Case Western Reserve University. He trained in Orthopedic Surgery and Anesthesiology at the University of New Mexico and University of California, Irvine and did his fellowship year in Manchester, England after finishing residency training.

Before he was recruited to run the University of Arizona Pain Institute in 1995, he practiced pain medicine at U of C, Irvine.

His special interest is in pain associated with spinal conditions and nerve injury. His comprehensive review of best practices for evaluating and treating pain in a primary care practice appeared in a recent issue of Practical Pain Management.

During his visit to CHC, Dr. Davis talked about addressing the current opioid epidemic. He also discussed the positive impact Project ECHO Pain training is having on primary care providers. What follows is an edited version of our conversation with him.

What inspired you to found the Integrated Pain Center of Arizona?

During my fellowship year in England I discovered that British Public Healthcare had a system of care that integrated behavioral and medical; it worked quite well. The outcomes seemed better than anything I had seen in the States. So, I thought: why not start something like that here?

What were the initial steps in starting the pain center?

In 1995, my colleagues and I were looking for ways for all medical departments at the pain institute to work together. So, we did a healthcare, consumer-focused-based research project over the next two years. We wanted to find out what the community wanted in a health clinic, and in particular, the problem of pain. Focus groups included patients, healthcare providers and employers locally and nationally, the payers--the government and private sectors. It also included the regulators --the board of nursing and so on. We asked them: what it would look like?

And their answer...

They described the British healthcare system I had observed--an integrated system of behavioral and medical health-- where there is a seamless flow back and forth of information.

What sets IPCAZ apart from other pain centers?

For one thing, we have a health psychologist in the office. We have regular meetings to discuss patients. You don't find that in other specialty care clinics. The patient gets what we think he needs.

Is that what is called "care coordination?"

Correct. We make sure, for example, that the physical therapist doesn't start therapy before the new pain is controlled. The focus is always on the patient.

Can you expand on what you mean by "patient focus?"

Questions we ask primary care providers in our teaching program are, "Tell us what a day in your patient's life is like." Also: "Do you know what the source of your patient's income is?" That's relevant if you're prescribing medicine that you know has street value. If the patient has major debts you can be pretty sure some of that medicine will end up being sold in the streets.

In Project ECHO Pain Training you stress that it's time for primary healthcare providers to change their approach to treatment? Can you explain?

Sure. Providers should be asking, "What is the right dose for the patient?" not "What do you want to give the patient?" Or, maybe it's in the patient's best interest to bring her in every month rather than see her every three months. This may sound simple, but it's not. Convincing providers to change their language is the first step in getting them to think what's right for the patient, rather than what's right for the provider.

I understand you do a lot of clinical research. What's your major area?

The big thrust of our research is what works for elevating the bar for primary care--we need a well-functioning primary care system. We do this research in partnership with the Weitzman Institute.

Zoning in on our discussion of pain: Why has the opioid crisis has become severe in the U.S.?

Two reasons. The number of milligrams of opioid measured in terms of an equivalent dose of morphine prescribed went up 800 percent in the last ten years. So, you'd expect an 800 percent rise in complications. Part of this rise reflects this increased use. The other part is that many healthcare providers don't understand their patients and their pain; so, they prescribe a lot of opioids thinking they are treating pain when they are really prescribing psychotropic medications.

So, pain patients have been taking anti-anxiety, anti-depressant opioids?

Correct. Care providers and pain specialists didn't perceive that. They have been functioning as mental health providers, not knowing that they were. You can imagine how chaotic and dangerous this can be. You think you're treating chronic pain with opioids when the patient is really coming to you complaining he can't sleep or has fatigue.

How do you explain this "misdiagnosis?"

A narrative that is becoming clear is that a lot of childhood abuse and trauma--adult and psychological--leads to changes in the patient. Providers were treating pain with opioids. Now that patient "population" is not terribly reliable. [These patients] can be unstable and likely to take other medications to shut down their discomfort and anxiety.

So, this can lead to overdose?

Yes. A lot of these patients don't keep track of their medicine. If they have kids, their opioids may get stolen by their children who take them or sell them. So, many of these people wind up in the E.R. [emergency room] and their lives end in tragedy.

It sounds like you're saying the right drug is being prescribed for the wrong people?

In most of our primary care training sessions the patients presented are mental health patients, presented as if they are pain patients. Providers need to back off prescribing [opioids] to make it safe.

What drives this decision to prescribe opioids? First of all, the term "pain management" has been coined by the opioid pharmaceutical industry so more of their drugs can get out. I suggest we eliminate the term "pain management" from our vocabulary because that perpetuates the problem.

What would you substitute for the term?

"Pain medicine."

Summing up, what is your advice for the primary care provider and the treatment of pain?

He needs to know enough about pain treatment so it's being done right--what can be done in his office and what needs to be outsourced. Some of his patients may not be doing well because the real drivers are psychological and unaddressed. These patients run their risk of ending up in the E.R. from taking a bunch of different medicines.

So, the solution is?

(chuckles) This primary care provider needs to enter the Project ECHO Pain program.

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