Understanding Your Patient

This is the second in a series of articles about Cognitive Behavioral Therapy (CBT) for chronic pain. Why should one learn more about CBT? This is an evidence-based intervention any physician can use during short office visits after a little investment in self-study or a course to learn the basics of this technique. Jonathan Borkum PhD of Waterville, Maine, is the author of Chronic Headaches: Biology, Psychology and Behavioral Treatment. He presents for us common CBT concepts from his 25-year experience in treating chronic pain.

Automatic thoughts fall into certain categories. Catastrophizing involves anxious appraisals of the pain (extreme overestimation of its threat value) and of one’s own coping resources (feeling helpless and overwhelmed), leading to prolonged attention to the pain (rumination). It is especially important because it predicts a downward spiral of pain, depression, and disability, and the future development of chronic pain in people who are initially pain-free.

In contrast, fearful beliefs about pain are more specific. They can lead to self-limiting activity, interfere with successful rehabilitation, and should be suspected in cases of excessive disability. In the laboratory, fear of pain has a priming quality: It amplifies the experience of a subsequent noxious input.

Sometimes the fear turns out to be one of losing mobility, or that a worsening course of pain will continue indefinitely, culminating in pain that is unendurable. There may be an unfounded sense that one is fragile to further injury – for example, that certain movements will herniate a disk or sever one’s spine. Or the issue may be as simple as a misunderstanding of the diagnosis. One patient learned from her MRI report, for example, that her “neural foramina are patent.” For over a year she had been too frightened to inquire about what she assumed was a dire finding.

Depression is a frequent reaction to pain that in turn increases the probability of onset, chronicity, and increasing frequency of pain. Depression may impair the endorphin system, contribute to spreading allodynia, and lower the success rate of lumbar surgery, medial branch nerve blocks, opiate medications, and possibly spinal cord stimulation. Its hallmark cognitive distortions include profound pessimism, irrational guilt, self-blame, and the belief that the pain is a just punishment. Mood-congruent recall, the ability to recall only prior negative events, may strengthen the depression in a self-fulfilling manner.

Also frequent is anger. Two causes seem particularly common: the psychological injury to one’s self-worth, and the psychosocial injury of economic or physical insecurity. A sense of injustice in how the pain came about can compound both of these, and make acceptance of the pain feel like a defeat. Perceived injustice – the sense that an injury is severe, irreparable, someone else’s fault, and unjust – predicts ongoing disability and treatment failure. It is hard to accept an injury and move on when it should never have happened in the first place. Acknowledging these beliefs, and the personal cost of anger, may be the turning point to a successful recovery.

More generally, depressing or angry thoughts about pain, in which the pain is relevant by virtue of being embedded in a network of associations – generate more pain-distress than nonspecific negative mood. For in real life, pain exists in context, for example, frustration over lax safety at the workplace, carelessness by the other driver in a motor vehicle accident, disappointment over previous failed treatments, or as existential punishment. Understanding the narrative, the schema, in which the pain is embedded can allow us to discern the emotional meanings that may be stabilizing a pain focus.

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We should also be aware of emotional reactions to concurrent stressors. Moreover, chronic pain itself is highly stressful, as a noxious physical stimulus, as a loss of physical capacity, social role, and economic security, and as a gateway to frustrating interactions with the legal, disability, and insurance systems. Especially important are shame, such as from losing one’s career or business, and recent losses, which can intensify the affective dimension of pain to a seemingly intolerable level. In these cases, distress may be extreme, and one should be alert to the risk of suicide.

Not uncommonly, a patient will note that a fair amount of their pain is self-inflicted through flare-ups from over-activity. Behind this may be guilt at seeing family members work, frustration and a desire to battle the pain, or a concern that moderation will lead to complete inactivity. Situational stresses that compel activity, a manic or hypomanic state, anxiety, or Type A personality are also potential contributors.

A patient’s thoughts can also contribute to their functional recovery. Particularly important are:

Acceptance — the moment-to-moment willingness to experience the pain as it is, without attempting to suppress it, and while continuing to pursue one’s goals and values. Acceptance is not a goal in itself, but a way of pursuing a full, meaningful life. This often arises from realizing the high cost of giving energy to the pain.

Values orientation — the deep personal commitments that are more important than the pain. This knowledge often arises from understanding the patient’s functioning prior to their pain — why they chose a particular career, for example — as well as major life events that may have crystallized their values.

Self-Efficacy — The opposite of catastrophic thinking, self-efficacy is a trust in one’s capacity to achieve one’s life goals in spite of pain.

By learning the characteristic patterns of thought and teaching our patients to look out for them, the session takes on a whole new meaning.

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The 126th Legislature has passed a number of bills that will affect physicians and physician assistants. The new laws which directly affect you through the board are summarized below. There are other laws which may affect you or your practice which are not summarized here. Detailed interpretation of each law is yet to be completed. You may wish to consult an attorney when the official language is available as a Session Law or Resolve. These laws and Resolves will become effective approximately September 19 – 90 days after the end of the regular session. As this list goes to press some of these bills could yet be vetoed. If you have further questions, feel free to contact the Board’s Executive Director, Randal Manning, at randal.c.manning@maine.gov or (207) 287-3605. Full information about the bills and their status can be accessed at www.mainelegislature.org

LD 148: An Act to Amend the Laws Governing Drugs and Vaccines Administered by Pharmacists. This new law specifies the certification required of a pharmacist to administer certain drugs and vaccines (listed in 32 MRSA 13834) to persons at least 18 years of age. It also empowers a pharmacy intern to administer drugs and vaccines under the direct supervision of the pharmacist.

LD 198: An Act to Clarify Physicians’ Delegation of Medical Care. This law provides that a physician may delegate to employees or support staff certain activities relating to medical care and treatment without being present on the premises at the time the activities are performed. The change allows delegation to those you supervise who are not your employees, and eliminates the direct presence requirement from delegation.

LD 388: An Act to Amend the Controlled Substances Prescription Monitoring Program Participation Requirements. Current law requires that a large majority of health care providers must be registered in the PMP by January 1, 2014 or ALL will be mandated to register. This Resolve orders a study to determine the most effective way to implement the mandate of registration. It is to be submitted by Jan.1, 2014.

LD 411: An Act to Amend the Health Care Practitioner Licensing, Disciplinary and Reporting Laws Regarding Alcohol and Drug Abuse. The law modernizes outdated language referring to substance abuse among physicians. It affirms that a physician has the obligation to report to the Board a peer who engages in gross or repeated malpractice, misuse of alcohol, drugs, or other substances that may result in the physician’s performing services in a manner that endangers the health or safety of patients, professional incompetence, unprofessional conduct or sexual misconduct.

LD 556: An Act to Modernize the Statutes Governing Physical Assistants. The law adds a physician assistant (PA) to both the medical and osteopathic Boards; requires
joint PA rules by the two Boards; authorizes delegation by PAs; repeals the law disallowing PA owned practice; and calls for a single PA license. These changes will require rule making this fall, and an increase in fees for PAs.

**LD 597: An Act to Inform Persons of the Options for the Treatment of Lyme Disease.** The new law requires health care providers to tell patients tested for Lyme disease that the test can produce false negatives, and to seek professional help if symptoms persist; and directs the Maine Center for Disease Control to establish web based education about the disease, including alternative treatments.

**LD 727: An Act Establishing Health Care Practitioner Transparency Requirements.** This law requires full disclosure in advertising of licenses held; requires name tags for health care providers in patient encounters; and defines failure to comply as unprofessional conduct.

**LD 882: An Act to Amend the laws Governing confidentiality of Health Care Information To Enhance Public Safety.** The law makes Maine law consistent with federal law, allowing disclosure of health care information to law enforcement or other providers when necessary to avert a threat to the health or safety of others.

**LD 990: An Act To Require Public Disclosure of Health Care Prices.** The law requires health care practitioners to maintain and make available to clients a price list (as billed without insurance coverage) of services and procedures which they provided at least 50 times in the past year. Pharmacists exempted.

**LD 1024: An Act To Enhance Enforcement of the Mandatory Reporting of Abuse and Neglect.** DHHS will be required to make a report to the licensing board of a professional who appears to have violated the mandatory reporting law and to provide appropriate records. The Boards are required to keep the information confidential and proceed with disciplinary proceedings under current laws.

**LD 1046 An Act To Provide Immunity for Prescribing and Dispensing Intranasal Naloxone Kits.** The law authorizes health care professionals to prescribe and dispense intranasal naloxone to persons at risk of opioid-related overdose and to others who may administer naloxone to a person who is experiencing an overdose.

**LD 1134: An Act To Allow Collaborative Practice Agreements between Authorized Practitioners and Pharmacists.** The Pharmacy Board and medical board are required to write joint rules allowing pharmacists to examine, diagnose, and treat under delegation of an “authorized practitioner”. The pharmacist must be trained in the area(s) of the collaborative. Each patient must be first monitored (only) by the pharmacist for 3 months before expanding the agreement to allow examination, diagnosis, and treatment under delegation.

**LD 1437: An Act To Amend the Laws Regarding Licensure of Physicians and Physician Assistants.** This law is the result of efforts by the Board to update and enhance certain provisions. Changes follow: (1) requires PAs to report PAs and physicians who are involved with unprofessional conduct or incompetence, including substance abuse (under 24 MRSA 2505); (2) requires reporting discipline of third party contract providers (under 24 MRSA 2506) to the Board; (3) requires PAs to provide appropriate informed consent; (4) allows Board ordered evaluations to be performed by other than physicians (under 32 MRSA 3286); (5) allows for licensing of a dual trained oral and maxillofacial surgeon/MD; and (6) adds the following as disciplinable behavior: practicing beyond the scope of the license held; mis-representation in obtaining a license; continuing to practice after expiration, suspension or revocation; non-compliance with an order of or agreement with the Board; failure to produce documents on request; and failure to timely respond to a complaint notification.

**LD 1500: An Act Regarding the Cost of Copies of Medical Records.** The law increases the per page cost of copies of medical records requested from hospitals to $5.00 for the first page and $.45 per page, and creates a ceiling charge of $250 for paper records or $150 for electronic records.

**LD 1523: An Act To Strengthen the Laws Governing Mandatory Reporting of Child Abuse or Neglect.** The law adds to the list of information to be provided by a mandated reporter for child abuse or neglect of a child who is under 6 months of age or otherwise non-ambulatory the following: A) Fracture of a bone; B) Substantial bruising or multiple bruises; C) Subdural hematoma; D) Burns; E) Poisoning; or F) Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ.
2013 Meeting Schedule

Meetings are held the second Tuesday of the month convening at 9:00 a.m. Sub-committees (except for PA Advisory Committee) meet prior to the start of the meeting at scheduled times.

Medical Board Meetings
January 8         July 9
February 12      August 13
March 12         September 10
April 9          October 8
May 14           November 12
June 11          December 10

PA Advisory Committee Meetings
Meetings are held on the following dates at 8:00 am:
March 5         September 3
June 4          December 3

Questions? Contact the Board Office at: 207 287-3601

Notify the Board of Business and Home Address Changes Immediately

Many people experience problems at renewal time because they have neglected to notify the Board of an address change. To prevent delays, or even loss of license due to lapse, notify the Board immediately of any change in your address.

To verify that the Board has your correct addresses on file, visit: www.maine.gov/md and click on “Find a Licensee” at the lower left. If the address is incorrect, simply send a signed note with changes to the Board or submit the new information online at:

www.maine.gov/online/doclicensing/

Confidential Help Available

Confidential professional help for substance abuse is available by calling 207 623-9266.

For more information, visit the MPHP website at https://www.mainemed.com/member-services/medical-professionals-health-program or send an email to mphp@mainemed.com

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