2026 Southern Pain Society Annual Meeting

Challenging Discussions

Opioid-Related Counseling for the Chronic Pain Patient

Learning Objectives

Participants will learn how to:

- Be compassionate but firm when conversing with patients
- Apply the Columbia-Suicide Severity Rating Scale to a patient to help guide clinical decision making
- Provide resources to patients for support in times of emotional stress (e.g. when weaning off opioids)
- Construct physical and mental supports for yourself and staff in your clinic

Why are difficult conversations difficult?

#1 Differing Goals of Care

#2 Differing Constraints

#3 Delivering Bad News

So how do we address?

Step 01

Align goals of care

Step 02

Address constraints directly

Step 03

Provide good news/hope

- Listen to the patient
- Hear their story

CORE PRINCIPLES OF PRESCRIBING

You're Not a Lackey

Your opinion is from experience – it matters.

Don't get bullied…by patients or any entities!

Patient Safety First

Best interest to start, continue or taper opioids?

Frame your answers in this context.

Risks versus Benefits

Every choice we make is a risk-benefit analysis.

Explain this calculation clearly to the patient.

D Sullivan M, Boudreau D, Ichikawa L, et al. Primary Care Opioid Taper Plans Are Associated with Sustained Opioid Dose Reduction. *J Gen Intern Med*. 2020;35(3):687-695. doi:10.1007/s11606-019-05445-1

THINGS TO SAY

A translation of these core principles.

#1	“In my professional medical opinion, this isn’t a good idea because of X, Y, and Z.” “There’s a drug-drug interaction between the alcohol you’re drinking and these pain meds.” .
#2	“I hear you, Mr. Jones. I want to help treat your pain and improve your quality of life, but your safety always comes first.”
#3	“All of these treatments have risks and benefits, and I’m not sure this lands on the favorable side of that. Remember that there are all kinds of treatment for pain, and they usually all help a little bit. Let’s discuss some other options.”

THINGS NOT TO SAY

#1	“The hospital/government says that we can’t prescribe these medications anymore.” → **UNTRUTH**
#2	“Prescribing these medications is a bad idea.” → **NON-SPECIFIC**
#3	“Your urine drug screen didn’t match what I prescribed. Unfortunately, I can’t care for you any longer.” → **ABANDONMENT**.

So HOW do we explain complicated topics?

01.
Respiratory Depression

“The normal human respiratory rate is 12-20 breaths per minute, and opioids tell your brain to breathe a fewer number of times. If you take too much, this is what could happen.”

02.
Morphine equivalents

“We compare all of the opioids to morphine to determine how strong they are relative to each other, and the total gives us some idea of how much you’re taking every day.”

03.
Where do opioids work?

“Opioids work primarily on changing the way your brain experiences pain and not on your back, or your knee, or your shoulder. They don’t really treat the source of the pain.”

04.
Side effects

“Although they are helpful, opioids can actually affect your mood, your libido, and even your immune system. There’s some evidence that opioids may contribute to cancer risk as well.”

Case #1:
The Inappropriate UDS

CASE STUDY

A common scenario.

HOW IT STARTED	Patient’s urine drug screen is negative for prescribed opioids – for the second time!
HOW IT’S GOING	Patient states that “I need more medicine, so I take more than you give me”
WHAT TO EXPECT	Some pushback...

Compassion

So what do I do/say?

Be curious!

Ask what happened instead of accusing!

Alternative Treatments

Continue to treat with other strategies!

Opioid Rotation?

Maybe it's this particular opioid that's not helpful?

Case #2:
The Depressed/Suicidal Patient

CASE STUDY

A common scenario.

HOW IT STARTED	New patient is requesting opioids for knee pain – not a good candidate.
HOW IT'S GOING	Patient states that "If you don't prescribe this, I'll kill myself"
WHAT TO EXPECT	Active vs. passive suicidality

Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry*. 2011;168(12):1266-1277.

Compassion

So what do I do/say?

Learn More...

"Tell me more about what you just said"

Alternative Treatments

"I really want to help you, but need to do it safely"

Enlist Help

MH professional
Family member

Suicidality Scale

Step 01

Assess active vs. passive

Step 02

You MUST take active suicidality seriously

Step 03

Provide resources for patient based on responses

Columbia Suicide Severity Rating Scale

Question	Past month	
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer Questions 3, 4, 5 & 6 If **NO** to 2, go directly to Question 6		
3. Have you thought about how you might do this?		
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thought but definitely would not act on them?	**High risk**	
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High risk**	
(Always ask Question 6)	**Lifetime**	**Past 3 months**
6. Have you done anything, started to do anything, or prepared to do anything to end your life? *Example: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc*		**High risk**

Compassion

When the situation goes awry...

Mann JJ, Michel CA, Auerbach RP. Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. Am J Psychiatry. 2021 Jul;178(7):611-624. doi: 10.1176/appi.ajp.2020.20060864.

Chaperone Patient

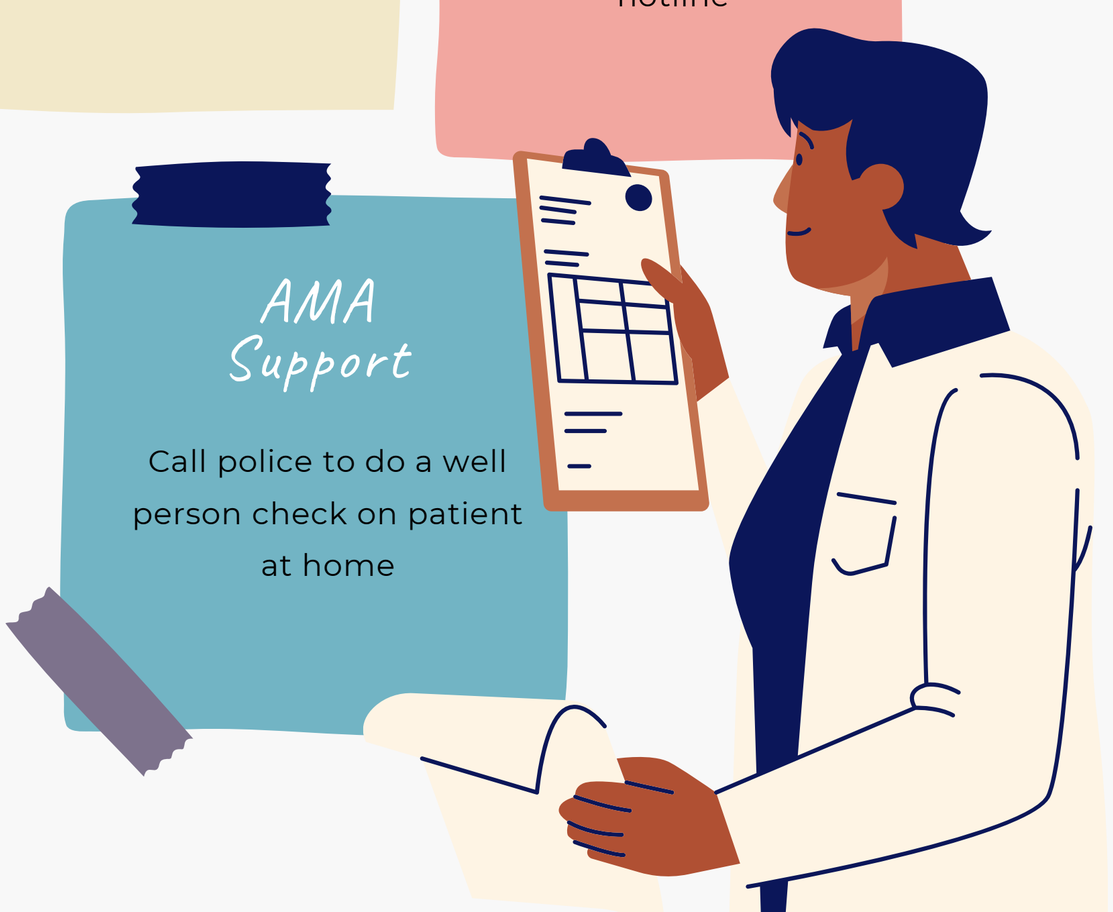
Keep them in your sight

Call for Help

5150 or psych hotline

AMA Support

Call police to do a well person check on patient at home



Case #3: Despite lack of efficacy, patient is resistant to tapering opioids

CASE STUDY

A common scenario.

HOW IT STARTED	54 y/o patient with PTSD is prescribed oxycodone 15 mg four times per day x 20 years. Pain level goes from 8/10 to 6/10, function not improved.
HOW IT'S GOING	Patient states "it takes the edge off and it helps me, please don't stop it!"
WHAT TO EXPECT	Opioids may actually be treating the PTSD symptoms!

Davis MA, Lin LA, Liu H, Sites BD. Prescription Opioid Use among Adults with Mental Health Disorders in the United States. J Am Board Fam Med. 2017 Jul-Aug;30(4):407-417. doi: 10.3122/jabfm.2017.04.170112.

Compassion

How to approach...

Be flexible.

Slow taper (often over months/years). Pause if necessary.

Alternative Treatments

-Treat the pain
-Stellate?

Motivational Interviewing

What are the downsides of using opioids for the patient?

Why taper?

Lack of improvement in function

“Mr. Brown, you’re saying that the hydrocodone 10-mg pill four times daily reduces your pain from 7/10 to 6/10, and you’re still in too much pain to leave the house. It’s not clear that the benefits outweigh the risks here.”

Side effects

“Mrs. Smith, these high-dose opioid medications you’re on are probably contributing a lot to that constipation and maybe even your depression. Let’s think about where to go from here to address your pain.”

Concern for illicit drug use/SUD

“Mrs. Johnson, we got your urine drug screen back and it was positive for cocaine and negative for your prescribed medications. Can you explain this result to me?”

So HOW do we explain the taper?

The medicine is the easy part!!

01.

Patient should show negative aspects.

“Mr. Michaels, I get that you think this hydrocodone is helping you. Has it caused any problems for you, whether in getting it at the doctor’s office, or at the pharmacy, or with family?

02.

Set clear, incremental goals.

“I think we need to see if your pain changes after decreasing by one pill per day. I strongly suspect that it won’t.”

03.

Be compassionate but firm.

“Mr. Michaels, it would be irresponsible and unethical for me to continue this same treatment that is obviously only giving very temporary relief and not really helping you. It’s time for us to make a change.”

04.

Summarize.

“Over the next year, we are going to decrease the hydrocodone and set up some more PT and injections. This road may not be easy, but better days are ahead.”

Questions?

Sudheer Potru, DO, FASA, FASAM

Pain Physician | Addictionologist | Anesthesiologist | Podcast Host | National Speaker | Communicatio...