The Gentle Art of Saying “No”:
How to Establish Appropriate Boundaries With Chronic Pain Patients

David Cosio, PhD

Biography

David Cosio, PhD, is the psychologist in the Pain Clinic and the CARF-accredited, interdisciplinary pain program at the Jesse Brown VA Medical Center, in Chicago. He received his PhD from Ohio University with a specialization in Health Psychology in 2008. He completed a behavioral medicine internship at the University of Massachusetts-Amherst Mental Health Services and a Primary Care/Specialty Clinic Post-doctoral Fellowship at the Edward Hines Jr. VA Hospital in 2009. Dr. Cosio has done several presentations in health psychology at the regional and national level. He also has published several articles on health psychology, specifically in the area of patient pain education.
Disclosure

- Nothing to disclose

DISCLAIMER:

- Dr. Cosio is speaking today based on his experience as a psychologist employed by the Veterans Administration. He is not speaking as a representative of or an agent of the VA, and the views expressed are his own.
Learning Objectives

- Describe patient-provider shared responsibility while prescribing pain medications
- Explain the model of collaborative care and the challenges of setting patient boundaries
- Explain the steps of resolution
- Discuss a plan on setting boundaries in example patient cases

The Pendulum Swings...

- Deemed a human right
- Believe entitled to opioids
- Providers feel pressured
- Reinforces patient’s beliefs and reliance on medication
Risk of Opioid Overdoses

- Side effects/addiction
- Dramatic rise in opioid misuse and deaths from OD
- High profile deaths like Heath Ledger and Prince
- Identified by CDC as “public health epidemic”
- CDC released guidelines in March 18, 2016

Why Are Patients Deemed Difficult?

- Mistreated, robbed, or ignored
- Personality conflicts
- Social or financial problems
- Lack of trust, information, or communication
- Cultural differences/language barrier
- Cognitive impairment
- Severe mental health/addiction concerns
- Secondary gain
- System concerns—What happened today?
- Negative drug interaction
“There are no difficult patients, just patients with difficulties.”

Common Provider Failures

- Use jargon and avoid certain topics
- Too much information and assume understanding
- Patient afraid to assert themselves
- Make jokes and ignore how impacts patient
- Fail to explain a teaching hospital and/or clinic’s functioning
- Provider feels like a police officer, judge, or deal-maker
Provider Relationship Expectations

- Patient is expected by provider to:
  - Be open
  - Honest
  - Obedient
  - Motivated to get better
  - Display gratitude
  - Display pleasure at improvement

Patient Relationship Expectations (cont’d)

- Provider is expected by patient to:
  - Be thoughtful
  - To listen
  - To be empathic
  - To be nonjudgmental
  - To do no harm
  - To be competent
Patient-Provider Shared Responsibility

- Model of collaborative care
- Known as “working alliance”
- Originated in MH (Greencavage & Norcross, 1990)
- Validated by strong research support

Patient-Provider Shared Responsibility (cont’d)

- Patients with rewarding relationships have:
  - Better outcomes
  - Less likely to seek assistance from other sources
  - Reduces the risk of conflicting treatment plans
  - Reduces risk of further confusion
Continuation of Care Plans

- Heightened interest in pain management
- NEED for appropriate boundary setting more apparent
- NEED for consistency of self-management message throughout disciplines

Gentle Art of Saying “NO”

- Sometimes what the patient wants may NOT be what they need
- Saying “NO” may be the therapy!!!
- Case study
Provider Training

- Communication is most important life skill
- Don’t usually put effort into this skill set
- 5 essential components:
  1. Really listen
  2. Express empathy
  3. Be concise
  4. Ask questions and reflect
  5. Watch your body language

Provider Training (cont’d)

- Communication training has been beneficial in improving relationship
- Essential elements of healthy relationship:
  — Compassion
  — Clear expectations, or established boundaries
  — Provider giving adequate explanations
  — Patient being active participant
  — Patient part of decision making
Boundary Setting

- Boundaries:
  - Simple rules or limits
  - Created by individuals
  - Identify reasonable, safe, and permissible ways for others to behave around them
  - Determine how they’ll respond when someone oversteps these boundaries
  - Pain management requires appropriate boundaries
  - Hard for providers to identify potential ruptures

Ask Yourself the Following:

- Is it hard for you to say no or yes?
- Are you ok when others say no to you?
- Do you take on other people’s problems or pain?
- Do you experience other people’s problems or pain?
- Do you share personal information quickly or slowly?
- Is it hard for you to share anything?
- Do you tell people in your life what you want, what you need, and how you feel?
- Are you able to ask for help when you need it?
- Is someone hurting or disrespecting you?
Difficulty Setting Boundaries?

- Boundary setting requires lots of thought and practice
- Providers learn little about this in clinical training
- To master skill, recognize:
  - Boundaries are not a threat
  - Not an attempt to control others’ behaviors
  - Setting limits improves relationships with patients

Practice Setting Boundaries

- Name or describe the behavior that is not acceptable to you
- Express what you need or expect from the other person
- Decide what you will do if he or she does not respect the boundaries you’ve established
- Validate your actions by recognizing that setting boundaries is important work and that your rights are important
**Boundaries are NOT Comfortable**

Providers feel uncomfortable during process...
- When reasonable limits placed
- Continue to step beyond those limits
- Review what conduct is expected from patient
- Maintain boundary
- Review precise actions can expect from staff
- Be consistent with message
- Remember Step 4...setting boundaries is important work
- Remember saying “NO” is the appropriate treatment!!

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**Boundary Setting Guidelines**

- Establish boundaries or restrictions early on
- Be consistent and document
- Use policy/procedures as backup
- Review opioid pain agreement
- Use other tools available
Use Other Tools Available

- Pain education school
- Random urine tox screens
- Prescription state monitoring
- Opioid risk tools (SOAPP)
- Use a “decision tree”

Handling Patient Refusals

- It is the patient’s decision and right—they should take responsibility to make choices/recommendations available
- Providers are NOT obligated to provide opioids
- Providers ARE obligated to provide the best level of clinical care—1961 Single Convention on Narcotic Drugs
- Goals are to maximize safety and minimize risk for patient and community
- Providers should avoid making decisions based on emotions and not facts
Patient presents with increasing pain complaints and requests for dose increases while decreasing activity. There is no indication the opioid is helpful.

Name—Requesting dose escalation and activity decrease

Express—Role of medication to be more active

Decide—Plan to titrate down opioid if does not increase exercise

Validate—Refer to PT for an assessment or therapy
Case Study #2

- Patient comes to your clinic as a walk-in and is reporting lost or stolen medications.

**Name**—Walk-in and reporting stolen medications

**Express**—Patient’s shared responsibility for medication safety

**Decide**—Will not refill without police report

**Validate**—Consult local paper or prescription state monitoring

Case Study #3

- Patient urgently calls you with increased pain and then shows up to your clinic for an unscheduled appointment and asking for an early refill.

**Name**—Show up unscheduled with increased pain

**Express**—Emergent pain treated in ED or Urgent Care

**Decide**—Unscheduled visits should NOT be used for opioid increases

**Validate**—Patients deserve to have a full visit
Case Study #4

- You ordered a urine screen during your patient’s last visit and it comes back:
  - negative for a substance you are prescribing
  - positive for a substance you did not prescribe

**Name**—Patient is not following prescription and using illicit

**Express**—Concerns about patient and community safety

**Decide**—Conduct urine tox screen again—d/c if repeat offender

**Validate**—Risk of diversion, sharing, or self dose escalation

Case Study #5

- Patient is upset and is making SI/HI threats after being told d/c opiates at this time.

**Name**—Patient is making SI/HI threats

**Express**—Concerns about patient, provider, and community safety

**Decide**—Call for police backup/refer to ED/refer to MH

**Validate**—Consult/debrief with other providers for support
Case Study #6

- Patient comes to your visit appearing intoxicated or somnolent/overmedicated. They also continue to report taking their opiates as prescribed.

**Name**—Patient may be abusing medications or using illicits

**Express**—Concerns about patient and community safety

**Decide**—Conduct pill count, urine tox screen, and speak to family

**Validate**—Consult with addiction services or refer to ED

References

References (cont’d)