The Co-Disciplinary Pain Clinic: A Unique Model for the Treatment of Complex Chronic Pain

Colin Fernandes, MD; Matthew J. Cordova, PhD; Liza Katz, PT; and Stephanie J. Wong, PhD

Recognizing the need for a new treatment paradigm for patients with chronic, refractory pain, a Co-Disciplinary Pain Clinic was instituted and offers a unique model for patient-centered collaborative care for complicated cases of chronic pain.

Among the patients referred to a specialty pain clinic, there exists a subset that is particularly challenging. Often these patients have been evaluated by multiple medical specialists without an identifiable organic cause for their symptoms and have proven refractory to an array of treatment modalities. They are severely debilitated by their pain and extreme in their presentations. These patients are referred to as cases of "complex chronic pain;" in the words of Carron, they display "minimal pathology with maximum dysfunction."[1] Frustrated with the lack of a diagnosis and resolution of their symptoms, these patients present to the pain clinic.

A NEW PARADIGM

Recognizing the need for a new treatment paradigm, in January 2008, a pilot Co-Disciplinary Pain Clinic was instituted to evaluate and treat cases of complex, refractory chronic pain. This clinic espouses the philosophy that the experience of chronic pain is not just biological (nociceptive), but also embedded within the contextual framework of psychological, social, and cultural factors. The clinic is staffed by an anesthesiologist, Board Certified in Pain Medicine, who has an interest in the practice of Narrative Medicine; a behavioral medicine psychologist who also facilitates a Chronic Pain Self-Management Class and sees patients individually for behavioral pain management and psychotherapy; and a physical therapist who augments conventional physical therapy with methods to restore self-regulating equilibrium in the autonomic nervous system.[2,3] The unique feature of the clinic is that all 3 providers are *simultaneously* present for the patient encounter, a technique known as the simultaneous interview technique (SIT).

All consults received by the clinic are screened by an electronic medical record review. The selection criteria for inclusion in the Co-Disciplinary Clinic are as follows: young age (recognizing the need to cultivate a balanced, rehabilitation-focused approach early); widespread pain; significant psychiatric comorbidity; history of substance abuse; dramatic presentation/symptom magnification; high utilization of Drop In/Urgent Care Centers for pain issues; and patient/provider interest in nonpharmacologic approaches to pain management. (All criteria need not be present for inclusion in the clinic.)

Patients are briefed that there will be multiple providers in the room via the mailed appointment letter and once again when the patient is in the waiting area. The initial visit is a 90-minute co-evaluation. The providers take turns eliciting a medical history, eliciting a psychosocial history, and performing a physical examination, respectively. The chronology and nature of the patient's symptoms and prior treatments are clarified, with a focus on sleep, mood, and overall functioning. Importantly, the providers are actively present for the patient, witnessing their story of pain and suffering. A vital point communicated to the patient is that the providers do not doubt the veracity of their subjective symptoms (ie, the pain *is* real).

Frequently, stories emerge that are being disclosed for the first time. Stories have included details of the brutality of war, childhood sexual and physical abuse, and military sexual trauma. Very often, these accounts are

Dr. Fernandes is director of the pain clinic and **Dr. Cordova** is a psychologist, both at the VA Northern California Health Care System, East Bay Division in Martinez, California. **Ms. Katz** is a physical therapist at the VA Northern California Health Care System, Sacramento Valley Division in Mather, California. **Dr. Wong** is a postdoctoral fellow at the VA Palo Alto Health Care System, Palo Alto Division in Palo Alto, California.

preceded by the statement, "I don't know why I'm telling you this, but…" It is believed that one reason these stories are being told *now* is that the moral-emotional weight of these narratives is felt to be too great to impose on an individual provider. These stories are used to help normalize physiological (autonomic nervous system) connections between psychological and physical trauma and organize them within the medical context. Using the providers' combined skills and presence, there is an attempt to stabilize patients through the emotional parts of the interview.

Following the interview and examination, the patient is provided a short break while a treatment plan is generated. The patient is then invited in again, and recommendations are presented and discussed collaboratively. Treatment may include specialized physical therapy, referral to a staff acupuncturist or chiropractor, procedural interventions (including nerve blocks, epidural steroid injections, radiofrequency lesioning, etc), medication adjustment, individual or group behavioral medicine follow-up, and referral to other specialized mental health care treatments (eg, posttraumatic stress disorder treatment).

The goal is to guide patients toward a shift in mind-set, eschewing the search for a cure in favor of self-care and preservation or improvement of functionality, despite pain. While developing a treatment plan, the providers take into account the patient's idiosyncrasies and belief system; patients, as well as family members, are encouraged to be active participants in the pain care.

After this initial visit, patients may choose to follow up with 1 or more providers. In some cases, patients are seen in the Co-Disciplinary Pain Clinic for follow-up visits. As treatment proceeds, the team continues to communicate closely to coordinate care. It is felt that this maintains a consistent message to the patient regarding the interactions between mind and body.

The unique feature of the clinic is that all 3 providers are* simultaneously *present for the patient encounter, a technique known as the simultaneous interview technique (SIT).

PATIENT SATISFACTION DATA

Many patients with pain report feelings of not being understood in consultations and have high levels of anger toward providers in pain clinics.[4,5] This is especially true for patients whose symptoms cannot be easily explained using a biomedical model. It is believed that by providing a different—better—experience at the first visit, providers can encourage patients to restructure their treatment goals and adopt more realistic expectations. With that in mind, beginning in January 2009, patients were given a Satisfaction Survey to complete at their initial visit.

The following represents the satisfaction data collected between January 1, 2009, and June 30, 2011. In all, 50 questionnaires were returned. Seventy-four new patients were evaluated, and 24 did not complete/return questionnaires. Of the 50 participants, 72% were male and 28% were female. The mean age of participants was 41 years old (SD = 13.6).

Patients were generally satisfied with the quality of care they received. Patients endorsed the responses *Excellent* or *Very Good* in regards to satisfaction with the visit (84%), quality of care received (90%), perceived competency of the treatment team (90%), accuracy of the diagnosis given (90%), the explanation provided about the treatment plan (94%), understanding the treatment plan provided (92%), and effectiveness of the treatment plan (50%). It is worth noting that several patients stated it was too early to judge the effectiveness of the treatment plan at the first visit.

Similarly, patients endorsed the responses *Extremely* or *Quite a bit* in regard to the likelihood of their following through with the treatment plan (96%) and the perception that the team took their pain seriously (94%), listened to them (98%), and were courteous (100%).

DISCUSSION

Prior studies have demonstrated the efficacy and cost-effectiveness of multidisciplinary pain clinics.[6,7] This model is unique in that it is not only multi- but also co-disciplinary, using the SIT. Although this model was arrived at independently, a literature review reveals that this technique has been previously reported at the Seattle Division of the VA Puget Sound Health Care System and the Children's Hospital of Philadelphia, as well as hospitals in Sydney, Australia, and Montreal, Canada.[8-11]

It is believed that there is a fundamental difference between sequential and simultaneous interviews. As stated by Jacobson and colleagues, the use of sequential, independent interactions "inadvertently fosters dualistic thinking," reinforcing a split between

mind and body.[8] By being present as a team the providers embody, in a very real way, the conviction that complex chronic pain is a biopsychosocial problem that cannot be treated through medical interventions alone.

The SIT model is time-efficient. Whereas 3 separate initial visits would have totaled 3 hours, the redundancy was avoided by eliciting a common history and performing a group-witnessed examination in 90 minutes. Ground rules and expectations are set in an effort to avoid the possibility of splitting (eg, sharing information with 1 provider but not another; 1 provider blaming another). The SIT model is truly patient-centered and collaborative, and patients recognize and respond to the novel setting. This is evidenced by the high ratings on the patient satisfaction survey. It is also not uncommon for patients to say, "I've been coming to the VA a long time, but this is the best thing to happen to me!"

In an age when patients often feel providers are busy tending to computer screens and not listening, the clinic is a welcome experience. When 1 provider is making notes, 2 other providers are "actively" listening. Because the providers are attentive listeners, patients are allowed to reclaim their pain narratives; throughout the interaction, patients are assisted in reframing their stories of suffering.

Not only is patient satisfaction high, but the providers have also found the clinic personally and professionally rewarding. It has opened up channels of communication and set up opportunities for collaborative care outside the forum of the clinic. The experience confirms the previously reported transfer of expertise between providers.[10] Psychology interns and other trainees who have observed the clinic consistently rate it as one of their most valuable clinical experiences.

However, this report has several limitations. The clinic is low volume, and there are no prospective pain/functionality data (the goal is to eventually collect longitudinal data to demonstrate improved outcomes). Due to the complexity and heterogeneity of the patients selected for the clinic, it would be hard to design a study that included controls. Despite these limitations, the co-disciplinary model is believed to be ideally suited for the treatment of complicated cases of chronic pain. This view was shared by Jacobson and colleagues at the Seattle VA Pain Clinic.[12] It is the providers' goal to expand the clinic to include larger numbers of patients, and it is the hope that the model will be used at other sites.

In recognition of the power of the narrative, what follows is an excerpt from a letter of appreciation penned by a patient who attended the Co-Disciplinary Pain Clinic in August 2010:

> "I felt extremely comfortable and relieved that I was being heard for the first time… just a wonderful appointment of caring professionals in their respective fields going beyond their call of service to… make sense of the chronic pain that I have been having to deal with…."

CONCLUSION

The Co-Disciplinary Pain Clinic, using the SIT, offers a unique model for patient-centered collaborative care of the complex patient. Satisfaction is high among patients as well as the treating providers. As stated eloquently by Jacobson and colleagues, "The SIT has evolved into a whole that transcends its component parts, ie, the impact of this combined approach is synergistic rather than additive."[8]

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom Inc., the U.S. Government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*

REFERENCES

1. Carron H. ASRA lecture 1988: The changing role of the anesthesiologist in pain management. *Reg Anesth.* 1989;14(1):4-9.
2. Levine PA, Mate G. *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness.* Berkeley, CA: North Atlantic Books; 2010.
3. Porges SW. *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation.* New York, NY: WW Norton & Company; 2011.
4. Fernandez E, Turk DC. The scope and significance of anger in the experience of chronic pain. *Pain.* 1995;61(2):165-175.
5. Walker J, Holloway I, Sofaer B. In the system: The lived experience of chronic back pain from the perspectives of those seeking help from pain clinics. *Pain.* 1999;80(3):621-628.
6. Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers: A meta-analytic review. *Pain.* 1992;49(2):221-230.
7. Gatchel RJ, Okifuji A. Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. *J Pain.* 2006;7(11):779-793.
8. Jacobson L, Mariano AJ, Chabal C, Chaney EF. Simultaneous interview technique for patients with persistent pain. *Pain.* 1991;45(1):105-106.
9. Covelman K, Scott S, Cohen DE, et al. Comment on 'Simultaneous interview technique for patients with persistent pain' by L. Jacobson, A.J. Mariano, C. Chabal, and E.F. Chaney in *Pain,* 45 (1991) 105-106. *Pain.* 1991;47(1):124-125.
10. Catchlove RFH, Ramsay RA. Comments on L. Jacobsen et al, *Pain,* 45 (1991) 105-106. *Pain.* 1992;48(2):291.
11. Mariano AJ, Jacobson L, Chaney EF, Chabal C. The simultaneous interview technique (SIT) and the co-disciplinary model of chronic pain treatment. *Pain.* 1992;51(1):119.
12. Jacobson L, Mariano AJ, Chabal C, Chaney EF. Beyond the needle: Expanding the role of anesthesiologists in the management of chronic non-malignant pain. *Anesthesiology.* 1997;87(5):1210-1218.