

INTERVIEW

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Interview with David Tauben: University of Washington, Chief of the Division of Pain Medicine



Dr Tauben* is Clinical Professor jointly appointed in the Departments of Medicine and Anesthesia & Pain Medicine, and is the Hughes M & Katherine G Blake Endowed Professor, board certified in both Internal Medicine and Pain Medicine. He is also University of Washington (UW) Director of Medical Student and Resident Education in Pain Medicine, and Medical Director of UW TelePain, a tele-video-conferencing program intended to provide innovative pain education and consultative support to a five-state northwest regional primary care providers. He served as a member of the NIH

National Pain Strategy task force on pain education and is principal investigator for the UW's prestigious NIH Pain Consortium Center of Excellence for Pain Education, leading curriculum development to extend the pain proficiency qualifications of interprofessional primary care providers.

Dr Tauben is a member of the American Pain Society and the International Association for the Study of Pain special interest study groups on Pain Education. He is a founding member of the State of Washington Agency Medical Directors panel of medical experts developing opioid prescription guidelines for the state, and a regular clinical and content expert for regulatory and legislative bodies involved in public policy regarding pain medicine practice and standards. He speaks as a clinical expert in medical management of chronic pain, especially as it applies to primary care practices. Dr Tauben served as an expert for several US Centers for Disease Control clinical outreach programs and policy reviews advising primary care providers on how to prescribe opioids for chronic noncancer pain. He is annually recognized by his peers as recipient of regional awards in care of pain patients, and brings decades of clinical experience of best practice medication management of acute and chronic pain.

Dr Tauben received his bachelors degree in philosophy from Yale University, medical degree from Tufts University School of Medicine and completed his residency training at the UW, in Seattle. He is a fellow of the American College of Physicians.

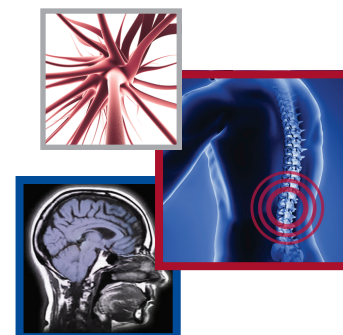
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Q In 2010, the Division of Pain Medicine at the University of Washington was awarded the Clinical Centers of Excellence in Pain Management Award by the American Pain Society. Could you tell us what is unique about the pain management program at University of Washington & what it meant to win this award?

Our program is a multidisciplinary model, which was originally developed at the University of Washington (UW) in the 1960s. It includes multidisciplinary medical experts as well as behavioral health specialists such as clinical psychologists, clinical

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rehabilitation counsellors, social workers and pain pharmacists, physical therapists and nurse care coordinators. We work as a team and strive to provide a coordinated near simultaneous inter-professional evaluation. Our multidisciplinary team model is hampered a bit by challenging reimbursement models, yet we are able to create a virtual concurrent patient treatment experience by working together, literally side-by-side, in a shared clinical and training workspace.

It was a great honor to win the American Pain Society Clinical Centres of Excellence award. The American Pain Society is part of the International Association for the Study of Pain and therefore, represents the international effort to improve the science, delivery and education of best practice pain medicine. In my own institution, this award carries weight as it reminds complicated organizations, such as a big university, that even a component part can represent the entire institution and can be a jewel in their crown. It also enables more leeway for our ideas as they have been validated by such a highly regarded international organization.

Q You are the founding member of the Washington State Agency Medical Directors & the co-chair of Opioid Prescription Guideline Committee, a panel of medical experts who are developing opioid prescription guidelines. Can you tell about this organization & your view on the opioid crisis?

The Opioid Prescription Guideline committee was formed by about eight to ten of us in the early 2000s when it became clear to a variety of stakeholders including state agencies and those of us in active clinical practice, that an over reliance on opioids and the absolute absence of any guidance for prescribers had created havoc in clinical practices and deaths in circumstances of relatively minor injury when patients were prescribed increasingly high doses of opioids. These accidental and shocking deaths generated a small group of both academics and private practice clinicians who began the discussion that there must be a better way of treating chronic pain rather than with the unchecked and undisciplined prescriptions of opioids.

The very first question that was put to our group was ‘is there a dose (of opioids) at which patients start to do badly?’ We had no published data available at that time either in the form of randomized trials or epidemiological studies. There were suggested dose limits that had been

proposed but again they were just consensus driven. At that time I was in private clinical practice and having prescribed opioids for over two decades I just proposed a number: I said “above 80 milligrams of morphine I think my patients start doing worse not better.”

Not surprisingly it took about 3 months and dozens of conversations and considerable consensus building to come up with the notion that there was a dose above which patients stop doing well and when clinicians should rethink their treatment strategy and identify alternative approaches. We ultimately moved the dose threshold up to 120 mg due to the reality that far too many people in the State of Washington were already on doses in the 80–120 mg range to possibly take on all at once. We initially published what we called ‘educational guidelines’ in 2007 that were roundly and profoundly denounced not only unsurprisingly by pharma companies, but also by many of the leaders in the pain community. The complaint was: how dare you come up with a dose limit when you do not have any data? Lawsuits were filed against us.

Our response was that we had data of overdose deaths correlating with dose; we had clinicians observing that patients are not doing well. It was time to act and while building the data we should not stand idly while there were increasingly high rates of mortality and morbidity linked to opioids.

From there we went on to improve the guidelines. In 2010 they were republished as treatment guidelines and not just ‘educational’ which gave them more weight with the state’s agencies and toward prescribers. These agencies included the insurance plan for state employees, the department of workers compensation, Medicaid and regulating entities including department of corrections, and the very important state’s department of health boards that oversaw the practice of medicine, osteopathy, pharmacy, nursing and others who deliver healthcare in the state of Washington.

The opioid crisis was initially driven by good faith and the best of intentions. However, transferring a model of care that was humane and sensible for end-of-life pain care and active cancer pain management onto a chronic non-cancer pain population, which involve different outcomes, trajectories and a vastly greater number of effected individuals, had led to the quite unexpected outcome we see today: no significant evidence of improvement in pain, function or

quality of patients' lives, a conflation of pain care with opioid monotherapy, an epidemic of prescription opioid misuse and abuse, and a flood of prescribed opioids helping fuel a quadrupling of American opioid-related fatal overdoses, since 2000 more than 300,000 total overdose deaths and over 33,000 deaths in 2015 alone.

This era of over-reliance on opioids was further pushed by the at times perverse incentives of the American healthcare delivery: rapid throughput, high volume, little time, poor or absent reimbursement for behavioral and physical therapy, and a tendency toward expedient solutions. The model of multidisciplinary care with its strong emphasis on behavioral health and physical activation had gone by the wayside because it requires more complicated care delivery systems to be put in place, and the value is not seen immediately but instead measured over a longer term. We did not then, nor even now have a model of healthcare delivery quite like Great Britain's, except in those few managed care organizations that quite systematically look at costs over the long term.

Opioids are the fastest way to get through an office visit, especially if you really feel like you are doing the right thing, the patient temporarily feels better and you can get on with your busy day in a general practice setting. What could be wrong with that? Well, it is now proved to be, quite a lot!

Q You are the medical director of the UW TelePain series. Can you tell us about this series & what impact the program has made?

The TelePain program is an effort that was offered as an immediate remedy to enable primary care practices to receive a multidisciplinary pain expert consultation on patients in their practice, without having to send their patient hundreds of miles to an academic center or having to arrange multiple appointments to see several different specialists and to deliver it almost in real time.

It is a program that includes a bit of didactic education, similar to a TedTalk lecture that gives a quick overview of a primary care topic. Being a primary care doctor, originally my career practice, I identified pain management topics that aligned with the International Association of the Study of Pain (IASP) pain curriculum and with our team we agreed to be very central to the primary care team.

Primary care practitioners want to know what to do in real time with their highly distressed

patient who is causing such turmoil in their practice. They have little to no formal pain management education, and particularly know little about safe and effective use of opioids. "What do I do right now?" They see poor outcomes, high levels of social and psychological distress, misuse of drugs; the patient cannot get appropriate treatment because they might be hundreds of miles away from a specialty clinician or service. By calling in to present the case to us TelePain becomes a provider-to-provider interaction, an educational consultation. The primary care clinician receives a shared multidisciplinary response; they receive the combined benefits of an anesthetist, physiatrist, pain-trained primary care doc, addictionologist, psychologist, nurse, social worker and others who we might additionally recruit depending on the cases we expect to hear. For example we might bring in an expert in pediatric pain medicine, or an expert in women's health with opioid use in pregnancy. We begin with a specific didactic topic, listen to the scheduled clinician's case, and then have a round table discussion about that specific patient. We discuss it for about 20 min, the clinician receives a written educational consultation and recommendations that they are free to use or not. They are able to respond to some of our suggestions and quite frequently do let us know when they have already been tried, and if a method was successful or not and see what they need to do next. This allows us to have a much richer history of the patient than we could ever receive ourselves in a traditional consultation, since these primary care providers have known many of these patients for months to years and really understand their patient's individual circumstances far better than any one of us consultants could.

The TelePain consultation is problem-centered and since it's conducted directly with the primary care provider a proxy for patient centered care, and we can quickly and efficiently cover a lot of complex territory. This gives us the ability to cover an exceptional breadth and depth of the complicated life of the individual patient. Ultimately it is the primary care providers who are going to have to be implementing the pain management plan, so we are speaking directly with those on the front line of patient care.

The state's department of health quickly agreed that this educational consultation would meet specialty pain consultant criteria following our state law in 2011 which required all high-dose opioid patients and those not doing well

on opioids at any dose to receive a consultation by an expert. There were effectively no experts available, so this immediately met an enormous community public health need when the department of health considered TelePain equivalent to a tradition face-to-face in-person consultation.

So we solved many problems with the UW TelePain series; ready access to pain expertise by reaching out to the community to support their practices. Many of our faculty also learned enormously about what our primary care colleagues were up against out there in their small and often remote clinical practice site, and how difficult and challenging the circumstances they and their patients faced. And so with a two-way case-based educational dialog we engaged a network of professionals who also then began talking among themselves, learning about what they're doing and sharing good advice and resources they had found in similar circumstances. I must say that the opportunity to conduct the UW TelePain series is the most satisfying aspect of my week. It has been a very positive opportunity for all concerned.

Biggest challenge is that we are underfunded. There is no structural way in current American healthcare reimbursement to cover costs of provider education even if it is about an actual patient, and even when it would lead to better and less costly health outcomes. We had been funded solely on grants and philanthropy, though we have just recently received some initial state sponsored support that has relieved some of the burden of grant seeking and eased my previous uncertainty for our future.

Q [UW is home to the world's first multidisciplinary pain clinic, can you tell us about how the field of pain management has evolved over your career?](#)

The world's first pain clinic was established here by Dr John Bonica. His original clinic design included an anesthesiologist, a nurse and a psychologist. He soon brought in many of the fields that were involved in pain medicine; neurology, neurosurgery, rehabilitation medicine and the UW became for over two generations the place where many of the world's pain experts got trained. It is quite a legacy. The initial multidisciplinary pain care began with an in-hospital stay of 4 weeks and while the patients were weaned off copious ineffective medications they received group education regarding the complex nature of pain, and both

group and personal cognitive behavioral therapy, occupational therapy/physical therapy, behavioral activation and so a very structured functional and behavioral rehabilitation. The intake process selected, in advance, those patients who were ready to go into that program, and they accepted only about 10% of the referrals, identifying only those ready for this kind of transformation into self-management. After I had completed my primary care internal medicine training where I had first enthusiastically learned about this model in 1980, I entered a private practice where I was challenged by those many patients not yet prepared to take on self-management, or who could not afford in-patient multidisciplinary pain care, and not surprisingly many of these individuals did continue to struggle. I struggled too, trying to create a model of care in the complex and disorganized and uncoordinated community setting that could mirror the very best of the Bonica multidisciplinary program. Not an easy challenge.

I think this is a big challenge for the field of pain medicine. I believe that pain medicine now needs to be about identifying those patients who are not yet ready for change and determine how best to engage and motivate them into that state of readiness needed to make the very dramatic changes in behavior, attitude and cognitive approach first offered by John Bonica. Pain medicine is about training and then locating those diverse health professional team members interested and knowledgeable in pain science and treatments, and identifying those patients who are best matched to receive those specific individual or multiple component services we have determined to be most likely be effective for them. We know that effective pain medicine offers patients with chronic pain an opportunity to step out and away from the barrage of overwhelming pain sensations and the heavy toll of emotional and social consequences arising from their debilitating pain problems. Our challenge ahead of us now is to advance the design and then implement those health systems to allow access to the best parts of the Bonica multidisciplinary care model I first saw working so well over 25 years ago.

The field has evolved in great strides scientifically, and there is a tremendous amount of new research in terms of understanding the experience of pain and how frequently pain resides in the brain, the 'CNS' not just in the periphery where we 'feel the pain.' Previously pain was so

mysterious that there were a lot of misunderstandings about ‘pain’ not being real, or it being spiritual or a personality deficit, which resulted in the further stigmatization of patients. Now we can actually see the footprints and pathways of abnormally functioning structures in the CNS. There have also been advancements in pharmacology, however, as of yet these are far from sufficient. New discoveries in targeted molecular therapies, possibly directed at peripherally acting opioid receptors and/or centrally modulating inhibitory receptors are still needed. Advancements in neurostimulation and modulation are highly effective for a small subset of patients. We are also making advancements in psychological approaches with a renewed emphasis on cognitive behavioral therapy and its subsets, such as mindfulness-based CBT, acceptance and commitment therapy models, resilience and dialectical behavioral therapy for those many patients whose pain is driven by post-traumatic stress complications.

So while we await further scientific advances, we can address those problems that remain with top-down health systems institutional support for multidisciplinary pain care. There is some positive evolution in the USA, in our very complicated health system that tends to focus far more on short-term costs and does not yet value investing in treatments that might offer far more effective long-term outcomes. Here, a strong call out to the US veterans administration and department of defense of credit for to their top down leadership and decisions about value based resources, who have now have lapped the rest of us all twice around the racetrack by making those investments in multidisciplinary pain care models.

The field of pain management has evolved from its origin but it still needs to go back to its roots of multidisciplinary care, focus on the life, mind and circumstances of the individual affected by pain. While the biomedical disorders must certainly be addressed, circling back we still have yet to solve the complicated processes and structural delivery models of multidimensional pain management.

Q [Where do you see the pain management field in 10 years from now?](#)

The first thing we need to do is put the opioid based model in better order. When pain equals opioids and opioids equal addiction, pain becomes addiction and thus ever more

stigmatized. It is tough enough to suffer chronic pain and then on top of that to have an overlay of addiction. And now we have also to deal with our legacy of millions of patients on high dose and long-term opioids, and are we are still struggling with how best to realign their care to nonopioid best-practice models.

Then the next question arises, if not opioids then what? We do have good models of alternatives. The psychological, social and situational remedies that for the vast majority of individuals is best managed in the primary care medical home is where the patient ought to have all their healthcare needs met and coordinated, where the families are often well-known, where their health and personal circumstances are understood for over a long period of time. Patients with chronic pain will have great trust in those providers, which has been earned over years of on-going clinician–patient interactions. This is where our emphasis has to be, moving into the primary care setting. Therefore, embedding pain expertise in the primary space should come first and foremost. One of those models I’ve just described is TelePain. Another is to create what are now widely have called ‘pain champions’ who could be any member of the primary care healthcare team, be they physicians, nurses, PAs, or social workers. Champions are likely already there in the primary care space, with special interest to lead the practice group into the processes necessary for standardization of treatment approaches, improve consistency among providers, tracking treatment outcomes automatically such as function and quality of life over time. With a pain champion present, the others busy with doing the numerous other tasks required in the primary care space can look to that individual for on-the-spot evidence-based pain expertise. In that same setting, pain care can be implemented into an established system of care that ensures a smooth and consistent workflow that improves quality and outcomes while it reduces poor outcomes and drives down the overall cost.

The role of the pain specialist will need to be continuously redefined. For many years specialists offered injections and complicated medication regimes and would make suggestions that might not be practical for a primary care provider. Hence, for many primary care providers pain specialists are seen as less useful when in fact the specialty has a tremendous amount to contribute. It is a matter of pain experts needing to come to a better understanding of what is

happening in the primary care context and for the primary care context to become the nidus for high-quality pain care delivery. I do see a rosy future, though it will still take quite a bit more feeding and watering, and time, and resources to achieve these goals.

Q Do you have a particular message to our readership or the general pain management community?

I will quote my medical students who teach us so much with their wide eyed optimism and still plastic minds. After a few weeks with us on rotation in our award winning clinic, fourth year medical students will say to me two very validating things.

The first is “These pain patients are really nice.” This still chokes me up because it tells me that after 3 or more years of medical school exposure they have stigmatized these individuals as low-life’s, drug seekers, people you want to keep at an arm’s length rather than embrace. We now know that social isolation and stigmatization increase the severity of the pain experience and make the interaction evermore dissatisfying for both the patient and provider. That is no way to take care of a patient.

The second thing they say is “my goodness, there is something you can do!” So again, away with this notion that chronic pain is about only terribly hopeless patients because anything we do is simply a waste of time.

The two messages that I would communicate is first, people with chronic pain are indeed unfortunate but like everyone else we might see in our routine clinical practices they have the remarkable potential to flourish with our good care. And second, we also have known about effective methods of multidisciplinary pain care for 50 years; we just now have to find better ways to implement these proven practices. Thank you for listening.

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