A Doctor and Patient's Perspective on Chronic Pain

Christopher C. Spanswick, MB, ChB, FRCA
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Patients with chronic non-cancer pain can be very challenging for FPs. Diagnosis is often difficult or sometimes impossible. Due to its nature, chronic pain has not responded to (standard) therapy and patients frequently become very distressed and increasingly desperate for a cure. This necessarily puts the FP under a lot of pressure and he/she will often feel that he/she does not have the knowledge, skills or resources to manage such a clinical problem on his/her own.

What is chronic pain?

Chronic pain is very different from acute pain. The relationship to injury is often tenuous (the injury may have long since healed) and the pain does not frequently represent a useful warning signal. The impact of chronic pain is however huge and patients with chronic pain find that it affects every part of their life, leading to:

- frustration,
- demoralization,
- anger,
- helplessness and even
- hopelessness.

It is important to be aware of this as it influences how and when patients present to their FPs. Sometimes the distress can be almost more prominent than the pain problem. This in turn may lead to a presentation in which the psychological features are overwhelming and can engender a sense of hopelessness in the physician (Table 1).

Table 1
Patient's response to chronic pain

- Distressed (depressed/anxious)
- Demoralized
- Disabled
- Misunderstood
- Frustrated
- Angry
- Desperate
- Catastrophize

The consultation

The patient and the doctor will often have different agendas (Table 2a, 2b). It is important to understand the patient's perspective and address the issues that are important to him/her before offering treatment or advice (Table 3). It is important to acknowledge the distress (and anger/frustration) during the consultation. The treatment plan should include addressing the (normal) consequences of chronic pain as well as the pain itself.

Perhaps the most important part of assessment is finding out what the patient (and their families) believe is wrong. Beliefs drive behaviour and may even influence pain experience, especially if fear of reinjury is prominent. You, the physician will often have to correct patients' misconceptions.[3] These beliefs may hinder attempt to help the patient improve.

Table 2a

A patient's agenda

- Seeking cure or palliation
- Diagnosis
- Reassurance
- Legitimization of symptoms
- Express distress, frustration or anger

Table 2b

A doctor's agenda

- Eliciting clinical information
- Appraisal of presenting symptoms
- Seeking confirmatory physical signs
- Arriving at a clinical formulation and decision
- Communicate findings to patient
- Eliciting support for plan of action

The examination

The examination is very important. It indicates that you take the patient seriously.[5] You may (indeed probably will) find nothing that is specific. This should enable you to reassure the patient of no serious underlying pathology on the basis of evidence rather than conjecture. The patient is more likely to believe reassurance on this basis. During the examination explain what you are looking for and why. Invite the patient to ask questions. At the end of the examination you should either have some ideas of diagnosis, potential diagnoses, be able to exclude some diagnoses or at least classify the pain problem.

Most chronic pain problems can be classified into:

- neuropathic,
- nociceptive,
- a mixture of both, or
- idiopathic.

You don't have to know the answers to everything. It is best to be honest as patients will rapidly lose confidence if they think you are not being honest with them.

The meaning of DI and other tests

Be careful about the choice of words when explaining the outcome of various tests.[2] Arthritis of the spine may imply a hopeless future to someone who simply has age-related degenerative changes. The spine of a 70-year-old in someone who is only 30 may lead to very guarded movements and considerable fear for the future. "I can't find anything wrong" implies it is in the patient's mind. Whereas "we don't fully understand why you hurt" is not only probably true, but shifts the blame away from the patient and explains the limitation of medical science.

Table 3

Tips for engaging with the patient

- Listen to the story (do not interrupt)
- Check that you understand what they meant
- Be non-judgmental (be aware of body language)
- Facilitate disclosure of sensitive information (*e.g.* precisely how many pain killers they actually take!)
- Predict how they may feel
- Give credence to the patient's story, even if you do not understand the mechanisms

Dr. Spanswick is an Medical Leader of the Regional Pain Program, Calgary Health Region, an Associate Professor, Department of Anaesthesia, Faculty of Medicine, University of Calgary and a Pain Physician, Calgary Health Region Chronic Pain Centre, Calgary, Alberta.

Self awareness

Be aware of your own emotional response to either the patient or their plight (Table 4). Patients often forget that doctors are human too. Patients often clutch at straws and physicians can do so too! The outcome of this can be bruising for both patient and doctor alike. Explain what you can do and what you cannot do and why. This will impart empathy and realism. You should make sure you do not end up agreeing to do things that are unhelpful or that you later regret, just for the sake of doing something. The patient needs to understand the limitations of medicine; the likelihood that there is no cure for their pain, but that there are some things (including some self-help strategies) that will help to lessen the burden of pain. Just as physicians need to understand the patient's perspective of his/her problem, the patient needs to understand the physician's dilemma. Only then can the physician, patient and patient's family work in partnership.

Table 4

The nature of doctors (and other health professionals)

- We are human just like anyone else
- We are faced with distressed patients
- We sometimes respond emotionally instead of intellectually
- We do what we are good at
- We often look for the quick way out
- We often ignore the psychosocial factors, especially if there is time pressure and limited resources

Goals

Moving the patient's focus from symptom cure to management of their problem is both appropriate and achievable. Negotiate some specific goals with the patient. These should include regaining physical and social functioning. Any treatments you give can then be used as tools to achieve the goals.

Take-home message

1. Biological:
   - Check for serious or treatable cause
   - Use appropriate pharmacology
   - Do not rush to the use of strong opioids
2. Psychological:
   - Acknowledge impact of pain
   - Check beliefs and educate
   - Treat mood and sleep
3. Social:
   - Check on and acknowledge the impact of pain
   - Encourage family to support rather than protect
   - Help patients return to social life and work activities

Treatment

Analgesics are not just to stop pain. They should be used to help improve function (mental and physical). It may be necessary to sell analgesics as tools to help reach the goals they want. The doctor and the patient should not expect more than a 30% to 50% reduction in pain, even with the use of strong opioids.[1] The patient will still need to learn to manage the rest of the pain and its impact, hence the need for learning self management techniques as well as using analgesics.

Conclusion

Therefore, the FPs role is to ensure there is no serious underlying cause of the pain. Treat underlying causes if they are found and reassure your patient if not. You should educate the patient and guide him/her in the direction of self-management that is to help him/her achieve their own goals by using analgesics as tools to help, rather than seeking cures.

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