The patient with complex chronic pain and the busy primary care physician

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Faculty/presenter disclosure

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- The views expressed are my own
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Key points

- The role of work
- Busy physicians
- Patients with chronic non-cancer pain
- The "drugs" used to treat

Work

Work is the search “for daily meaning as well daily bread, for recognition as well as cash, for astonishment rather than torpor.”

—Louis Studs Terkel: Role of work

Work

- Central role of work in life
- Defines our social role and social behaviours
- Provides social contribution, meaning in life, autonomy and independence
- Primary source of identity for most adults
- Majority of waking hours and energy invested in or absorbed by work
- Evidenced by social historical practice of adopting occupation as last name – cooper, baker, smith weaver
- Only secondary to love as a compelling human activity
- Beneficial as a good marriage/toxic as a destruction one
- Defines people at death – obituaries

Effects of not working

Can act as a:

- Predisposing factor for MH, physical or interpersonal issues:
  - Job loss uncovers preexisting issue
- Precipitating
  - Job loss stress precipitates further episode or exaggerates maladaptive personality traits
- Perpetuating factor in onset of mental and physical health issues
  - Alters course of existing issue
- Difficult to separate effects of unemployment from the primary mental/physical health problem and work caused problem
- Depression the prominent mental health outcome
- Clear risk factor for poor health (Talmage and Melhorn 2005)
  - Increased overall mortality and CV disease mortality
  - Psychosomatic problems – HA, ulcer, dermatitis
  - Loss of identity – strongly related to degree of meaning derived from work

Work-stress-disability connection

- Quality of work experience
  - Critical factor – determines benefit
- Quality determinants
  - Job demands (work load, task control) organizational factors (role ambiguity, management practices, interpersonal relations) skills set, conflict w/values, conflicting role demand, physical conditions and financial conditions
  - The fit
- Stress – when employee perceives the environmental demands tax or exceed their adaptive capacity and resources
- Society's model of the "ideal worker" (how to measure a FTE)
  - White, male, middle class experience of work
  - Social norm against which employers and employee measure workplace behaviour and performance
  - Women, poor, minorities, disabled, older experience different
  - Results in perceived/actual prejudice and discrimination – stress
- Attendance, behavior, performance, burnout, physical and MH issues
- Most often we only have pt's viewpoint

Burnout and withdrawal

- Stress (work demands) chronically exceed emotional resources (adaptive capacity) to manage stress
- Pathological affective reaction causing emotional depletion and maladaptive detachment
- Ultimate negative consequence of job w/ poor fit, job dissatisfaction or prolonged occupational stress
- Distinct from depression – more job related/situation specific
- Three dimensions
  - Emotional exhaustion – depleted phys and psych resources (key)
  - Depersonalization and cynicism – detached from workplace
  - Feelings of inefficacy – personally ineffective, incompetent, no achievement
- Withdrawal from workplace
  - Rarely an ideal solution to workplace conflict
  - Experience stigma and discomfort associated with DB’ed status
  - Guilt, anger, helplessness and depression

Qualities that medical school selects for

- Competitiveness
- Compulsiveness
- Perfectionism
- Altruism
- Qualities that can become vulnerabilities

Educational system

- Apprentice-style learning
- Culture of overwork
- What does the patient need vs. what does the patient want?
- Poor mentoring in boundaries

The outcome – a physician

- Discomfort with uncertainty
  - Diagnostic model
- Focus on acute disease model
  - Most disease are chronic
- Lack of clear policies, procedures and guidelines
- Poor communication and conflict skills
  - Improving
- Lack of time…too busy
  - How we are paid
- Conflict averse

The patient

- Change
- Preventing it occurring
- Wanting immediate change
- Buying into a process of change
- Who needs to change?
  - Physician or the patient
  - Or both

Where is the disease?

- Patients we like
  - Clear compliant
  - Takes care of self
  - Informed and honest
  - Involved in own care
  - Motivated by negative outcome
  - Disease is in the patient
  - “You need to do something about your problem.”
  - Diabetes or COPD?
- Patients we like less
  - Multiple unclear issues
  - Demanding +/- angry
  - Unreliable, unmotivated and non-compliant
  - “Drug seeking”
  - Disease is between me and the patient
  - “What are we going to do about this?”
  - CNCP and addiction

Physician at risk?

- Strong relationship with patient – “special”
  - Over-identify with patient
- Pharmacological overconfidence
  - Just the bio piece
- Rescue fantasies
- Inability to set limits
- Denial about possible boundary issues
- Burnt out
- Doesn’t like “pain”

Codependence

- A syndrome seen in people affected by someone's addictive/abusive behaviour
- Learned behaviour
- Is not about a pathological relationship with an addicted patient, it is the absence of a healthy relationship with self

Enabling

- What happens when we prevent the patient from experiencing the consequences of their unhealthy behaviour
- Characterized by a need to meet the needs of, to fix, or to control others

What it looks like

- Alexithymia
- Conflict adverse and feel safest when giving
- Need dependence in doctor/patient relationship
- Over-controlling, over-responsible
- Helping others is primary source of self worth
- Feel compelled to fix other’s problem
- Feel anger when their help is ineffective
- Find it difficult to say no
- Attract and be attracted to needy people
- Put other’s needs ahead of their own
- Find it difficult to accept help

History of enabling behaviours?

- Taking too much responsibility
  - I am working harder than my patient?
- Embellishing sick notes (stress leave)
  - Facilitating disability
- Failing to confront with feedback
  - Unwillingness to change
- No accountability for “contracts”
- Prescribing to treat emotional consequences
  - Lorazepam for grieving
- Continuing to supply drugs when they are not achieving therapeutic goals, or doing more harm than good
  - Maintains dependence

Enabling: emotional status

- Emptiness
- Low self-esteem
- Shame
- Anger
- Confusion
- Numbness

Is it all about the provider?

- If you find that you have a constant need to help others…
- Notice how you must keep them helpless

—R. Anthony 1986

“Universal precautions”

- Establishing defined boundaries from the outset
  - What is my role?
  - What do I expect from the patient
- Treatment takes place within a structured and conceptual place defined by certain parameters
  - Consider treatment contract
  - Define the outcome and how to achieve it
- Doesn’t mean being defensively inflexible
- Boundaries exist to prevent harm to the patient
- May also prevent harm to the physician

Boundaries?

- Who negotiates them?
- Who is primarily responsible?

“The onus for boundary safeguarding is primarily on the physician, him or her being the only professional on duty.”

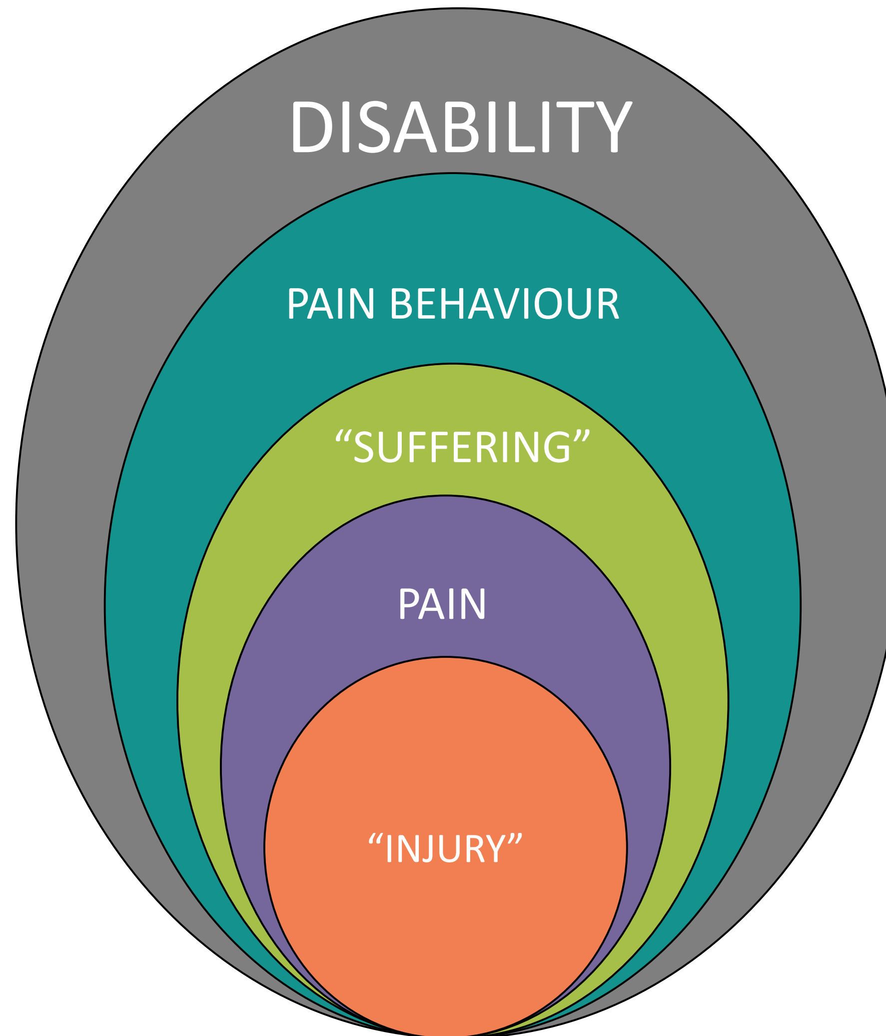
Summary

- Tough patient population
- Qualities and vulnerabilities
- Empathy and sympathy
- We all have enabling traits
- “Codependence”: the syndrome
- Interferes with boundaries, relationships
- Causes enabling rather than empowerment
- Sets up patient for somatization and physician for burnout
- If identified is remediable
- With help, we can make change

How to stop acting and feeling codependent

- Literature: e.g. Woititz, Cermak, Beattie
- Go to some meetings: Al-Anon, CODA, ACOA
- Study and practise health boundary setting (Boundaries, *Cloud & Townsend*)
- Learn and practice meditation/mindfulness
- Get a mentor
- Take a Prescribers Course, FME
- How to make change occur
  - Viewpoint matters

Which patient does the pain get?



Loeser

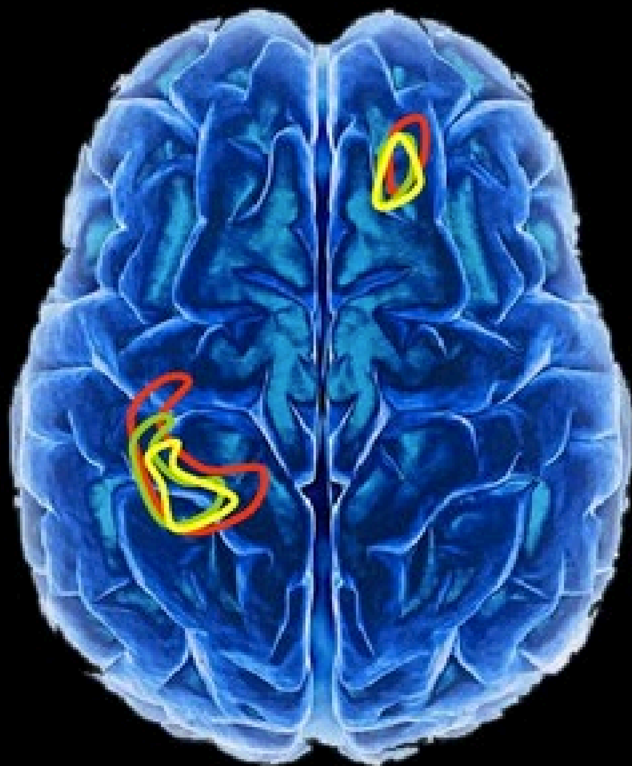
Patient with chronic pain is psychologically vulnerable and subject to strong emotions….

It is not surprising that physicians respond to these patients with emotions of their own.

“I feel your pain”

- Mirror neurons connect us to one another
- They make us feel like we know what the other person is feeling

Implications



Response is similar for:

- Performing the action
- Witnessing the action
- Hearing about the action

Mirror Neurons enable:

- Empathy
- Skill building through mimicry
- Vicarious experience

“I need you to fix my pain, doctor”

“I will find the seed of your pain and I will destroy it. I will do it, not you.”

Caring too much?

- We go into the health-care professions so that we can care for people
- Physicians who over-identify with patients and who have unresolved rescue fantasies are especially vulnerable

“If I work hard(er), I will be loved”

Roots of Physician Stress Explored

Lynne Lamberg JAMA 1999; 282: 134-14

Empathy or sympathy?

- Both involve sharing
- Empathy – share understanding… “as if”
- Sympathy – share emotion, feelings
- Sympathy – if excessive could interfere with objectivity in diagnosis and treatment
- An abundance of empathy should not impede patient care?

Thank you

- Questions?
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