Ask any clinician which patients he or she considers the most difficult to manage, and odds are patients with chronic pain will top the list. Anecdotal reports abound detailing the challenges such patients pose for providers. The limited published research in patient–provider communication in chronic pain care corroborates these anecdotal reports, telling of adversarial, unproductive clinic visits, often characterized by competing demands between patients and providers [1], struggles for dominance and control [2], and mutual lack of trust [3]. Research has described a “burdened physician–patient relationship” [4] and power struggles between patients with chronic pain and their providers [2, 5]. Such problematic relationships pose significant challenges for providers, who have described caring for patients with pain as a “thankless” task, in which they are “confronted with failure” every day [5]. In managing patients with fibromyalgia, physicians described interactions as time-consuming, demanding, and emotionally challenging [4]. In a VA study, 73% of providers surveyed considered caring for patients with chronic pain a “major source of frustration” [6]. Patients, too, feel the relational strain prevalent in chronic pain care. In one study, female patients with chronic pain described actively working to establish credibility with their physicians, characterizing their interactions as “strenuous,” “complicated,” and “heavy.” [3] Patients may experience stress, depression, anxiety, and feelings of alienation when PCPs do not believe their pain complaints or when they perceive that they have not received adequate information about their condition and its treatment [5, 7, 8]. Staiger et al. found that when patients with back pain disagreed with their physicians about the cause of their pain, or the recommended diagnostic and treatment plans, patients reported decreased satisfaction with care and lower health-related quality of life than patients who agreed with their physicians [9].

Such reports are concerning, not only because awkward, hostile, or strained clinic visits are unpleasant, but also because productive relationships are associated with greater patient satisfaction, better treatment adherence, and improved health outcomes [10, 11]. For example, Stewart and colleagues found that patients who perceived that their physicians conducted patient-centered consultations (i.e., considered patients’ preferences, involved them in decisions, encouraged self-management behaviors) experienced greater relief from their symptoms, had better emotional health at follow-up, and required fewer diagnostic tests and referrals [12].

While research highlighting the importance of effective patient–provider relationships is compelling, productive relationships may be even more critical in chronic pain management. Because pain is a subjective experience, reliable assessment is largely dependent on a patient’s self-report. As a result, the physician-patient interaction is the primary source of important diagnostic information [1]. Effective communication is especially crucial in light of studies suggesting that physicians may not accurately judge patients’ pain levels. Tait and Chibnall found that physicians are more likely to base clinical decisions on diagnostic test results, even when these tests contradict a patient’s own report of pain [13]. Moreover, physicians tend to be inconsistent when judging patients’ pain [14].

Despite the relational challenges that are widely accepted to exist, little research has sought to gain a more complete understanding of patients’ and providers’ perspectives on the problems surrounding pain care. Without a better understanding of the nature of these problems, it is difficult, if not impossible, to improve patient–provider relationships in chronic pain care.

The article in this issue, “ ‘They don’t want anything to do with you’: Patient views of primary care management of chronic pain,” by Carole Upshur, Gonzalo Bacigalupe, and Roger Luckmann [15], helps to advance our understanding of patients’ perspectives on the relational difficulties accompanying chronic pain care. The authors describe a qualitative focus group study of 72 primary care patients with chronic pain. Study participants were asked their views on various topics including their pain conditions and care received, types and effectiveness of treatments, any difficulties adhering to clinician recommendations, and advice patients would give their providers to improve pain management.

Study patients identified both positive and negative aspects of their relationships with providers. Among the negatives, some patients reported being labeled as either “hypochondriacs” or “drug seekers,” while some felt their providers did not believe their reports of pain. Others perceived receiving lower quality care than patients without pain, manifested as their providers spending less time with them during an office visit.

Conversely, participants also reported positive relationships with providers, especially PCPs whom they perceived as genuinely concerned about them and their pain.
These patients believed their pain complaints were validated and felt listened to and understood. Patients appreciated providers who invited them to participate in shared decision making, particularly surrounding treatment decisions related to analgesic management.

Patients also identified system-level barriers to effective chronic pain care. They complained of problems with access to care and wished for alternative methods to contact their providers (via email and voice mail). Patients acknowledged needing frequent contact with clinic staff for their chronic pain care needs, but were concerned that they posed a burden to providers and other staff that could be mitigated with a “team” approach to pain management.

This study [15] adds to the limited research related to patient–provider relationships in chronic pain care. In particular, these findings corroborate those of an earlier qualitative study with patients who participated in a clinical effectiveness trial for comorbid depression and chronic musculoskeletal pain [16–18]. Most noteworthy is that Upshur et al.’s study used a relatively large sample size for qualitative research and unique sampling characteristics, including an over-sampling of Latinos (44% of the sample).

One limitation of the above studies is their exclusive focus on the patient perspective. While patients’ concerns should be taken seriously by both researchers and clinicians, it is important to remember that PCPs too find chronic pain care challenging and demanding. In a qualitative study we recently completed, PCPs described a number of difficulties with patients with pain, including questions about the credibility of some patients’ pain complaints, feeling pressured to treat with opioids, and worries about opioid abuse or secondary gain issues [19]. Furthermore, providers described the heavy emotional burden that often accompanies caring for patients with chronic pain; they described feeling guilty, and even unsuccessful as physicians, when unable to adequately relieve pain. PCPs also recounted particularly troublesome situations in which they perceived patients as deceitful, hostile, or “abusive.” Given that providers’ comments in our study mirrored many of the remarks made by patients in Upshur et al.’s study, it is apparent that both parties recognize the challenges to the patient–provider relationship in chronic pain care.

Upshur et al.’s study [15] adds to the growing body of research that not only demonstrates the problematic nature of patient–provider communication in pain care, but also the compelling need for additional research that seeks to help patients and providers successfully navigate through pain management—to communicate effectively with one another, to listen to each other, to share decisions about treatments, and to cultivate an atmosphere of empathy and trust. Indeed, empathy is increasingly recognized as an indispensable component of chronic pain treatment [20–22], and is in essence a prerequisite to many of the other ideals listed above.

While the goals described previously can be difficult to achieve, some preliminary research, particularly with shared decision making interventions, has shown promise. Sullivan et al. found that a shared decision making intervention helped general internists to feel more competent and confident in treating chronic pain, and experience relationships with patients that were less antagonistic [23].

In another intervention, Bieber and colleagues trained patients with fibromyalgia in shared decision making [4]. Although they found no improvement in pain scores, both patients and providers described subsequent clinical encounters as more productive and less difficult. Patients reported feeling understood; physicians reported having fewer negative feelings about their patients with fibromyalgia, even describing some interactions as “pleasant.” Further, patients were better able to cope with their pain and were more actively involved in their treatment plans.

As we continue to gain a deeper understanding of how both patients and providers view relationships in chronic pain treatment, the challenge facing us now is to move beyond descriptive studies, to develop and test effective interventions that foster productive, mutually rewarding clinical encounters. No matter how far chronic pain treatment advances, if patients and clinicians cannot communicate effectively, openly, and with trust, chronic pain management will remain a burden.

Conflicts of Interest

The authors have no conflicts of interest.

References


