Pain Medicine Fellows Need Explicit Training in Engaging Patients in Patient-Centered Pain Management

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The majority of pain medicine physicians complete residency in anesthesiology, during which they learn to safely care for patients rendered unconscious or insensible to pain and stress during surgical, obstetric, and other medical procedures. During pain medicine fellowships, trainees learn to examine, diagnose, and treat these challenging patients. Most training is on learning the administration of regional nerve blocks, other injection interventions, and the pharmacological management of acute and chronic pain in both outpatient and inpatient settings [1]. In addition to these somatic interventions, the ACGME requires fellows to 1) perform several complete mental status examinations (both supervised and unsupervised) and 2) “understand the principles and techniques of the psychosocial therapies, with special attention to supportive and cognitive behavioral therapies, sufficient to explain to a patient and make a referral when indicated” [1]. Given the need for a strong working alliance between patients living with chronic conditions and their physicians, more training is needed to effectively engage patients with chronic pain in a patient-centered model of chronic care.

The article by Matthias and colleagues [2] describes the experiences of military veterans participating in a multi-component intervention for chronic musculoskeletal pain. Their article identifies the interventions deemed of value by chronic pain patients. The 12 telephone-based sessions, delivered by a nurse clinician, included training in 1) analgesic management; 2) pain self-management instruction; and 3) brief cognitive behavioral therapy. Broadly, the intervention 1) helped patients find what worked for their pain; 2) held patients accountable for pain management; and 3) motivated and provided emotional support.

Patients in the project were provided guidance and encouragement in achieving the goals of identifying the causes of pain, managing pain flares, minimizing bed rest, setting behavioral goals, and using relaxation techniques. Achieving these goals involved tailoring exercises, relaxation skills, and communication abilities to the particular needs and preferences of each patient, delivered in the spirit of developing healthy lifestyle changes needed to live successfully with a chronic condition.

Other than requiring familiarity and knowledge about when to refer, these clinical skills are neither routinely taught to nor administered by fellows in pain medicine. For example, at our well-regarded pain medicine fellowship at the University of Pittsburgh, trainees receive the following lectures by our pain psychologist: 1) history and evolution of chronic pain psychology; 2) the role of psychology in pain rehabilitation; 3) psychological assessment of chronic pain patients; 4) psychological interventions for chronic pain; and 5) psychological factors of spinal cord stimulators and intrathecal opioid pump procedures. As our on-site psychiatric consultant, I provide a lecture about the diagnosis and psychopharmacological management of psychiatric conditions in patients with chronic pain. These lectures are useful, but fellows are not required to learn how to effectively deliver brief psychological or self-management interventions as described in the article of Matthias.

In the article by Matthias and colleagues [2], patients expressed varying positive perceptions of the nurse. These included describing her as a brainstorming partner, coach, supportive listener, and motivator. I would challenge the current pain medicine curriculum and competency requirements to include teaching fellows how to motivate patients and instruct them in self-management skills as core competencies that must be taught to proficiency. These can be accomplished by training fellows in 1) empathy; 2) supportive and active listening; 3) how to coach healthy lifestyle behaviors; and 4) motivational interviewing.

Teaching fellows in pain medicine how to interact with patients in a compassionate and empathetic manner while still attending to the facts, data, and biomedical science guiding diagnosis and treatment should receive a greater focus in fellowship curriculum. Many patients seeking care for chronic pain are psychosocially complex and have high rates of psychiatric and substance misuse comorbidity. Teaching fellows how to project empathy and behave in a consistently compassionate manner when working with patients who are often demanding, at times unlikeable, and who often have a different understanding of and expectation for the clinical encounter with a pain medicine physician is a dimension of training often overlooked. I have often thought that the waiting room at our pain clinic, populated by many patients with evident poverty, unhealthy behaviors (e.g., smoking and overeating), and psychosocial distress, mirrors the waiting room at our outpatient psychiatric clinic. Psychiatrists, psychologists, and social workers spend much of their education receiving supervised training in how to manage countertransference, engage individuals in...
treatment, and develop empathy for challenging patients. The goals of teaching the skills of empathy and supportive listening are to foster understanding of a patient’s experiences and encourage sensitive communication, both of which have been shown to improve clinical outcomes [3,4]. It is remarkable that pain medicine fellows, most of whom have spent the majority of their residency training in the operating room and post-anesthesia care unit, should be expected to innately possess the skills that are needed to work effectively with these patients [5,6].

Pain motivates behavior. Many patients living with chronic pain, however, are ambivalent about engaging in healthy behavior and rehabilitation recommendations that may improve analgesia and function. This ambivalence may result from catastrophic thinking (e.g., “If I exercise, my pain will flare-up,” “I need to smoke cigarettes or my nerves will be shot”). Patients may also be ambivalent about adhering to treatments that are not what they anticipated would be prescribed (“But I just wanted you to prescribe me Percocet or give me an injection”). This ambivalence about implementing and adhering to treatment may be addressed by Motivational Interviewing (MI), a collaborative, patient-centered form of guiding to elicit and strengthen motivation for change. The participants in the article of Matthias identified motivation as a useful component of the telephone-based intervention. The provision of MI, like empathy and active listening, is a technique that is easy to master and results in improved clinical outcomes. These skills can be seamlessly and efficiently integrated into the clinical encounter. Indeed, curricula linking MI skills to the management of chronic conditions (like pain) have been successfully implemented in several primary care programs and resulted in improved physician confidence with health behavior and adherence counseling, and with preparing patients to become active participants in the management of their chronic conditions [7,8].

Given the epidemic rates of chronic pain in the United States [9], there will likely be a greater need for expertly trained pain medicine physicians. We owe it to our patients to revisit how pain medicine fellows are trained. As described by Wagner and the Institute of Medicine [10,11], during fellowship we should make primary the goal of teaching pain medicine physicians to 1) know how to manage the challenges of living with a chronic condition and 2) learn how to inform and activate patients to take responsibility for self-management using the skills of empathy and motivational interviewing.

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