

PRIMARY CARE & HEALTH SERVICES SECTION

Original Research Article

The Patient–Provider Relationship in Chronic Pain Care: Providers’ Perspectives

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Abstract

Background. Pain is the most commonly reported symptom in primary care and is a leading cause of disability. Primary care providers (PCPs) face numerous challenges in caring for patients with chronic pain including communication and relational difficulties.

Objective. The objective of the study was to elicit providers’ perspectives on their experiences in caring for patients with chronic pain.

Design. The design used was a qualitative study using open-ended, in-depth interviews.

Participants. Twenty providers (10 men, 10 women) from five different clinics were interviewed at the Roudebush Veterans Affairs Medical Center.

Results. Three broad themes emerged from the analysis: 1) providers emphasized the importance of the patient–provider relationship, asserting that productive relationships with patients are essential for good pain care; 2) providers detailed difficulties they encounter when caring for patients with chronic pain, including feeling pressured to treat with opioids, believability of patients’ reports of pain, worries about secondary gain/diversion, and “abusive” or “difficult” patients; and 3) providers described the emotional toll they sometimes felt with chronic pain care, including feeling frustrated, ungratified, and guilty.

Findings. Findings were interpreted within a model of patient-centered care.

Conclusions. The clinical implications of these findings are two-fold. First, PCPs’ needs cannot be ignored when considering pain care. PCPs need support, both instrumental and emotional, as they care for patients with chronic pain. Second, improving PCPs’ patient-centered communication skills—including demonstrating empathy and encouraging shared decision-making—holds promise for alleviating some of the strain and burden reported by providers, ultimately leading to improved patient care.

Key Words. Chronic Pain, Patient–Provider Communication, Opioids, Primary Care, Qualitative Research

Introduction

Pain is the most commonly reported symptom in the primary care setting [1–3], with 57% of American adults suffering from chronic or recurrent pain [4]. In the Veterans Health Administration, chronic pain affects 40–70% of veterans and is a leading cause of disability [5,6]. Moreover, pain was the most frequently reported symptom in Persian Gulf War veterans and is associated with mental disorders and work loss [7]. Chronic pain is also costly,

with an estimated \$100 billion per year spent on health care and lost worker productivity [8].

Despite innovative organizational efforts, such as “Pain as the 5th Vital Sign,” initiatives and other campaigns to raise awareness of pain as a public health problem, chronic pain is still undertreated in a variety of settings [9–12]. Because specialized pain clinics are not widely available, most chronic pain is managed in primary care. Primary care providers (PCPs) face serious challenges in providing effective treatment, including lack of training in pain management, time constraints, lack of consensus on optimal treatments, and controversies surrounding the use of opioids for chronic noncancer pain [13–15].

Further challenging PCPs as they care for patients with chronic pain are problems with the patient–provider relationship. This is concerning because this relationship has long been recognized as fundamental to good patient care and positive health outcomes [16]. Patient-centered care, in particular, is widely recognized as critical to fostering productive communication and positive relationships [17,18], which may be even more important in pain treatment [19]. Central to the model of patient-centered care is demonstrating empathy, empowering patients, and treating patients as partners in their health care [19–21]. This involves behaviors such as 1) assessing not only the illness, but the patient’s experience of the illness; 2) understanding the patient as a person; and 3) engaging in shared decision-making [21,22]. Research on patient-centered care has demonstrated that patients are more satisfied and change physicians less frequently when their physicians communicate in a patient-centered manner [17,18,23]. Additionally, patient-centered care has been associated with fewer patient concerns, better emotional health, and a decreased need for diagnostic tests and referrals [18].

Because of the adverse long-term effects associated with chronic pain and the challenges related to its management, positive patient–provider interactions may be especially important for pain relief and functional outcomes, as patients with chronic conditions usually have more frequent contact and longitudinal relationships with their providers. However, the limited research on communication and chronic pain suggests that patient-centered care is likely to be impeded by interactions that are often strained and adversarial, marked at times by anger and even deception [24,25]. Patients have used war and legal metaphors to describe their interactions with their physicians [26], while physicians have called caring for patients with chronic pain a “thankless” task [27]. These strained and often unproductive interactions undermine patient-centered care and are concerning given the links among patient–provider communication, patient satisfaction, and health outcomes [16–18,28].

Further complicating these problems, PCPs juggle competing demands and make difficult treatment decisions daily without clear research evidence guiding their choices. For example, providers must frequently decide

whether opioids are appropriate for patients with chronic pain, while relying on guidelines based on low- to moderate-quality evidence (i.e., trials that are too small and/or too short to adequately determine risk of abuse, dependence, and other potential harms) [29,30]. Complicating this lack of evidence is a greater than four-fold increase in opioid prescriptions for chronic musculoskeletal pain from 1980 to 2000, coupled by similar increases in opioid abuse [29]. The uncertainty surrounding opioid-prescribing and concerns of abuse amplify the potential for communication problems between providers and patients with chronic pain.

These challenges may take a toll on providers, adversely affecting both providers and patient care [31]. While we know that PCPs find caring for patients with chronic pain frustrating at times [24,25,27], little is known about how PCPs experience these difficulties, the role of the patient–provider relationship in these struggles, and how these issues impact how PCPs view their work, their patients, and even themselves as providers. Furthermore, the patient–provider relationship, long recognized as integral to quality patient care, is largely unexplored in chronic pain, and much remains to be learned [32]. Hence, to better understand providers’ perspectives on chronic pain care, to help to inform how such care can be improved for both patients and providers, we conducted in-depth interviews of PCPs from a single Veterans Affairs (VA) Medical Center to understand their perspectives on treating veterans with chronic pain.

Method

Twenty in-depth, semi-structured interviews were conducted with VA PCPs.

Setting

The study was conducted at the Roudebush VA Medical Center in Indianapolis, IN. PCPs were sampled from the medical center’s five outpatient primary care clinics, which see about 30,000 patients per year. Patient demographics reflect those of the national VA population, with 38% of patients over the age of 65, 94% male, and 89% Caucasian.

Participants

Participants were sampled based on the following criteria: 1) varying levels of clinical experience; 2) representing all five VA primary care clinics; and 3) including both male and female PCPs. Sampling continued until theoretical saturation was reached (i.e., no new themes emerged from the interviews) [33]. The first 20 PCPs who were approached all agreed to be interviewed. All interviews were conducted by the same member (KN) of the research team. Providers were asked open-ended questions designed to elicit their experiences with chronic pain management [34] (see Appendix for sample interview questions).

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Development of interview questions was guided by the research team's prior clinical and research experience in pain management. Additionally, formulation of some questions was informed by a resource manual for pain management that outlines barriers to adequate pain management [35]. As initial interviews were conducted, members of the research team discussed the responses, clarified questions as needed, and added probing questions if necessary. Through this process, core questions (see Appendix) remained the same for all interviewees. Because interviews were semi-structured, probes and follow-up questions sometimes varied depending on providers' responses. Interviews took, on average, 45 minutes. All participants signed an informed consent statement, and the research was approved by the local Institutional Review Board.

Data Analysis

All interviews were transcribed verbatim from audiotapes, checked for accuracy, and imported into Atlas-ti qualitative software (Atlas-ti Scientific Software Development GmbH, Berlin, Germany). Five members of the research team participated in an inductive, emergent thematic analysis, employing techniques recommended by Miles and Huberman [36] Bernard [37], and Patton [38]. Over a 2-week period, the analytic team read the transcripts individually for overall impressions, taking careful notes and highlighting patterns or particularly salient statements. Team members then met to discuss initial impressions. After these initial discussions, the team continued to cull through the data individually and met weekly over a period of 3 months to develop, discuss, and modify codes.

Each team member worked individually to develop a coding scheme, and during weekly meetings we compared each member's codes, identifying and collapsing overlapping categories, eliminating categories based on lack of support from the data, and resolving discrepancies by consensus. Team members worked back and forth between the developing classification system and the data, to ensure that categories were meaningful within the context of the data. During this process, we also took care to search for negative cases (i.e., disconfirming evidence in the data) that might call our observations and codes into question [39,40]. This process continued until our codes remained stable and consistent.

In order to ensure that team members were grounded in the data and not influenced by preconceived notions or biases, the analytic team took care to ensure that identified themes met the criteria of recurrence, repetition, and forcefulness [41]. Once coding was completed, the first author then searched for patterns and variations among providers' responses to ascertain whether some PCPs had generally more negative experiences and attitudes toward treating pain than others.

Results

All participants (n = 20) were either part- or full-time PCPs and ranged in age from 33 to 54 years. Ten were women;

10 were men. Fourteen were Caucasian, five were Asian, and one was African American. Length of time in practice varied from less than 5 years to more than 20. Four participants were nurse practitioners; one was a doctor of pharmacy; the remainder were physicians.

Providers identified several issues related to the treatment of chronic pain and the patient-provider relationship. An emergent issue was the emotional toll attached to taking care of these patients.

The Importance of the Patient-Provider Relationship

Many providers emphasized the importance of their relationships with patients. They pointed to the advantage of spending time in conversation with their patients, and how developing strong relationships enhances trust. One provider even suggested that time spent getting to know and understand a patient helps to make her more comfortable prescribing opioids:

It's like how much you believe a patient is really in pain and how much effort and time you spend talking about it . . . So I think some people are uncomfortable with narcotics; some people are uncomfortable talking about pain. And I think I probably prescribe more narcotics than the average person, and I probably spend more time with pain patients than some others in my clinic. (PCP 8)

Another provider noted that conversation was the best pain assessment tool available:

I have not seen the value yet other than just talking to somebody. I don't use any standardized instrument to assess function . . . just talking to the patient about what they can do, what they want to do, more importantly. (PCP 20)

Others spoke of the important role communication plays in treatment. One provider noted: "Well, I think chronic pain takes time, and so it takes a lot, if people really want to talk, they want you to hear, and sometimes, it's the discussion that is the therapeutic intervention." (PCP 9)

Another PCP said, simply, "I think a big part of pain management is continuity, and seeing the patients, and listening to them." (PCP 11)

Yet another provider pointed to the value of building a trusting relationship to achieve optimal pain control:

I think a big part of pain control is your ability to tinker. So if you have a longstanding relationship with a patient, there is this level of trust. And, so you . . . say, "I am going to try this today; and, if it does not work, we will be able to readdress your pain in a week, two weeks, whatever." (PCP 18)

Difficulties in the Patient-Provider Relationship

While the literature points in general to strained interactions related to chronic pain, our interviews yielded vivid, detailed examples of PCPs' experiences with difficult patients.

Pressure to Treat Pain with Opioids

Some providers believed that the medical center culture was a source of pressure to prescribe opioids; however, PCPs also felt pressure from the patients themselves. Many feared being “fired” by patients whom they could not please, and voiced concerns that this would reflect badly on them professionally. One provider voiced these concerns as follows:

It tugs on your guilt that you really don't want people to be in pain. You want the patient to like you . . . And, they fire you . . . and the number of patients that fire me is part of my performance review. (PCP 18)

PCPs also described an expectation that some patients seemed to have that, if they desired opioids, then they should receive opioids without question. One PCP compared a particular patient's request for opioids to a fast-food order: “You know . . . it was like you go to the McDonald's drive-through and you order what you want, and they should give it to you.” (PCP 9)

Believing Patients

Providers voiced concerns about the subjectivity of pain and frequent inconsistencies between diagnostic test results and a patient's account of his or her pain.

Of particular concern was the credibility of a patient's assessment of his or her pain. In some instances, providers voiced distrust:

Provider: You can pretend you're in a lot of severe pain too and it's . . . easy to pretend, if you want to deceive somebody.

Interviewer: And you think you're pretty good at discerning who is pretending and who is not?

Provider: No . . . Some of them are good actors. (PCP 3)

One provider gave an example of a patient who, she believed, was “pretending:”

I'll never forget. He comes and says, “I have this C-spine pain, 10 out of 10.” Every time. He sits with a cell phone . . . When somebody has that much neck pain, you don't sit like that lounging in a chair, talking on a cell phone with a C collar on . . . You have to sit straight, otherwise the C collar will hurt your neck. So off right I know this guy is not having as severe pain as he claims. (PCP 13)

Still other providers acknowledged that all they can do is trust their patients and treat accordingly: “Pain is so subjective that you just have to take their word for it. If they hurt, they hurt. You just have to take their word for it.” (PCP 5)

Another provider echoed a similar sentiment:

I do believe that there are patients who have pain when they say they have pain. I tend to not question, because there is no adequate measure, and I believe most patients . . . they're not drug-seeking. So I tend to . . . err toward giving more pain medication than less. (PCP 15)

Secondary Gain

The pursuit of disability claims was another situation that contributed to distrust. If they suspect that disability compensation is the patient's primary goal, providers may become skeptical of the patient's report of pain and its severity.

Patients that are either on disability or trying to get disability . . . it makes it very hard, at least for me, to know how much pain they are having . . . Unfortunately, it makes me kind of cynical about how much to believe their pain and how much is just they are trying to make a case for something. (PCP 8)

Another provider noted that for patients receiving disability payments, “it is in their best interest to never be better.” (PCP 19)

Suspicion of Diversion

Distrust also surfaced when providers suspected that patients were selling their opioids as “street drugs.” One provider said,

Some patients don't take the narcotics but they sell them. I check the urine test and find out if it's negative. It happens. Some of the patients are very poor, always have pain, and you give them narcotics. Two years later they changed, good brand name shoes, clothes. (PCP 3)

This provider went on to say that, because pain is subjective, when a patient claims to be in pain, even if diversion is expected, “What can you do? They're in pain. You give them the narcotics, but they probably sell half or two-thirds on the street, and they only take one-third to control the pain. They make money.” When asked how to prevent such diversion, the provider responded, “No, no way. That's a barrier.”

Difficult Interactions with Patients

It is no surprise that the problems described above by providers sometimes lead to strained, uncomfortable interactions. Several PCPs described in rich detail their experiences with difficult patients, including anger, deceit, lack of adherence, and “doctor shopping.”

Some described patients with chronic pain as “abusive” at times. One provider described caring for chronic pain patients as “scary, you know . . . they're very abusive, and I don't think we have any support system for doctors.” (PCP 13)

One PCP told of a patient who became angry about his treatment:

All we ended up finding was posttraumatic stress disorder, fibromyalgia, and headache, and tried to get him to back off on the medication slowly and explained why. He's young, he's got a family, he's not working . . . And he really became upset. He would cry and get all sweaty and angry with me and I would just calmly explain, this is my opinion . . . so that was very frustrating. (PCP 4)

Another provider spoke of a patient who

clearly changed the quantity on the prescription. And he came in with his wife, who was part of it too. And they just attacked me . . . The guy peed in the urinal and poured it all over the room. Urine all over the floor . . . We have had a number of them that we have had to call the cops on. They get really belligerent . . . They want the narcotics. (PCP 18)

Other difficult interactions stemmed from patients' lack of adherence to treatment recommendations. A provider described a situation with one patient in particular:

He was resistant to the TENS unit, but he would just keep saying, I'm in pain, I'm in pain, I'm in pain, and he was also chronically depressed, but he won't go to mental health. You know, he says there's no point. It's like the dog chasing its tail. So I keep going up on the morphine, but where am I going with it? (PCP 5)

Lack of adherence can also lead to "doctor shopping," as one provider shared:

I had a patient who came in, she had fibromyalgia, she wanted her OxyContin because it works for her daughter, who also has fibromyalgia. She had never tried anything else. She didn't do any exercise. She just watches TV all day, and she didn't want to talk about anything else . . . except several of my colleagues that she'd fired recently, and so, you know, you look back in the chart, and she has seen six or seven . . . docs in the last year. She'd walked out on many different people. (PCP 9)

The Emotional Toll: "It's a Pain to Take Care of the Pain."

Perhaps the most striking finding that emerged from the data was PCPs' descriptions of the emotional toll they experienced interacting with patients in pain. They pointed to the stress, lack of satisfaction, and even hostility they have encountered with some patients. One provider summed up these feelings as follows: "In China there's a very common phrase, 'Patient's back pain, doctor's headache'." (PCP 3)

Words such as "frustrating," "overwhelming," and "ungratifying" were frequently used when providers discussed caring for patients with chronic pain, and providers often contrasted treating pain to treating other conditions that produce greater satisfaction. One provider said:

It's much more gratifying to treat people that either get better or have something that's more treatable . . . there are days when I walk into the clinic and I see a name and I say, this is not going to be a gratifying visit. And in those cases, all you can do is listen, and that in itself is probably therapeutic, but it's not very gratifying. (PCP 11)

Many providers were critical of themselves when discussing chronic pain. One provider even suggested that he is unsuccessful as a physician because he is not able to treat chronic pain effectively:

I spend time with a patient with diabetes or a heart condition [and I] can make a difference . . . save their life. I can see a tangible result of what I do . . . I

really feel success with somebody whose pain is diagnosed, treated and cured . . . That's the problem. Are there many of those? Not many. So that's why I see myself as not a big success. (PCP 15)

Another provider lamented:

I beat myself up with it . . . You want to be liked by your patients. You want to be respected by your peers. You don't want to personally feel like you are being Cruella Deville by denying taking them out of pain. Of course, you want to relieve their pain, so I beat myself up. I feel guilty when these people end up yelling at you, and they do. (PCP 18)

Discussion

This qualitative study corroborates, in rich and particular detail, a recent study finding that 73% of PCPs surveyed at a VA Medical Center found patients with chronic pain to be a major source of frustration [42]. While some of the issues identified in this study are reflected in the current literature, the specific insights our interviewees provided of their own experiences, frustrations, and feelings of guilt and failure paint a detailed, vivid picture of a PCP's daily struggle caring for patients with chronic pain—and provide insight into *why* PCPs face these struggles. Previous survey studies report PCPs' knowledge, attitudes, and behaviors [15,42], and discuss issues such as competing demands, the absence of clear guidelines [29,30], and lack of specialized training in pain management [12,43–45], but this study's unique contribution is an exploration, in PCPs' own words, of what these challenges mean to them in their daily practice and the adverse effects such struggles may have on them personally and professionally [32,46,47].

Many providers internalized their lack of success with patients suffering from chronic pain, feeling guilty and ungratified. These negative feelings were compounded by descriptions of hostile interactions, suspicion and distrust of patients, and fear of being "fired." PCPs often described dread when seeing a patient's name on their clinic schedule, knowing the interaction was going to be unsuccessful at best, difficult or hostile at worst. PCPs described feeling ineffective and unsuccessful in their ability to treat many of their patients with pain. Interestingly, reports of frustration and negative experiences were present throughout the sample. Even PCPs who were generally positive about their relationships with their patients reported difficulties, distrust, and other relational issues at times.

These findings are concerning for both patients and PCPs. In spite of the importance they placed on their relationships with patients, PCPs described numerous relational difficulties when caring for patients with pain. They described feeling pressure from patients to prescribe opioids, struggling with the credibility of patients' pain reports, and worrying about secondary gain and diversion, all of which take a toll on the patient-provider relationship, leading to strained, even hostile interactions, and ultimately to provider frustration, stress, and burnout. Stress and burnout, in turn, can compromise effective patient

care, draining PCPs' energy and reducing their capacity to show empathy to patients [31,48,49].

Empathy is not only an important ingredient in patient-centered care [19,21,22], but has also been recognized as absolutely essential when treating chronic pain [19,48–50]. Empathic, patient-centered care is associated with better health outcomes, in part because seeking to understand a patient's pain and actively involving a patient in his or her care fosters trust (a key issue for providers in this sample), thereby encouraging the patient to reveal important diagnostic information and to participate more fully in treatment [18,19,21,49,51,52]. And, particularly relevant to PCPs' complaints in this study, empathy can defuse moments of conflict and reduce the need for each party to feel as if he/she needs to dominate [19,24].

Not only can empathy help to build trust and decrease conflict, but an empathic relationship, in which both parties feel understood and respected, helps to foster an effective working alliance between patient and physician. The power of the physician-patient working alliance has been well demonstrated in psychological treatment [53,54]. A working alliance allows patients and providers to share both an emotional bond and instrumental goals, such as partnering with one another to identify treatment objectives, and deciding together how to realize these objectives [21,55]. When this occurs, patients are more satisfied and adherent to treatment [32,55,56], and experience improved health [52,56]. Clearly, relationships with patients who are satisfied, adherent, and work in partnership with their providers are less likely to be hostile or frustrating.

This study has some important clinical implications. First, the struggles voiced by PCPs in this sample underscore the need to consider, not just patients' needs, but providers' needs in chronic pain care. The adverse effects on providers associated with taking care of patients with chronic pain are largely unexplored and may exacerbate difficulties treating pain [32,46].

As a result, our current findings highlight the need for physicians to care, not just for their patients, but also to adopt self-care strategies to reduce "compassion fatigue" brought on by caring for difficult patients [57]. Diesfeld [46] recommends that providers actively engage in self-reflection and anticipate conflict in pain care before it arises. She suggests asking questions such as, "What interpersonal conflicts are most worrisome for me? Have I been honest and frank with myself regarding my beliefs and attitudes toward the patient?" (p. 1122). Additionally, Papadimos recommends strategies to be taught in medical school or residency, such as critical incident analysis, modeling behaviors, and mentorship [58]. Beyond medical school and residency, there is a clear need for clinics and medical centers to provide support, both instrumental and emotional, to PCPs as they face challenges with patient pain care.

An example of instrumental support was an opioid renewal program evaluated by Wiedemer and colleagues

[45]. These authors examined a multidisciplinary program to help PCPs manage chronic pain for patients with a previous history of substance abuse or aberrant behaviors related to opioids. The program provided formal structure to pain care (opioid agreements, urine drug screening, pill counts, and frequent and regular follow-up appointments), as well as a resource for PCPs to turn to for help with opioid titration and rotation. After the intervention, PCPs were highly satisfied with the program and reported fewer complaints from patients regarding opioids as well as improved relationships with their patients with chronic pain. PCPs also noted that they were able to spend more time on patients' other medical problems and that they felt supported in the safe and effective management of opioids.

The results from Wiedemer et al.'s study are encouraging, although our data, as well as other literature, suggest that PCPs need interdisciplinary support beyond opioid prescribing [32,59,60]. For example, because chronic pain and psychological disorders such as anxiety and depression are often comorbid conditions [44], involving psychologists or other mental health professionals may help to alleviate some of the PCP's burden, as well as to provide more comprehensive care to patients with these conditions.

Another clear implication of the current study is that efforts to improve patient-centered care are needed and hold promise to improve pain care for both patients and providers. Indeed, patient-centered care has been endorsed as the optimal approach for providers treating patients with chronic pain [32].

Although little research has been conducted on patient-centered care in patients with pain, two recent studies indicate that even interventions focusing on one aspect of patient-centered care, shared decision-making, show promise. Sullivan and colleagues [59] trained internists in shared decision-making techniques, while Bieber and colleagues [25] taught patients with fibromyalgia shared decision-making strategies. Physicians in the Sullivan et al. study reported feeling more competent in caring for patients with chronic pain. After Bieber et al.'s intervention, both patients and providers described communication as more productive and less difficult; both parties were more satisfied with their interactions. And, although patients did not experience measurable improvement in pain symptoms, they were better able to cope with and self-manage their pain after the intervention.

These studies demonstrate promising avenues for improving communication in pain care; however, there is a dearth of research in this domain. Further, while shared decision-making interventions are an appropriate beginning, providers likely need training that extends beyond the sharing of decisions and teaches PCPs an array of patient-centered communication skills that foster a trusting working alliance between patient and provider. Indeed, the challenges described by PCPs in this sample suggest that many of the problems described require other patient-

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centered behaviors, such as showing empathy, to ameliorate relational difficulties. Improving patient-centered care may be particularly important given that relatively few physicians appear to employ this model in pain treatment [61]. Moreover, training PCPs in patient-centered behaviors has proven highly effective, yielding positive, long-term effects on patient-provider communication and patient satisfaction [62–65].

Another option to enhance empathy is to adopt a narrative approach to understanding patients with chronic pain. Narratives rely on the telling of stories to help others make sense of complicated experiences, often characterized by intense affect [47,66]. PCPs may benefit from writing or telling a story about a difficult clinical situation with a patient with pain, for example. These stories may then be analyzed to produce new understandings of the communication and relational dynamics in the situation, as well as to promote self-reflection among PCPs. Such activities, in addition to being cathartic for PCPs, could be used to improve both patient-centered communication skills and physicians' confidence in treating pain [47].

Although formalized training requires planning and resources, providers can also practice strategies on their own to improve their communication skills. Banja offers suggestions for physicians to improve their empathic communication [48]. Among these strategies, Banja recommends using effective body language with patients, such as sitting rather than standing, and maintaining eye contact, to create an empathic environment. He also suggests checking for patient understanding, stopping frequently to allow for patient interruptions, and validating patients' responses (e.g., "That's an important point.").

This study illustrates that providers' needs should be considered if communication in chronic pain care is to be improved. However, potential solutions to communication difficulties in chronic pain care extend beyond the individual provider. The culture of the organizations and settings in which providers practice play an important role in providers' experiences, potentially either contributing to or helping to mitigate difficulties in chronic pain care. For example, feeling pressure to prescribe opioids because of an organization's culture may be problematic in many health care settings and may explain in part the dramatic rise in opioid prescriptions in recent decades [29]. Moreover, clearly written and readily available policies on tools such as urine drug testing and opioid agreements, organizational leadership support and resources for multidisciplinary opioid renewal programs (e.g., Wiedemer et al.'s opioid renewal clinic [45]), and opportunities for training in patient-centered care for chronic pain, all have the potential to support and instruct providers as they navigate through difficult interactions with patients. Educational initiatives and interventions to improve communication in pain care should take into account the organizational context (e.g., culture, resource constraints) in which they are being planned and delivered.

While the current findings provide a valuable glimpse into PCPs' own personal and professional struggles with patients with pain, our study is limited in that we interviewed 20 providers from a single VA medical center. Although we sampled providers with varying clinical experience and from different clinics, to maximize variation in PCPs' experiences with pain management, it is still possible that many of the PCPs in our sample had particularly negative experiences with patients with pain, either as a function of a higher prevalence of substance use or Axis II disorders in their patient panels, or as a function of the PCP's individual communicative style. However, the literature suggests that the experiences and viewpoints expressed by PCPs in this study are not atypical [12,24,27,42]. Nonetheless, while this study's strength, consistent with qualitative research, is in understanding the struggles of these 20 providers, in their own words, from their own perspectives, it is important to note that these results may not generalize to other providers, nor to other settings outside the VA, given the demographics of VA patients (e.g., mostly white males, higher prevalence of financial disadvantages), veterans' unique military experiences, and the substantial burden of coexisting medical and psychiatric disorders among veterans [67].

Future research is needed to determine the extent to which this study's findings apply to other clinical settings. Moreover, research using direct observation and patient-centered coding techniques [62–65] will be essential to better understand the relationship between patient-centeredness and difficulties in the management of chronic pain. Research should also be directed toward determining whether patient-centered communication interventions are as effective in pain care as they are in primary care as a whole [63–65]—or whether such interventions need to be adapted to meet the unique challenges of communication in chronic pain care. Early indications from shared decision-making studies [25,59] demonstrate potential to achieve measurable improvements in communication related to pain care for patients and providers, but future research must systematically investigate whether such initiatives will help to alleviate many of the struggles providers described in this study.

Conclusions

Few studies have examined the lived experiences of PCPs as they care for patients with chronic pain. The detailed accounts in this study illustrate that chronic pain takes a toll on providers as well as patients, and that providers' needs should not be ignored if pain care is to be improved. Strategies such as self-care, enhancing patient-centered communication, and organizational support, all hold promise to ease frustrations and defuse potential hostility in clinical encounters—ultimately improving pain management for both patients and providers.

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Conflict of Interest Statement

The authors have no conflicts of interest.

References

- 1 Kroenke K, Manglesdorff AD. Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. *Am J Med* 1989;86:262–6.
- 2 Kroenke K, Price RK. Symptoms in the community. Prevalence, classification, and psychiatric comorbidity. *Ach Intern Med* 1993;153:2474–80.
- 3 Kroenke K, Arrington ME, Manglesdorff AD. The prevalence of symptoms in medical outpatients and the adequacy of therapy. *Ach Intern Med* 1990; 15:1685–9.
- 4 Peter D. Hart Research Associates. *America Speaks: Pain in America Survey 2003*. 12-2-2008. Available at: http://www.researchamerica.org/uploads/poll2003_pain.pdf. Accessed December 2, 2008.
- 5 Kerns RD, Otis J, Rosenberg R, Reid MC. Veterans' reports of pain and associations with ratings of health, health-risk behaviors, affective distress, and use of the healthcare system. *J Rehabil Res Dev* 2003;40:371–9.
- 6 Crosby FE, Colestro J, Ventura MR, Graham K. Survey of pain among veterans in Western New York. *Pain Manag Nurs* 2006;7:12–22.
- 7 Kroenke K, Koslowe P, Roy M. Symptoms in 18,495 Persian Gulf War Veterans: Latency of onset and lack of association with self-reported exposures. *J Occup Environ Med* 1998;40:520–8.
- 8 Turk DC, Okifuji A, Kalauolalani D. Clinical outcome and economic evaluation of multidisciplinary pain centers. In: Block AR, Kremer EF, Fernandez E, eds. *Handbook of Pain Syndromes: Biopsychosocial Perspectives*. Mahwah, NJ: Erlbaum; 1999:77–98.
- 9 Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA* 1993;269:1537–9.
- 10 Cleeland CS, Gonin R, Hatfield AK, et al. Pain and its treatment in outpatients with metastatic cancer. *N Engl J Med* 1994;330:592–6.
- 11 Zhukovsky DS, Gorowski E, Hausdorff J, Napolitano B, Lesser M. Unmet analgesic needs in cancer patients. *J Pain Symptom Manage* 1995;10:113–9.
- 12 Green CR, Wheeler JRC, Marchant B, LaPorte F, Guerrero E. Analysis of the physician variable in pain management. *Pain Med* 2001;2:317–27.
- 13 Bendtsen P, Hensing G, Ebeling C, Schedin A. What are the qualities of dilemmas experienced when prescribing opioids in general practice? *Pain* 1999;82:89–96.
- 14 Eriksen J, Sjogren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: An epidemiological study. *Pain* 2006;125:172–9.
- 15 Turk DC, Brody MC, Okifuji EA. Physicians' attitudes and practices regarding the long-term prescribing of opioids for non-cancer pain. *Pain* 1994;59:201–8.
- 16 Brown JB, Stewart M, Ryan BL. Outcomes of patient-provider interaction. In: Thompson TL, Dorsey AM, Miller KI, Parrott R, eds. *Handbook of Health Communication*. Mahwah, NJ: Erlbaum; 2003:141–61.
- 17 Stewart MA. Effective physician-patient communication and health outcomes: A review. *Can Med Assoc J* 1995;152:1423–33.
- 18 Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *J Fam Pract* 2000;49:796–804.
- 19 Tait RC. Empathy: Necessary for effective pain management? *Curr Pain Headache Rep* 2008;12:108–12.
- 20 Stewart M, Brown JB, Weston WW, et al. *Patient-Centered Medicine: Transforming the Clinical Method*. Thousand Oaks, CA: Sage; 1995.
- 21 Mead N, Bower P. Patient-centredness: A conceptual framework and review of the empirical literature. *Soc Sci Med* 2000;51:1087–110.
- 22 Fiscella K, Meldrum S, Franks P, et al. Patient trust: Is it related to patient-centered behavior of primary care physicians? *Med Care* 2004;42:1049–55.
- 23 Kaplan SH, Greenfield S. Characteristics of physicians with participatory decision-making styles. *Ann Intern Med* 1996;124:497.
- 24 Eggly S, Tzelepis A. Relational control in difficult physician-patient encounters: Negotiating treatment for pain. *J Health Commun* 2001;6:323–33.
- 25 Bieber C, Muller KG, Blumenstiel K, et al. Long-term effects of a shared decision-making intervention on physician-patient interaction and outcome in fibromyalgia: A qualitative and quantitative 1-year follow-up of a randomized controlled trial. *Patient Educ Couns* 2006;63:357–66.
- 26 Werner A, Malterud K. It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Soc Sci Med* 2003; 57:1409–19.

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- 27 Kenny DT. Constructions of chronic pain in doctor-patient relationships: Bridging the communication chasm. *Patient Educ Counsl* 2004;52:297-305.
- 28 Kaplan SH, Sheldon G, Ware JE, Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care* 1989;27:S110-S127.
- 29 Von Korff M, Deyo RA. Potent opioids for chronic musculoskeletal pain: Flying blind? *Pain* 2004;109:207-9.
- 30 Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain* 2009;10:113-30.
- 31 du Pre A. *Communicating about Health: Current Issues and Perspectives*, 2nd edition. Boston, MA: McGraw Hill; 2005.
- 32 Frantsve LM, Kerns RD. Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision making. *Pain Med* 2007;8:25-35.
- 33 Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF, Miller WL, eds. *Doing Qualitative Research*. Thousand Oaks, CA: Sage; 1999:33-45.
- 34 Miller WL, Crabtree BF. Depth interviewing. In: Crabtree BF, Miller WL, eds. *Doing Qualitative Research*, 2nd edition. Thousand Oaks, CA: Sage; 1999:89-107.
- 35 Gordon DB, Dahl JL, Stevenson KK. *Building An Institutional Commitment to Pain Management: The Wisconsin Resource Manual*, 2nd edition. Madison, WI: The Resource Center of the American Alliance of Cancer Pain Initiatives; 2000.
- 36 Miles MB, Huberman AM. *Qualitative Data Analysis*. Thousand Oaks, CA: Sage; 1994.
- 37 Bernard HF. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Walnut Creek, CA: AltaMira Press; 2002.
- 38 Patton MQ. *Qualitative Research and Evaluation Methods*, 3rd edition. Thousand Oaks, CA: Sage; 2002.
- 39 Inui TS, Frankel RM. Evaluating the quality of qualitative research: A proposal pro tem. *J Gen Intern Med* 1991;6:485-6.
- 40 Agar M. *The Professional Stranger*, 2nd edition. San Diego, CA: Academic Press; 1996.
- 41 Owen WF. Interpretive themes in relational communication. *Q J Speech* 1984;70:274-87.
- 42 Dobscha SK, Corson K, Flores JA, Tansill EC, Gerrity MS. Veterans Affairs primary care clinicians' attitudes toward chronic pain and correlates of opioid prescribing rates. *Pain Med* 2000;9:564-71.
- 43 Bair MJ. Overcoming fears, frustrations, and competing demands: An effective integration of pain medicine and primary care to treat complex pain patients. *Pain Med* 2007;8:544-5.
- 44 Bair MJ, Robinson RLM, Katon WM, Kroenke KM. Depression and pain comorbidity: A literature review. *Ach Intern Med* 2003;163:2433-45.
- 45 Wiedemer NL, Harden PS, Arndt IO, Gallagher RM. The opioid renewal clinic: A primary care, managed approach to opioid therapy in chronic pain patients at risk for substance abuse. *Pain Med* 2007;8:573-84.
- 46 Diesfeld K. Interpersonal issues between pain physician and patient: Strategies to reduce conflict. *Pain Med* 2008;9:1118-24.
- 47 Crowley-Matoka M, Saha S, Dobscha SK, Burgess DJ. Problems of quality and equity in pain management: Exploring the role of biomedical culture. *Pain Med* 2009;10:1312-24.
- 48 Banja JD. Empathy in the physician's pain practice: Benefits, barriers, and recommendations. *Pain Med* 2006;7:265-75.
- 49 Banja JD. Toward a more empathic relationship in pain medicine. *Pain Med* 2008;9:1125-9.
- 50 Gallagher RM. Empathy: A timeless skill for the pain medicine toolbox. *Pain Med* 2006;7:213-4.
- 51 Tait RC, Chibnall JT. Physician judgments of chronic pain patients. *Soc Sci Med* 1997;45:1199-205.
- 52 Di Blasi Z, Harkness E, Ernst E, Georgiou A, Kleijnen J. Influence of context effects on health outcomes: A systematic review. *Lancet* 2001;357:757-62.
- 53 Wampold BE. Outcomes of individual counseling and psychotherapy: Empirical evidence addressing two fundamental questions. In: Brown SD, Lent RW, eds. *Handbook of Counseling Psychology*, 3rd edition. New York, NY: Wiley; 2000:711-39.
- 54 Horvath AO, Symonds BD. Relation between working alliance and outcome in psychotherapy: A meta-analysis. *J Couns Psychol* 1991;38:139-49.
- 55 Fuertes JN, Mislowack A, Bennett J, et al. The physician-patient working alliance. *Patient Educ Couns* 2007;66:29-36.

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- 56 Michie S, Miles J, Weinman J. Patient-centredness in chronic illness: What is it and does it matter? *Patient Educ Couns* 2003;51:197–206.
- 57 Huggard P. Compassion fatigue: How much can I give? *Med Educ* 2003;37:163–4.
- 58 Papadimos T. Stoicism, the physician, and care of medical outliers. *BMC Med Ethics* 2004;5:8–14.
- 59 Sullivan MD, Leigh J, Gaster B. Brief report: Training internists in shared decision making about chronic opioid treatment for noncancer pain. *J Gen Intern Med* 2006;21:360–2.
- 60 Turk DC, Okifuji A. Interdisciplinary approach to pain management: philosophy, operations, and efficacy. In: Ashburn M, Rice L, eds. *The Management of Pain*. Baltimore, MD: Churchill Livingstone; 1997:235–47.
- 61 Phelan SM, van Ryn M, Wall M, Burgess D. Understanding primary care physicians' treatment of chronic low back pain: The role of physician and practice factors. *Pain Med* 2009;10:1270–9.
- 62 Frankel RM, Stein TS, Krupat E. *The Four Habits Approach to Effective Clinical Communication*. CA: Physician Education and Development, Kaiser Permanente Northern California Region; 2003.
- 63 Stein T, Frankel RM, Krupat E. Enhancing clinician communication skills in a large healthcare organization: A longitudinal case study. *Patient Educ Couns* 2005;58:4–12.
- 64 Rodriguez H, Anastario M, Frankel R, et al. Can teaching agenda-setting skills to physicians improve clinical interaction quality? A controlled intervention. *BMC Med Educ* 2008;8:3–9.
- 65 Runkle C, Wu E, Wang EC, Gordon GH, Frankel R. Clinician confidence about conversations at the end of life is strengthened using the four habits approach. *J Psychosoc Oncol* 2008;26:81–95.
- 66 Kleinman A. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books; 1988.
- 67 Kazis LE, Miller DR, Clark J, et al. Health-related quality of life in patients served by the Department of Veterans Affairs: Results from the Veterans Health Study. *Ach Intern Med* 1998;158:626–32.

Appendix

MAIN QUERY ONE: In general, do you find managing your patients with chronic pain in your practice difficult or easy?

- Why do you find managing these patients difficult (or easy)?
- What difficulties do you have (or what successes have you had) with performing specific aspects of pain management—such as pain assessment, diagnostic work-ups, or making treatment decisions?
- Are there particular pain conditions (or situations such as chronic opioid treatment) that you find difficult (or easy) to manage?

MAIN QUERY TWO: What do you view as the biggest (most important) barriers to effective pain management for your patients? On the other hand, what helps you manage your patients with chronic pain effectively?

If the provider cannot think of any barriers or facilitators, try and stimulate discussion in the following areas.

- Provider-related barriers (knowledge deficits, lack of training, time constraints, other priorities, fear of prescribing opioids, etc.)
- Patient-related barriers (Fear of becoming addicted, lack of adherence to treatment, patients cant' pay for treatments)
- System-level = hospital or clinic level (Lack of access to comprehensive pain services/specialists, no accountability, lack of pain care standards and policies, lack of available clinical guidelines, no institutional commitment to improving pain care)