

"Professional Helper" or "Helping Professional?" The Patient-Physician Relationship in the Chronic Pain Setting, With Special Reference to the Current Opioid Debate

Emmanuel Bäckryd

Journal Article



N.B.: When citing this work, cite the original article.

Original Publication:

Emmanuel Bäckryd , "Professional Helper" or "Helping Professional?" The Patient-Physician Relationship in the Chronic Pain Setting, With Special Reference to the Current Opioid Debate, Journal of Continuing Education in the Health Professions, 2016. 36(2), pp.133-137.

<http://dx.doi.org/10.1097/CEH.0000000000000062>

Copyright: Lippincott, Williams & Wilkins

<http://www.lww.com/>

Postprint available at: Linköping University Electronic Press

<http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-133282>

FORUM

“Professional helper” or “Helping professional”? The patient-physician relationship in the chronic pain setting, with special reference to the current opioid debate

Emmanuel Bäckryd

Abstract

There seems to be a strong cultural expectation among patients for effective pain relief. As a result, physicians often find themselves trying to bridge the gap between the chronic pain patient's expectations and harsh biomedical reality. Emanuel and Emanuel's typology of four models for the patient-physician relationship is used in this article as a conceptual tool to examine the possible roles of physicians in the context of chronic non-cancer pain. Their typology is reconceptualized as a “pathway” along which the physician is able to walk more or less far, starting from the “information” end of the path. The other end of the pathway is “caring deliberation”. I then propose that, in pain medicine today, consumerism is a powerful incentive for physicians to stay at the “information” end of the spectrum. Against this background, I discuss the current opioid epidemic in the United States and the need for what has been called a new medical professionalism. I conclude by challenging educators involved in pain medicine continuing professional development to not only design adequate biomedical-educational programs, but also to consider issues like professionalism, personal development, critical self-reflection, and the ethics of engaging in “caring deliberation” with chronic pain patients.

Keywords

chronic pain; consumerism; deliberation; patient-physician relationship; professionalism/ethics.

Introduction

Non-cancer chronic pain, which is experienced by 20% of the population,¹ remains strikingly difficult to treat.² At the same time, there seems to be a strong cultural expectation for effective pain relief in all situations of life, at least in so-called developed countries. Hence, physicians often find themselves trying to bridge the gap between the chronic pain patient's expectations and harsh biomedical reality. The difficulty and often impossibility of "curing" non-cancer chronic pain results in many frustrated and desperate patients.³ This challenge is exacerbated by the "ongoing lack of pain care competency by the majority of health care providers".^{4(p1823)} Continuing professional development (CPD)⁵ is therefore arguably very important in the chronic pain context. However, the present paper argues that there are also important hidden assumptions concerning the physician's role in chronic pain management. More precisely, the use of opioids to treat chronic pain will be used as an example of the potentially profound effects these assumptions can have for the individual patient. This analysis challenges CPD educators in pain medicine to focus not only on biomedical issues, but also those of professionalism, personal development, critical self-reflection, and the ethics of engaging in caring deliberation with chronic pain patients.

Emanuel & Emanuel's fourfold typology

More than two decades ago Ezekiel Emanuel and Linda Emanuel published an influential typology of four models for the patient-physician relationship: paternalistic, informative, interpretive, and deliberative.⁶ (Table 1). In the *paternalistic* model the patient is a passive object for medical decisions made by the physician. This model has been heavily criticized, and Emanuel & Emanuel note that a clear shift has occurred in favour of the *informative* model according to which the physician's duty is to objectively inform the patient about medical facts and the options available to her. Patient autonomy here means that the patient is in total control of the decisions to be made. The model views the patient as a consumer and the physician as a technical expert. The model also sharply differentiates between facts and values; the physician should focus on the former, and the latter are supposed to be the patient's own business. There is no need to help the patient elucidate what her own values really are, as these are supposed to be self-evident to her. In the *interpretive* model, however, the doctor is more like a counsellor who guides the patient so that she discovers what values she actually wants to achieve. Here, being an autonomous person means being aware of the

values one wants to attain. The model assumes that patients may need guidance in order to elucidate the values they want to achieve in a given situation. Emanuel & Emanuel, however, advocate a fourth alternative: the *deliberative* model. In this model, the doctor is not content with being a counsellor; she is more like a teacher. The doctor not only helps the patient to become aware of her own values, the physician may also sometimes *deliberate* with the patient about what health-related values are desirable to achieve in a given situation. Somehow, the model assumes that patients do not always understand what is best for them. Emanuel & Emanuel deny that this is paternalism. They concede that the deliberative physician may on occasion lapse back into paternalism, but they are adamant that the deliberative model, properly understood, “is not a disguised form of paternalism”^{6(p2225)}. They contend that it is important that doctors not only inform about facts but also try to persuade patients about the importance of certain health-related values (e.g, concerning smoking). According to this view, autonomy is congruent with (sometimes at least) the patient meeting some kind of resistance. The patient is truly autonomous when she has been empowered to argue her case with the physician. Emanuel & Emanuel are thus critical to what they perceive is a simplistic view of autonomy.⁶

But what is a “health-related value”? According to Emanuel & Emanuel:

The physician’s objectives include suggesting why certain health-related values are more worthy and should be aspired to. At the extreme, the physician and patient engage in deliberation about what kind of health-related values the patient could and ultimately should pursue. The physician discusses only health-related values, that is, values that affect or are affected by the patient’s disease and treatments; he or she recognizes that many elements of morality are unrelated to the patient’s disease or treatment and beyond the scope of their professional relationship.^{6(p2222)}

Arguably, these health-related values should not be the physician’s own personal, idiosyncratic values. Instead, they should be values widely shared within the medical community. Being a deliberative doctor entails working for such widely shared health-related goals and values.

Reach's ethical pathway

Using Emanuel & Emanuel's typology, Gérard Reach recently proposed that patient education can be viewed as an "ethical pathway" that goes from *information* (the doctor first gives the facts) to *interpretation* (the doctor helps the patient to elucidate her own preferences), and then from interpretation to *deliberation* (the physician enters into a caring dialogue with the patient concerning what health-related values and preferences the patient actually should strive for).⁷ The process of deliberation gives the patient a real (i.e. not only theoretical) possibility to test her preferences against other alternatives. Hence, the path of patient education leads to increased patient autonomy. In other words the educated patient is a more autonomous person, and part of the process of education involves caring deliberation. Presenting facts is not enough.

Inspired by Reach's "ethical pathway", and broadening its scope to include more than patient education, I propose to view the physician-patient relationship as a continuum or a pathway with "pure information" and "caring deliberation" at its extremes. Beginning at the information end of the pathway, physicians walk down the path more or less far – some remain information providers, others walk down the path all the way to caring deliberation in order to help their patients realize certain health-related values.

"Caring deliberation" should not be seen as antithetical to patient-centered care. For example, "caring deliberation" should always entail active listening, and the physician should view each consultation as a learning opportunity, as a two-way communication process where she can learn something very important from her patient, not least concerning the subjective experience and the social consequences of ill-health and disease. I propose that "caring deliberation" should be viewed as an inherently patient-centered activity. I also propose that "shared decision-making" is only truly "shared" if the physician's professional views on health-related values are allowed to play a role. It is too simplistic to think that "facts" and "values" are possible to completely disentangle from each other. They are different, of course, but they are intertwined. Hence, "shared decision-making" cannot be equated with the informative model. On the contrary, sometimes, the "making" of well-grounded decisions entails serious (although caring) deliberation about what health-related values are worth striving for.

The chronic pain context

Let us now apply the above-mentioned pathway thinking to the non-cancer chronic pain context. According to the informative model, the physician uses her technical expertise to propose treatment options, the aim being that the patient be able to exercise control over the situation by choosing between alternatives. Then, if the physician informs her patient that there are no more evidence-based biomedical interventions available to treat her chronic pain, that would count as a major failure, at least from the perspective of the informative model. In such a situation it is not surprising if the doctor eventually comes up with “something to do”, giving back a sense of control to the patient. Instead of walking down the path into *deliberation*, the physician remains at the information end of the path and, being there, has to be ingenious enough to figure out new treatment options.

It is here important to distinguish between, on the one hand, acute and cancer pain, and, on the other hand, chronic non-cancer pain. Although chronic non-cancer pain itself is a very heterogeneous category, it has been called a "disease in its own right"^{8(p179)}. The related concepts of pathological pain, or maladaptive pain, are important in this respect.^{9,10} Generally speaking, biomedical interventions are rather well suited for treating acute and cancer pain, whereas current available treatments provide only modest improvements for chronic non-cancer pain.² In the chronic pain setting, it is therefore not enough to consider the patient as a passive recipient of health care interventions. According to the biopsychosocial model, presented by Engel in 1977 and which has had a great impact on the treatment of chronic pain, biological, psychological and social factors interact in an intricate and indissoluble manner.¹¹⁻¹³ In accordance with this view, the patient's own activity is of great importance, and the chronic pain patient is nowadays increasingly viewed from a rehabilitative perspective.¹⁴

However, pain is a strong motivational drive for human behaviour.¹⁵ Pain is an unpleasant emotion, and the organism will do what it takes to avoid it. Thus it is no wonder if a pain patient focuses on seeking a “solution”. The following fictional (but realistic) chronic pain patient case illustrates this, and it also illustrates the above-mentioned pathway, the pain physician going from *information*, to *interpretation*, to *deliberation*.

Pain management patient case

A 25-year-old woman, who works as a secretary, is referred from a primary care physician to the multidisciplinary pain clinic of a university hospital. She's had widespread pain for a year now, and she's desperate. It started with a localized trapezius myalgia but has gradually worsened, and the pain is now generalized to more or less the whole body. Her primary care doctor has tried to relieve her pain by using first paracetamol and non-steroidal anti-inflammatory drugs, but later shifted to opioids. He began by prescribing codeine, then shifted to tramadol. He then combined tramadol with long-acting oxycodone which, the patient says, helped a little. The patient wanted to increase the dosage, which he first refused but then accepted, and she is now on long-acting oxycodone 40 mg twice a day. She is also taking duloxetine 120 mg per day.

After a long consultation of over an hour, the pain physician *informed* the patient about chronic widespread pain, its postulated mechanisms, and the lack of evidence for opioids. The best approach would be to taper the opioids and instead focus on a broad chronic pain rehabilitation program. At that point, the patient interrupted and said that this was surely unacceptable. "I'm the one feeling this pain", she said, "and pain relief is a human right! I want this pain to disappear, I do not want to live with it! Something must be done. At least, you could increase the dosage of the medicines I'm on now."

The physician therefore *informed* her about the potential long-term consequences of opioid treatment. "Now," he said, "do you still think it's a good idea to increase the opioids? Now that you have the options laid out before you?" Not getting any answer, he shifted strategy to a more *interpretive* stance. "If you really think about it," he said, "what is it that you want deep inside? What do you value?" The patient then replied, "I want to get rid of this pain! Nothing else matters! I can't live like this!"

Seeing the patient was very upset, the pain physician asked her if it was okay for a pain nurse to attend for the rest of the consultation. She accepted. He then began gently *deliberating* with her. He would give her time for thought, she would not be required to decide at once what to do, but he wanted her to know that as far as he was concerned, he would *not* increase the dose of opioids, because that would simply be the wrong thing to do. "And you're very young," he said, "so we have to think long-term, not short-term. I understand your feelings, and I respect them, but it would simply be unprofessional to augment your opioid dosage. It will only harm you. It's not good for you to be on high-dose opioids long-term. If you want

to, we can look together on the internet, and I can show you that what I tell you is not my personal views but is an opinion widely shared among doctors. Shall we have a look together?”

The impact of consumerism?

According to Reach, it is often the case that patients with chronic conditions are more present-oriented than physicians, doctors focusing more on long-term effects.⁷ Hence, in the chronic pain setting, it might be difficult for the physician to communicate the necessity of a more rehabilitative, long-term approach (“living with the pain”) in face of the patient’s present-orientated expectations (“I want to get rid of the pain now”). Communicating a rehabilitative approach to a chronic pain patient entails deliberation, i.e. moving towards “caring deliberation” on the aforementioned pathway. I propose that contemporary consumerism might be a powerful incentive against engaging in such “caring deliberations”.

Although it has been said that the impact of consumerism has been somewhat overstated,¹⁶ and although most health care consumers are not "customers" in the usual sense since they consume health care out of perceived necessity, it has nonetheless been argued that healthcare today is regarded in much the same way as other consumer goods and services.¹⁷ Indeed, concerns have been raised about the possibility that the influx of money into health care and financial incentives to maximize income might undermine medical professionalism.^{3,18} Writing from an American perspective, Lebovits talks about today’s increasingly business-oriented practice environment for pain medicine and “the economic lure of aggressive intervention”^{3(p1155)}. Also from a US perspective, according to Relman, medical professionalism is facing a crisis as “professionals have an ideology that assigns a higher priority to doing useful and needed work than to economic rewards”^{19(p2668)}, and in a commercialized health care market, this professionalism is at risk.¹⁹ Relman writes that “the current focus on moneymaking and the seductions of financial rewards have changed the climate of US medical practice at the expense of professional altruism and the moral commitment to patients”^{19(p2669)}. It has been claimed that pain medicine is gradually being transformed, going from being a profession to being a business²⁰, and that there is a need for “a new medical professionalism”.^{16(p469)}

Opioids and chronic pain

During the last decades, the use of opioids in chronic non-cancer pain has accelerated, not least in the US where the term “epidemic” has been used.^{21,22} Indeed, during the first decade of the millennium, sales of opioids quadrupled in the US.²³ Although the sales of opioids have since then plateaued, a very recent report from December 2015 shows that more persons died from drug overdoses in the United States in 2014 than during any previous year on record.²⁴

Given what has been discussed in the previous sections, it seems sensible to ask whether there might be a relationship between the above-mentioned hypothesis and the “US opioid epidemic”. Is the escalation in opioid prescriptions at least in part a sign of lessened professionalism, the physician focusing too much on trying to come up with “something to do” in a difficult situation instead of walking down the pathway to caring deliberation? If the physician does not want to disappoint her consumer-patient, there seems to be a strong incentive to regress from deliberation to simple information and choice offering. This is not to suggest that such a physician is immoral. Underlining the powerful incentives of consumerism does not entail claiming that these doctors lack compassion. On the contrary, it might be argued that the lure of consumerism is enhanced in the context of non-reflective compassion.

“Helping professional” or “Professional helper”?

Some authors are keen on emphasizing the importance of human warmth, understanding, generosity and caring in the patient-physician relationship.¹¹ However, I contend that such virtues, central as they are to medical practice, must be supplemented by other virtues like discernment, wisdom, foresightedness, and integrity. Helping patients, being a compassionate doctor, will always be at the centre of the medical profession. The question is whether compassion or professionalism should have primacy. If compassion has the primacy, the incentives of consumerism will meet very little resistance, and the physician becomes a “professional helper”. The physician’s knowledge and skills are placed in the service of non-reflective compassion, the goal being to satisfy the wishes of the consumer-patient in accordance with the informative model. The physician sees herself primarily a “helper”, i.e. a person whose duty first and foremost it to provide help on the patient’s own terms. In the context of consumerism, the physician may feel an obligation not to disappoint the patient.

After all, one wants to be a good doctor, and what kind of a doctor is it who doesn't come up with a solution that the patient likes? A "professional helper" thus stays at the information end of the pathway, and standing there must be ingenuous enough to figure out something to do. A "professional helper" does not like deliberating with patients about health-related values. For a "professional helper", professionalism has to do with, on the one hand, respecting the patient's wishes and, on the other hand, being a technical expert. There is no place for deliberation.

As a contrast, I would propose the concept of "helping professional" as a better ideal. According to this view, helping and compassion are still important, but these virtues are controlled by the overarching vision of professionalism. The achievement of this vision entails developing and being socialized into many different skills and virtues, among which discernment, wisdom, foresightedness, and integrity are important. Hence, being a "helping professional" sometimes means going down the path all the way to "caring deliberation". Of course, paternalism is an ever-present risk. The "helping professional" knows that, but she is also convinced that the practice of medicine is much more than delivering a goods to a consumer. The "helping professional" has learnt over the years that humans do not always choose rationally what is best for them. In the chronic pain context, she understands that pain is a powerful driver of behaviour, and she is professional enough to risk communicating to the patient that there is not always a simple "solution" to chronic pain. She is helping in the sense that she really deeply cares about the patient, but she has integrity and wisdom not to be overrun by the feeling that "something must be done". She is a professional who knows the limits of her art. If there is no pill that fixes the problem, she will say it, and argue for it.

Implications for CPD educators

It has been argued that continuing education for opioid prescribers should be mandatory,⁴ and this for three reasons: (1) the amount of time devoted to pain education is disproportionately low in comparison to the prevalence of pain; (2) the conflict of interest disclosures associated with accredited CME would help learners differentiate evidence-based educational material from product promotion and marketing; and (3) the opioid epidemic and its consequences necessitate dissemination of new knowledge to prescribers. The question of whether continuing education should be mandatory for opioid prescribers or not, falls outside the scope of the present paper. Regardless of how one answers that specific question, the views developed in this paper have potential broad implications for CPD educators.

CPD occurs in a socio-cultural context and its effectiveness cannot be abstracted from the context in which it occurs. In their synthesis of systematic reviews concerning the impact of CME, Cervero & Gaines recently wrote that “future research on the effectiveness of CME must include the wider social, political, and organizational factors that impact physician performance and patient health outcomes”^{25(p131)}. One such wider contextual factor is arguably the cultural expectations experienced by physicians. If the analysis of the present paper is correct, there are potential implications for chronic pain CPD, and perhaps for CPD in general.

First, CPD educators in pain medicine should consider which assumptions concerning the role of the physician underlie their educational intervention. Is the physician to be viewed as a “professional helper” (in accordance with the informative model), or as a “helping professional” (in accordance with the deliberative model)? Those involved in CPD should consider their own assumptions in these matters, and perhaps consider if they should make these assumptions explicit and public. In the chronic pain setting, I contend that neglecting the deliberative model and its non-consumeristic professionalism can lead to the misapplication of pain treatment principles that are otherwise helpful and well-needed.

Second, the educational *content* of CPD in pain medicine should not only be about giving health care professionals biomedical tools; it should also be about empowering them to critically reflect on such matters as professionalism, the patient-physician relationship, and larger cultural and societal assumptions concerning the experience of pain and the practice of medicine. Third, CPD in pain medicine should therefore be viewed in a broad biopsychosocial perspective, not a strictly biomedical one. Educating health professionals in the biopsychosocial model and its implications could perhaps broaden the mind of physicians who all too often forget that psychologists, physiotherapists, health sociologists and other professionals have an important contribution to make in medicine. Caring for chronic pain patients is truly an interdisciplinary endeavour.

Lessons for practice

- Given the high prevalence of chronic pain in the general population (20%) and evidence of a physician knowledge gap, continuing professional development (CPD) in the field of pain medicine should be a priority.
- CPD educators in pain medicine should take a broad biopsychosocial stance when designing their interventions, empowering physicians to critically reflect on issues like professionalism, the patient-physician relationship, and larger cultural and societal assumptions concerning the experience of pain and the practice of medicine.
- Professionalism sometimes entails deliberating with the patient concerning the achievement of health-related values.
- Consumerism can be viewed as a powerful incentive against such deliberations.

References

1. Breivik H, Collett B, Ventafridda V, Cohen R, Gallacher D. Survey of chronic pain in Europe: prevalence, impact on daily life, and treatment. *Eur J Pain*. 2006;10(4):287-333.
2. Turk DC, Wilson HD, Cahana A. Treatment of chronic non-cancer pain. *Lancet*. 2011;377(9784):2226-2235.
3. Lebovits A. Maintaining Professionalism in Today's Business Environment: Ethical Challenges for the Pain Medicine Specialist. *Pain Medicine*. 2012;13(9):1152-1161.
4. Manworren RCB. Mandatory Continuing Education for Opioid Prescribers. *Pain Medicine*. 2013;14:1821-1825.
5. Karle H, Paulos G, Wentz DK. Continuing Professional Development: Concept, Origins, and Rationale. In: Wentz DK, ed. *Continuing Medical Education - Looking Back, Planning Ahead*. Hanover, N.H.: University Press of New England; 2011:281-290.
6. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA*. 1992;267(16):2221-2226.
7. Reach G. Patient autonomy in chronic care: solving a paradox. *Patient preference and adherence*. 2013;8:15-24.
8. Niv D, Devor M. Chronic pain as a disease in its own right. *Pain Pract*. 2004;4(3):179-181.
9. Dickinson BD, Head CA, Gitlow S, Osbahr AJ, 3rd. Maldynia: pathophysiology and management of neuropathic and maladaptive pain--a report of the AMA Council on Science and Public Health. *Pain Med*. 2010;11(11):1635-1653.
10. Grace PM, Hutchinson MR, Maier SF, Watkins LR. Pathological pain and the neuroimmune interface. *Nature reviews. Immunology*. 2014;14(4):217-231.
11. Borrell-Carrio F, Suchman AL, Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Annals of family medicine*. 2004;2(6):576-582.
12. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196(4286):129-136.
13. Gatchel RJ, Peng YB, Peters ML, Fuchs PN, Turk DC. The biopsychosocial approach to chronic pain: scientific advances and future directions. *Psychol Bull*. 2007;133(4):581.
14. Stanos S. Focused review of interdisciplinary pain rehabilitation programs for chronic pain management. *Curr Pain Headache Rep*. 2012;16(2):147-152.
15. Craig AD. A new view of pain as a homeostatic emotion. *Trends Neurosci*. 2003;26(6):303-307.
16. Tousijn W. Beyond decline: consumerism, managerialism and the need for a new medical professionalism. *Health Sociology Review*. 2006;15(5):469-480.
17. Sturgeon D. The business of the NHS: The rise and rise of consumer culture and commodification in the provision of healthcare services. *Critical Social Policy*. 2014;34(3):405-416.
18. Timmermans S, Oh H. The continued social transformation of the medical profession. *Journal of health and social behavior*. 2010;51 Suppl:S94-106.
19. Relman AS. Medical professionalism in a commercialized health care market. *JAMA*. 2007;298(22):2668-2670.
20. Schatman ME. Physician Complicity in the Transformation of Pain Medicine from a "Profession" to a "Business": Strategies for Reversing a Growing Trend. *Pain Medicine*. 2012;13(9):1149-1151.
21. Centers for Disease Control and prevention (CDC). CDC grand rounds: prescription drug overdoses - a U.S. epidemic. *MMWR. Morbidity and mortality weekly report*. 2012;61(1):10-13.
22. Manchikanti L, Helm S, 2nd, Fellows B, et al. Opioid epidemic in the United States. *Pain Physician*. 2012;15(3 Suppl):ES9-38.
23. Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers---United States, 1999--2008. *MMWR. Morbidity and mortality weekly report*. 2011;60(43):1487-1492.
24. Rudd RA, Alleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. *MMWR. Morbidity and mortality weekly report*. 2015;64 (early release).
25. Cervero RM, Gaines JK. The Impact of CME on Physician Performance and Patient Health Outcomes: An Updated Synthesis of Systematic Reviews. *J Contin Educ Health Prof*. 2015;35(2):131-138.

Table I: Emanuel & Emanuel's four models of the patient-physician relationship

| | Paternalistic Model | Informative Model | Interpretive Model | Deliberative Model |
|-----------------------------------|--|--|---|---|
| The physician is like a... | guardian | technical expert | counselor | teacher |
| ...who... | decides what is best for the patient | informs the patient about medical facts | helps the patient understand his/her own values | may deliberate with the patient about what health-related values should be aspired to |
| Patient autonomy is... | only assent to the physician's point of view | control over the decision making process | self-understanding | moral self-development |