

Review of clinician stressors in chronic pain management and addiction medicine

Abstract

The purpose of the paper is to highlight some stressors common to clinicians working in the field of pain management and addiction medicine. These stressors help explain the shortage of providers who specialize in managing complex pain patients. The lack of qualified providers adds to the challenges many patients have in finding safe and effective help for pain management and substance use disorders. The paper reviews some common psychological and emotional factors that confront clinicians who care for patients with chronic pain and addiction related concerns. A partial list of these factors includes: a sense of not being in control, the stress of being lied to, social and professional expectations, interactions with the criminal justice system and other regulatory agencies, limited pertinent clinical literature, complicated comorbid psychiatric issues, transference & counter transference, delayed rewards, and frequent patient setbacks or relapses. Some suggestions are provided to address these stressors.

Keywords: chronic complex pain, pain management, addiction, substance use disorder, opioid use disorder, patient access, clinician stress, physician burnout, physician shortage, dual-diagnosis, chronic opioid agonist therapy(COAT), informal review

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Introduction

There are many possible explanations for the shortage of physicians working in the field of pain management and addiction medicine. Some of the logistical and financial challenges were discussed in the author's article about the OPAS experience.¹ The focus here is to review some of the stressors that confront providers who care for patients with chronic pain and substance use disorders (addictions). This paper is an informal review. The author is not familiar with any formal studies or body of literature on this specific subject. The review is based primarily on clinical experience and expertise stemming from a semi-rural specialized medical practice in the United States. Some of the stressors enumerated are nonetheless likely universal. Indeed, clinicians who help manage chronic pain and substance use disorders deal with limited pertinent clinical research. Physicians and others are likely to have varied responses to these complex patients. In addition to individual and unique responses, common responses can be expected based on physician selection, training, experience, and even physician personality traits.² One must also not overlook significant cultural influences.³ Because of the lack of formal research that addresses appropriate clinician attributes for providing this specialized medical care, skills and attributes considered to be clinically relevant are listed in Appendix.¹

The clinical stressors discussed are not unique to the fields of pain management and addiction medicine. Nonetheless, by the nature of their concerns these patients often bring significant dysfunctional patterns into their relationships, including their relationships with caregivers. Once a sound therapeutic relationship is established, challenging displacement of feelings may occur. In early drafts of this paper the stressors confronting clinicians appeared to be primarily psychological or emotional. While the psychological and emotional stressors are significant, one must consider cultural beliefs and regulatory concerns as significant sources of stress. Though the order in which stressors are listed does not convey importance, the review starts with the psychological stress or associated with not feeling in control. Perhaps this is the greatest challenge?

The sense of not being in control

Physicians are repeatedly reinforced to have answers and to be in control. They are to have scientifically valid explanations for complex and life-threatening situations. Physicians may be especially committed to this sense of control because they have worked and trained in situations where a lack of appropriate control can result in unnecessary mortality and morbidity. Understandably, issues around control and maintaining it are a primary concern for most physicians.⁴ A common control issue pertinent to all clinical areas of medicine relates to medical adherence. The lack of medical adherence in all areas of medicine is common and continues to receive attention.^{5,6} Psychiatrically impaired patients arguably benefit the most from support and structure to better assure they take their medicines as prescribed. "Chemical copers" and patients with substance use disorders have similar serious adherence problems. Patients who abuse substances tend to take too much of their substance of choice in contrast to the typical psychiatric patient who takes too little. The rate of adherence problems is high in both groups and obviously complicates clinical care. For substance abusers the lack of adherence relates to significant higher mortality rates often related to overdoses. Suicide rates alone associated with pain and addiction are amongst the highest of any subgroup of patients, even when compared to those patients with serious mental health diagnoses.⁷⁻⁹ In the United States the leading single cause for death under the age of sixty is reportedly suicide. Inadequately managed pain and substance use disorders are likely primary drivers for this high rate of suicide. In Washington State during the period overdoses from prescription opioids went down significantly, purportedly because of the implementation of the "Pain Rules",¹⁰ heroin overdoses skyrocketed.

If one were to strictly follow the primary directive, Premium non nocere, prescribing medications with abuse potential would be contraindicated. This is clinically impossible because of the clear benefits of opioids and other clinically essential medications that are abused. Nonetheless, some colleagues refuse, especially on an outpatient basis, to prescribe opioids or other controlled substances

to a patient who is, or is at risk of abusing their medication. The lack of a prescription for an opioid simplifies responsibility for medical adherence problems. And perhaps by some it is defensible on ethical grounds or based on regulatory and liability concerns?¹¹ This approach is not tenable, however, for those familiar with current evidence and experience in safely and effectively prescribing controlled substances to high risk patients. These patients have life threatening conditions, suffer greatly, and the evidence strongly supports pharmaceutical care with opioids, as well as behavioural care even in those with moderate to severe opioid use disorders.^{8,9} Chronic persistent pain alone is associated with higher mortality.^{12–14} Furthermore, even when the patient has a moderate to severe opioid use disorder, there is robust data supporting the effectiveness of providing agonist therapy with methadone and buprenorphine.^{15–17} Medication-assisted treatment (MAT) is an effective response to opioid use disorder.¹⁸

To mitigate some of the risk of dosage abuse and provide for more control, methadone clinics most often dispense daily. In practical terms, however, it is untenable to provide the vast number of patients and at-risk patients the structure associated with methadone clinics. In a recently published review by the author estimates are higher and in the 20% or higher range.¹⁹ Recent estimates from the CDC are that 25% of patients on Chronic Opioid Agonist Therapy (COAT) have an opioid use disorder. In a specialized pain and addiction practice, universal precautions can mitigate some of the risks by helping to recognize and properly manage high-risk patients. Deaths occur also from overdoses in patients who attend methadone clinics, perhaps less so than in high risk patients being prescribed opioids for pain management? As in other areas of medicine, physicians who regularly prescribe controlled substances to high risk patients on an outpatient basis must acknowledge they are not in full control. They must come to accept an occasional poor outcome including suicides and accidental overdoses. Indeed, chronic pain patients and those with substance use disorders are good reminders that our control as clinicians is limited. These patients are unpredictable, and their erratic behaviour is not limited to missing appointments. Their emotional states are labile and “borderline personality” behaviour is not uncommon.

With this lack of control, concerns for the safety of staff and other patients do arise. In dealing with these patients one needs to establish clear boundaries while one expects the unexpected. While not a daily occurrence, staff members may be called to defuse overtly angry and verbally abusive patients. It is no coincidence that addressing issues around control is part of the first step in 12 step programs: “We came to accept that we were powerless over and as result our lives have become unmanageable.” This first step often holds true for patients with chronic pain disorders as well as for those with addictions. The first step principles also apply to patient caregivers, family, and friends.

The stress associated with being lied to

Police and interrogators are conditioned to not believe what they’re told. In contrast, the clinical practice of medicine is highly dependent on credible patients. Physicians and patients generally honor the mutual trust involved in the patient-physician relationship. Emotional equanimity is disturbed when confidentiality or other components of a trusting patient-physician relationship are compromised. Many chronic pain patients consciously or unconsciously magnify or “catastrophize” their symptoms. These “white” lies are generally overlooked by a seasoned clinician. It is the bold or criminal lies of a patient with an active substance use disorder that most physicians

have difficulty with.²⁰ Even when one intellectually accepts the strong conditioning which prompts some patients to lie, and even though one is often lied to, there still often remains an “emotional hit” when a patient lies. I suspect it has to do with a feeling of vulnerability associated with not being able to trust those we have a relationship with.

Social and professional expectations

Patients expect their physician to have their best interests always foremost and often believe the physician should be able to fix them. There are numerous examples where the tension between the patient’s well-being and the collective good create potential dilemmas for a clinician. These dilemmas come up in all areas of medicine and their resolution can be challenging. In the field of pain and addiction there seems to be a higher frequency and greater intensity of these dilemmas. An example might be helpful: A woman in her early thirties was referred because she had been formally accused of selling her medications. Charges were dropped, and she presented with a bona fide chronic pain condition warranting opiates. She was stabilized on methadone and was a “star” patient. She participated well in group and individual sessions and she reported promotions at work and credible improvements in all areas of her life. Because there were no red flags and because the distance between her home and the office was approximately three hours, the time between her visits was extended to six weeks. I then received a call from a clinician in her hometown informing me of reports from two credible sources that this patient was selling methadone to high school students. How is one to respond to such a call? I consider the best response to these sorts of dilemmas are often very contextual in nature. Furthermore, obtaining professional support with same can be daunting, particularly in rural settings.

My response to this dilemma could be rightfully debated, and I think it illustrates well the challenges of some of the clinical dilemmas that emerge. Dilemmas often occur, as in this case, because of competing values. In this case I had my innocent until proven guilty value, as well as my value in being first and foremost a patient advocate, and the value I place on confidentiality. I also recognize the risks associated with triangulating with patients and their family and friends. These values compete with a clear mandate to help protect the health of vulnerable youth and to work toward our laws being respected. My response was to call and speak to an investigating officer about my concerns. When the patient returned for refills I reported to her my concerns and she quickly informed me that the clinician who called me was the same one that charged her before and that it was all related to a personal grudge. She added I could confirm this by talking with another clinician from their community. While the final resolution of this case may be of interest, the point in sharing it is to provide an example of how complex and difficult managing these patients can be. I tend to feel a little queasy about calling the police even when the facts are clear. I suspect most physicians might hesitate especially when they have a well-established therapeutic relationship with a patient. Patients commonly lie about their medications to their prescriber. Under federal law, related to scheduled drugs, this is a crime. Most reasonable physicians would not report all cases of lying, whether legal or not, to the authorities.

The conflict between the patient’s good and the collective good also plays itself out in the political and regulatory arena. Concerned physicians and national and international policies recognize that efforts to control abuse and diversion of pain medications should

not interfere with their availability for legitimate medical purposes. Nonetheless, the concern about abuse and diversion has resulted in a variety of regulations that have inadvertently created barriers to the treatment of pain.²¹ In Washington State after the Pain Rules¹⁰ regulating the uses of opioids were legally mandated, a clear and persistent exodus of physicians willing to prescribe opioids has been observed. This observed response is consistent with the sometimes heard and often unspoken physician fear of being reprimanded for prescribing a controlled substance to someone in pain, particularly if the pain is non-cancerous and chronic. When treating pain with controlled substances in patients with known addictive disorders this concern is further heightened.

As to meeting patients' expectations of the doctor being able to fix them, that is relatively easy to deal with. All physicians regularly encounter problems they don't have a solution for. As a caring clinician I am still baffled and even a little frustrated, when after numerous attempts to inform and demonstrate to a patient the treatable chronic and relapsing nature of their disease, they still expect to be permanently fixed, or on the other end of the spectrum they never expect to get better.

Need to work with the criminal justice system and other regulatory agencies

Most physicians working in an out-patient practice rarely call the police or other regulatory authorities. In most clinical outpatient settings, issues that relate to children protection services probably are the most common cause of regulatory agencies being called. Even then, one rarely calls the police. In the State of Washington, we report child abuse concerns to Children's Protective Services. In contrast, it is not unheard of in the practice of pain and addiction medicine to call the police or even request an officer immediately come to the office for example, when a patient's alcohol breath test is consistent with significant intoxication and the patient intends to drive home. Another example would be when the patient badgers the staff or clinician and refuses to leave when requested.

Calling the police is stressful by itself, but having an officer in the waiting room asking questions and wanting a statement is extra stressful for patients and the entire staff. What's more, the patient may be angry, in withdrawal, and they may act out inappropriately. These stresses are compounded by the feelings associated with competing values being in conflict. Physicians recognize the importance of a therapeutic relationship in the care of patients. This therapeutic relationship can be essential for those with substance use or chronic pain disorders. The punitive aspect of the laws concerning substance abuse are such that most physicians knowledgeable in addiction often find themselves more or less opposed to the widespread punitive aspect of our legal system as it relates to substance misuse. As physicians we need to work with the police -as some of the above examples illustrate but there may be a lingering doubt or uncomfortable feeling that by calling the police to report a patient, a physician is forsaking the privileged patient-physician relationship. The result could compromise what might be an essential and life-saving therapeutic relationship. On the other hand, we recognize some patients benefit from clear boundaries and unless some patients are confronted with legal sanctions they seem unable to accept or change their behaviour. Our communities and staff clearly warrant protection from dangerous behaviour.

Limited clinical evidence

While a burgeoning number of effective medications for the

treatment and prevention of addictions are available, and some are FDA approved for this purpose, the clinical practice of addiction medicine and managing chronic non-cancerous pain is based primarily on experience and the application of solid principles. There are no clear biomarkers to guide us. While this is the case in other areas of medicine, in this context we are most often dealing with more variables that affect the evaluation and decision-making process. In this field we often encounter very ill patients with a lot at stake. Many of the common decisions we make, such as dosage, frequency of monitoring, and proper response to "aberrant" behaviour, are often based on experience and intuition. There is, in general, limited clinical evidence to guide the practitioner. When evidence is provided such as the lack of efficacy data at one year for opioids in chronic pain, one must ask what pharmaceutical intervention does have such evidence? While I commonly advise against elective surgeries until a patient's substance use disorder is well under control, the questions of how much clinical structure is indicated, when to intervene surgically, and how best to address the triggering aspects of uncontrolled pain are all serious clinical concerns that commonly occur. These concerns and others can turn the simple decision of when best to see the patient back into a very complex clinical question. Care must be individualized.

Complicated comorbid psychiatric issues

In a specialized pain and addiction practice it is the exception when a patient does not have another psychiatric disorder in addition to their chronic pain or substance use disorder. Since most of us caring for these patients are not psychiatrists, and access to formal psychiatric consultations are often difficult to obtain, the management of complex psychiatric disorders often fall into the lap of the clinician managing pain or substance use disorders. While this can be rewarding intellectually and professionally, there is a corresponding apprehension associated with practicing on the edge of one's formal training. Regardless, a lot of responsibility may fall on a clinician who has little formal psychiatric training. In a rural setting this can be complicated by difficulty in obtaining ongoing professional consultations and support.

Anger, shame, and grief

Patients suffering from substance use disorder and chronic pain patients are commonly dealing with large doses of anger, shame, and grief. We the treating physicians are not immune to these emotions. In our deep concern and caring for patients these feelings can easily be suppressed, and have consequences to one's emotional and physical health. Indeed, if these feelings are not acknowledged and properly responded to, one's judgment may be significantly impaired. In addition, when these emotions are not processed effectively, they create a potential to act as lightning rods to the same emotions the patients struggle with. This brings up the subject of transference and counter transference.

Transference and counter transference

Patients with chronic pain and addiction are at high risk of having been abused by people in authority, including physicians. Not surprisingly, they will transfer their feelings and attitudes from these past experiences onto their treating clinician. Even though one might be aware that this is going on, it remains emotionally challenging not to be affected by a patient's anger and blaming, especially when they are directed personally towards the caregiver. I prefer the term displacement rather than transference to describe this phenomenon. As common as it is in pain and addiction specialized setting, there is little training or support on how best to prevent and address it. Counter-

transference of course is best avoided. One suggestion for avoiding it is in the case when a clinician, one self, or a close family member has had problems with chronic pain or addiction. In this context, it is most prudent to have formal if not professional opportunities to properly process the associated feelings and thoughts.

Lack of immediate rewards and frequent setbacks

While physicians are skilled in delayed gratification, the brain does take time to heal and the brain slowly unlearns highly reinforced patterns. As a result, rewards and progress often takes months or years to become apparent in many of these patients. If one expects rapid cures this work is particularly stressful. Chronic complex pain and addictions are chronic relapsing disorders. There are no cures per se. Unlike many clinical contexts, we must satisfy ourselves with progress not perfection. For those in medicine who expect perfection, this work is particularly challenging, because as already discussed, there is most often a lack of control over a lot of what happens.

Lack of formal training

In general, when we are confronted with dying patients or other challenging patients it can be comforting to know, that one is doing all that one has been medically trained to do. When dealing with patients with pain and addiction, however, if one only does what they have been formally “trained” to do, care is likely to be woefully lacking. This is a conundrum for the physician who have been trained to do the same as their colleagues do. When one is properly managing complex pain or substance use disorders, I expect it is common to feel a bit on the “edge”. Clinically I find myself commonly asking if I am doing what I can to create a context in which patients are likely to improve. Those familiar with the serenity prayer: “God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference” will recognize the value of this prayer for both caregivers and patients alike. In part because of the lack of formal training and consensus regarding the use of opioids in chronic pain patients, the author recently wrote a book to help patients as well as clinicians navigate the question as to when opioids are part of the solution or the problem in chronic pain management.²² Individualized care is emphasized.

Stress on marriages and other intimate relations

It is almost certain that personal relations outside of the work setting are significantly affected by the nature of this work. Marital stress is common for many medical specialties.^{4,22,23} The above enumerated stressors contribute to special additional liabilities associated with this work. The author’s spouse confirms the benefit of Al anon and couples counselling in managing the impact on our relationship. In addition to the typical stressors of time and money, incidences of turmoil are perhaps less tolerated at home because of the burden of addressing the same at work? Personal and home safety issues can arise, in part because of the criminal backgrounds or anger management and boundary issues for many of the patients. Emotional fatigue can interfere with normal drives for intimacy. What’s more, support from families and friends can be lacking because of poor appreciation for the nature or the importance of the work. A sense of isolation can occur even within one’s medical community. The author has had colleagues make reports to the State’s Medical Quality Assurance Commission and other third parties. These reports stem from common ignorance of the safe and effective use of scheduled medications in patients with opioid use disorders, chronic pain, and

comorbid psychiatric concerns. Sometimes there is even ignorance or misunderstandings of the laws and regulations themselves. Given the complexity of same this is quite understandable.

Regulatory zeal

Little has been formally written on the impact of regulatory zeal when it comes to managing substance misuse. I consider the unintended consequences are seriously contributing to the current opioid use epidemic and other substance use epidemics. Are there other specialized areas of medicine in which regulatory zeal is greater? When it comes to addictions, pain management with opioids, are there other areas of medicine where general and professional ignorance and fear is greater? Lawmakers and administrators seem intent to create more laws and rules to assure that substance abuse and overdoses do not happen. Are there any examples when criminal and administrative laws and policies that address specific patient care, and limit individualized physician judgment, have had favourable health outcomes? As Americans we experimented with Prohibition less than 100 years ago. What did we learn from that failed experiment? Perhaps we diverted our rage over lack of control of alcohol and tobacco onto other abused substances? Our current United States Attorney General seems to believe he’s in the best position to prevent further deaths from substance misuse. Is the best solution to “criminalize” or create greater punishments for abusing substances. In this culture we appear much too ready to blame someone or something.³

I personally can testify to the devastating legal and financial liabilities that can be associated with properly caring for patients with complex pain and substance use disorders. Culturally there is a strong tendency to believe that all these patients need to do is to just say no, or to simply “buck up” and learn behavioural ways to bear the horrendous morbidity and mortality. The unintended consequences of our laws and policies that pertain to substance use and the prescribing of controlled substances are not well appreciated. Let us appeal to a more robust Public Health approach and with it better prevention and access to proven safe and effective care.^{24,25}

Positive attributes of this work!

With these stresses and challenges why would one be tempted to begin or continue this work? One could reasonably argue it is not reasonable or prudent. The answers to explain why to do this work will likely differ between different practitioners. The opportunity to be of service to the disadvantaged and those suffering readily promotes a powerful sense of well-being and meaning. Indeed, in this respect the work could not be better. If one is looking for an avenue to experience and express compassion through intellectually and emotionally challenging work, this field of work provides plenty of opportunities. If one tends to think in non-linear ways, what some philosophers call abductive forms of reasoning, the complex nature of this clinical care is likely to be more satisfying. Opportunities for personal emotional and spiritual growth are enormous. I find it easier to be more comfortable with myself despite apparent shortcomings, ignorance, and naivete. The patients served are also wonderful teachers about what it is to be human. The quality of the relationships one establishes, particularly when they are long and meaningful, greatly contribute to the satisfaction of providing this specialized care.

Finding extra support

While professional and collegial support is helpful if not essential,

I suggest one will benefit from some sort of an emotional support group. While regular attendance at Al Anon meetings would likely be helpful, it's understandably an awkward step for a clinician or a staff member to take. It is helpful to have supportive colleagues to talk with and I think some regular "debriefing" with co-workers is also helpful. Indeed, debriefing is a regular agenda item for staff meetings. Speaking with colleagues who do similar work has also been helpful. Finally, my relationship with God as well as my wife, family, and friends are immensely supportive and likely essential to avoid burnout. In recent years there has been much written and reviewed regarding physician burnout. The consensus is that physician burnout has reached epidemic levels. A systematic review and meta-analysis on the subject was published in 2016.^{26,27} Individual clinician as well as structural and organizational changes can help physician burnout. Familiarity with what helps prevent burnout is recommended for all physicians.

In summary

The issues covered by this review warrant extensive clinical research. Physician burnout is significant and thankfully is starting to be studied and addressed. Different medical specialties have their unique challenges and each likely warrant some different preventive measures. There is an immense need for qualified clinicians in the areas of chronic pain management and addiction medicine. Further work to determine appropriate selection, training, and support for specialists in the fields of pain management and addiction medicine is indicated. Appropriate incentives to attract qualified and capable physicians need to be explored. Structural and organizational changes in the delivery of medical care which promote collaboration and team approaches are needed in all areas of medicine where patients have complex needs, as is the case for those with comorbid chronic pain and substance use disorders.

This informal review of some of the challenges confronting practitioners caring for patients with pain management and substance use disorders is most likely of interest for those already serving high risk chronic pain patients. Hopefully this review might attract others to the field and make it easier for others to get started. Ongoing support directed not only toward the staff but to the overall structure and organization of the work place warrants ongoing attention.

Appendix - suggested indicated clinician skills

There are specialized "skills" and prerequisites for caring for patients with substance use disorders and chronic pain management needs. Some are relatively easy skills to obtain, others require extensive training or experience, and others may even require certain personal attributes. The following 10 items are not extensive or complete. They hopefully reflect a helpful framework to better provide this clinical work:

- a. One is to be sensitive to and adept at not shaming patients. One might respond entirely appropriately and in a non-shaming way, yet some patients might still construe it as shaming. "You don't trust or believe me" are common responses. The issue is to be sensitive to these issues and continue to not fault the person but acknowledge how disabling their behaviour can be. Have non-challenging responses prepared for some of these comments. I commonly provide a "Trust" handout to patients.
- b. Being comfortable with establishing proper boundaries. Patients often resist healthy boundaries and establishing same can be challenging while conveying care, concern, and an eagerness to maintain the relationship.
- c. Being comfortable with a sense of "powerless" over people, places, and things as in an AL anon fashion. Both/and ways of thinking usually work better than either/or ways of thinking and responding. Develop clear limits to what you will tolerate or not but avoid intentional punitive or shaming responses. Focus on providing more support and structure when needed.
- d. "Getting it" perhaps is the best way I can describe this provider quality. I do not believe one needs to have had a substance use concern to "get it". It helps having had a SUD, though having a SUD is no guarantee of "Getting IT". One must accept this disease is not about intelligence, moral integrity, or knowing the facts. While recovery may be helped by the grace of God, one best addresses the disease similarly to diabetes or other chronic relapsing diseases which benefit from both medical and behavioural care. Most people have difficulty changing their belief systems particularly when they perceive their beliefs have worked for them in the past. Avoidance plays a major role in addictive disorders and chronic pain. Appreciating same is part of "getting it".
- e. Focus on active listening. When patients are talking more than 50% of the time this is generally a good sign.
- f. Be adept at helping patients develop and manage a plan for ongoing better brain health.
- g. Have options for responding to acute anxiety producing situations whether it be acute pain, legal, or financial concerns, as well as medical ones. Prevention and behavioural options need to be emphasized.
- h. Enjoy and get good at establishing and maintaining long term therapeutic relationships. Recognize the challenges and contextual variables that help determine when a patient is to be seen back.
- i. Be familiar with clinical and scientific data particularly on alcohol and opiate use disorders. Tobacco dependence is common, and benzodiazepine/sedative use disorders are common.
- j. Be familiar with common comorbid psychiatric conditions: PTSD, ADHD, Mood Disorders, Personality Disorders, major psychotic disorders, and the large spectrum of "anxiety" disorders.

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Conflict of interest

The author declares no conflict of interest.

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