

## Virtual Mentor

American Medical Association Journal of Ethics  
May 2013, Volume 15, Number 5: 430-433.

### JOURNAL DISCUSSION

#### Physicians' Responsibility to Understand Patients' Pain

Robert Learch, DO, and Jeremy Cumberledge, MD

**Crowley-Matoka M, Saha S, Dobscha SK, et al. Problems of quality and equity in pain management. *Pain Med.* 2009;10(7):1312-1324.**

Pain has risen to epidemic levels in the United States, and how we as physicians manage it best has become a widely debated issue. More than 100 million American adults suffer from chronic pain [1], the financial implications of which are astounding. It is estimated that the direct cost of pain treatment is around \$300 billion dollars annually. That is more than treatment for cancer and diabetes combined [2]. Joint pain alone is responsible for 12.5 million emergency department and clinic visits annually [1]. While pain management has become an issue that physicians deal with on a daily basis, there is not yet consensus on how best to address it. In "Problems of Quality and Equity in Pain Management," Crowley-Matoka et al. identify three elements of biomedical culture that contribute to the current problems in managing pain: (1) mind-body dualism; (2) a distinction between disease and illness; and (3) bias toward cure rather than care [3].

The principle of mind-body dualism—viewing body and mind as being separate [4, 5]—as well as the favoring of objective over subjective data are certainly pervasive and cause damaging inequities in our current medical culture. The situation stems, in large part, from an unclear understanding of the pathophysiology of pain and how social, cultural, and psychological factors affect it. The authors note that mind-body dualism may be at least partly responsible for the fundamental structure of modern medical knowledge—diseases of the mind and body are taught separately in the classroom and treated individually in the clinical setting. The current biomedical model inclines physicians to label the easily measurable findings related to pain as "real" and to treat them more proactively. Alternatively, in the absence of objective findings, physicians are more likely to doubt the authenticity of reported pain and the potential for lack of proper treatment increases. The nature of pain involves both mind and body.

There are some signs that point to change from the classic biomedical model of medicine to a biopsychosocial model with increased use of psychotropic medications, specifically antidepressants and atypical antipsychotics [6, 7]. It is not outside the realm of possibility that improvements such as these could correlate with advances in the awareness and treatment of chronic pain as we learn more about how pain uniquely affects both the mind and body together, and not at all separately.

The contrast between disease and illness implies a separation of the two, as though they reside at opposite ends of a continuum. Crowley-Matoka and colleagues note that it is easy for physicians to identify diseases, represented by a collection of exam findings, lab results, and other tangible objective information. Patients, however, experience “illness,” which is not limited to objective findings but encompasses psychosocial effects of being unwell in the setting of a patient’s culture. It is the summation of these factors that ultimately affects their lives, manifested as pain or any number of physical or mental ills. The disease model of medicine is insufficient because it places an inappropriately high value on classic presentations of particular diseases. When the patient fits the criteria for diagnosis, they are enthusiastically treated, and physicians are satisfied by a job well done. Conversely, patients who do not precisely fit a discrete syndrome may be inadequately treated or disregarded completely. Correcting the “disease-vs.-illness” approach involves understanding patients as a whole, and not just diagnosing and treating their disease or pain. This understanding comes at a cost, however, since physicians must overcome the tendency to view patients in pain or with atypical presentation of illness as frustrating or difficult [8, 9]. Instead they must commit themselves to considering and understanding the often unpleasant social situations of their patients.

The bias toward cure and away from care can also be viewed as a continuum, the pendulum having swung far toward cure with rapid advances in biotechnology and in the availability of novel treatments for a number of ailments [10, 11]. Pain management lags behind other treatable ailments in this sense. Opioids have become a mainstay in the treatment of chronic pain, though the data is severely lacking to guide our management [12]. We tend to focus on “curing” and yet we know little about how to diagnose pain and have comparatively few tools to manage it. Before there were treatments for many diseases, a culture of caring for patients prevailed because there frankly was no way to cure them. With the advent of these curative measures, physicians are now pushed to be efficient in “curing” and often are not able to spend the time required to understand their patients’ situations and diagnoses [13]. We assert that if chronic pain cannot be cured, we must at least seek to care for patients in the same way we did before so many “cures” came along.

Crowley-Matoka et al. report that the characteristics of modern biomedicine manifest themselves in inadequacies in three phases of clinical pain management. First, the communication of pain between patients and physicians may suffer because of the current model. The fact that complex illnesses like chronic pain syndromes cannot be easily measured or classified may result in physician reluctance to address them. When social or cultural differences are present, the communication breaks down further. Physicians can view pain management as frustrating or difficult, which may limit their commitment of time and effort to communicating with these patients [3].

Assessment and management of pain are flawed under the current biomedical model, and this error has significant social and cultural ramifications. Physicians and patients commonly identify with very different culture groups. Though some group overlap may exist, membership related to socioeconomic status, education, and

ethnicity often does not. Our inability or potential unwillingness to recognize that a patient's illness occurs within social context can lead to mislabeling difficulties in treatment as misunderstandings with the patients themselves [3]. The harsh reality is that mislabeling these problems can affect the quality of medical care. Recognizing this should call us to reflect and introspect about how we as individual physicians approach patients from different cultures, ethnicities, and socioeconomic backgrounds.

We agree with Crowley-Matoka et al. that there is a weakness in the current biomedical culture and there are a number of factors that contribute to our problems. These factors may include, but are not limited to, our patients' personal or cultural views toward illness, the business of health care under which we all operate, and our own personal opinions about the ideal of health and wellness. As the leaders in the health care arena and the "healers" of our day, physicians must take the reins to ensure equity for our patients' sake. If we can begin to analyze our actions and motives and honestly assess how we approach these patients, perhaps we will drive the transformation of our biomedical culture. Individuals can navigate between cultures and cultures themselves can change over time [14]. It is past time for a shift towards a biopsychosocial orientation to pain, and we are the physicians who are called to see that through.

## References

1. Paulose R, Hertz RP. The burden of pain among adults in the United States: findings from the National Health and Nutrition Examination Survey, the National Health Care Surveys, and the National Health Interview Survey. Pfizer; 2008. [http://www.pfizer.com/files/products/PF\\_Pain.pdf](http://www.pfizer.com/files/products/PF_Pain.pdf). Accessed April 19, 2013.
2. Gaskin DJ, Richard P. Appendix c: the economic costs of pain in the United States. In: Institute of Medicine Committee on Advancing Pain Research, Care, and Education. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: National Academies Press; 2011: 301-308. <http://www.ncbi.nlm.nih.gov/books/NBK92521/>. Accessed April 19, 2013.
3. 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(7):1312-1324.
4. Scheper-Hughes N, Lock MM. The mindful body: a prolegomenon to future work in medical anthropology. *Med Anthropol Q*. 1987;1(1):6-41.
5. Miresco MJ, Kirmayer LJ. The persistence of mind-brain dualism in psychiatric reasoning about clinical scenarios. *Am J Psychiatry*. 2006;163(5):913-918.
6. Ruths S, Sorensen PH, Kirkevold O, et al. Trends in psychotropic drug prescribing in Norwegian nursing homes from 1997 to 2009: a comparison of six cohorts. *Int J Geriatr Psychiatry*. Epub Nov 13, 2012.

7. Stephenson CP, Karanges E, McGregor IS. Trends in the utilisation of psychotropic medications in Australia from 2000 to 2011. *Aust N Z J Psychiatry*. 2013;47(1):74-87.
8. Walker EA, Katon WJ, Deegan D, Gardner G, Sullivan M. Predictors of physician frustration in the care of patients with rheumatological complaints. *Gen Hosp Psychiatry*. 1997;19(5):315-323.
9. Wassan AD, Wootton JD, Jamison RN. Dealing with difficult patients in your pain practice. *Reg Anesth Pain Med*. 2005;30(2):184-192.
10. Starr P. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books; 1982.
11. Porter R. *The Greatest Benefit to All Mankind: A Medical History of Humanity*. New York: Norton; 1997.
12. Chou R, Ballantyne JC, Fanciullo GJ, Fine PG, Miaskowski C. Research gaps on use of opioids for chronic noncancer pain: findings from a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *J Pain*. 2009;10(2):147-159.
13. Fiscella K, Epstein RM. So much to do, so little time: care for the socially disadvantaged and the 15-minute visit. *Arch Intern Med*. 2008;168(7):1843-1852.
14. Ortner SB. *Anthropology and Social Theory: Culture, Power and the Acting Subject*. Durham, NC: Duke University Press; 2006.

Robert Learch, DO, is a resident physician at the University of Kentucky Hospital in Lexington. A native of Omaha, Nebraska, he is a graduate of Kansas City University of Medicine and Biosciences and is interested in primary care internal medicine and palliative care.

Jeremy Cumberledge, MD, is a resident physician at the University of Kentucky Hospital in Lexington. A native of Charleston, West Virginia, he is a graduate of the Marshall University School of Medicine and is interested in gastroenterology.

#### **Related in VM**

[Chronic Pain Patients and the Biomedical Concept of Pain](#), May 2013

[Pain and Ethnicity](#), May 2013

[Pain and the Paintbrush: The Life and Art of Frida Kahlo](#), May 2013

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2013 American Medical Association. All rights reserved.