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Victims, villains, crocks, and criminals—Rewriting the scripts in the chronic pain drama

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Summary Examining the doctor-patient encounter as a drama reveals opportunities to maximize positive therapeutic outcomes by exploring the "roles" of the participants. Through education, realistic goal setting, and explicitly negotiated expectations, revising the customary "scripts" each cast member unconsciously follows can alter and possibly eliminate the barriers to effective management, particularly in the "chronic pain drama."

Objectives

After reflecting upon the concepts presented in this article, the reader will be able to (1) identify barriers to effective management of chronic, intractable pain by recognizing dynamics—both discreet and explicit—that govern doctor-patient relationships; and (2) describe strategies for overcoming management barriers by changing "scripts" that direct behavior.

All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts
—William Shakespeare (from *As You Like It*)

The recent advances in our understanding of the etiology and mechanisms of chronic, unremitting pain provide a beacon of hope for the 70 million people in the United States who suffer with this condition, and the providers who care for them.[1,2] Unfortunately, that hope is mitigated by persistent reports of suboptimal treatment and mismanagement that results in as many as 40% of this population reporting that at least some of the time their pain is "out of control."[3,4]

The barriers to effective management of chronic pain are admirably documented and discussed in a variety of position papers published by professional pain groups, such as the American Pain Society, the Association of Pain Management Specialists, the American Academy of Pain Medicine, and others.[5-7] Among these are a woefully insufficient number of pain management specialists available for timely consultation, an acknowledged deficiency in the training of physicians in the fundamentals of pain management, and a lack of appropriate provider reimbursement commensurate with the skill, time, and effort that these patients require. In addition, a common theme that emerges in the list of management hurdles involves physician and patient attitudes and behaviors inherent in the health care provider–pain patient interaction.

Shakespeare's observation (quoted at the beginning of this article) provides a creative construct that allows exploration of some of these obtrusive features of the drama that are played out in the doctor-patient interaction. Identifying several prominent "roles" (Tables 1-5) that physicians and patients adopt (often unconsciously) and understanding the impact they have on the therapeutic encounter can help physicians seize the opportunity to adapt their own behaviors as well as become change agents in the lives of their patients by motivating them to develop and implement strategies that result in health-promoting behaviors.

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Table 1 Roles in the chronic pain drama

Victim: One who is harmed by or made to suffer from an act, circumstance, agency, or condition
Villain: One who does evil deliberately; a wicked or evil person
Crock: One whose ideas or convictions are considered nonsense or irrational
Criminal: One who violates the law

The players

Victim: One who is harmed by or made to suffer from an act, circumstance, agency, or condition

By its very nature, the experience of chronic, unremitting pain fosters the perception of being victimized. In particular, the commonly encountered disparity between what physicians can document objectively with diagnostic tools and the subjective experience the patient reports nurtures a sense of doubt, confusion, and isolation for which the patient feels he/she should not be held responsible and accentuates the conviction that he/she is being treated unfairly.

Compounding the physical suffering is the increasingly common challenge of economic support. Their chronic pain prevents many of these patients from holding jobs, eliminating the opportunity for employer-provided health care benefits. This effectively denies them access to the multidisciplinary resources—drugs, counseling, physical therapy, and alternative treatments—that are crucial for appropriate comprehensive pain management. The emotional demands placed on chronic pain patients and those they love and the impact the condition has on all aspects of their lives (relationships, sleep, work, social activities, sex), often trigger a sense of desperation and nurture the conviction that they have no advocate within their immediate social circle and, perhaps more importantly, in the medical system. There is ample scientific evidence that individual responses to pain vary considerably because of physiologic, even genetic, differences, resulting in significant variance in individual pain thresholds.[8] The experience of being judged as "weak" because of their lack of conformity to an arbitrary standard ("You can't be having that much pain") augments their frustration over such perceived injustice. Add to these the common occurrence of medication intolerance, erroneous lab tests, and seemingly unsympathetic, judgmental providers, and it is small wonder why many chronic pain sufferers feel they have been arbitrarily chosen to play the role of victim.

Table 2 Factors contributing to the role of victim

Patient	Physician
Inadequate support system	"No show" patients
Ambiguous patient advocacy	Unreliable patients
Insufficient funding	Dishonest patients
Ineffective coping skills	Manipulative patients
Low pain threshold	Adversarial regulatory agencies
Medication intolerance	Third-party payer policies
Erroneous lab tests	Insufficient training
Judgmental providers	Lack of objective measuring tools
Pseudo-addiction	

Health care providers express similar sentiments of injustice. Personal interactions, bureaucratic policies, and regulatory mechanisms often conspire to place the physician in the role of victim. Noncompliant, demanding, manipulative, or deliberately dishonest patients are all sources of aggravation. Physicians are particularly sensitive to governmental and regulatory policies that seem deliberately adversarial by creating unnecessary impediments to their altruistic intention simply to deliver quality medical care. Third-party payer policies occasionally appear unjust and arbitrary, making physicians' best efforts seem unrecognized, unappreciated, and undercompensated.

Table 3 Factors contributing to the role of villain

Patient	Physician
Office routine disrupters	Moral judgments
Liars	Patient abandonment
Work avoiders	Comfort over commitment
Recreational substance users	Suspicious or adversarial attitudes
Fakers	
Substance abusers	Biases
"Drug seekers"	Ethnic
	Socioeconomic

Villain: One who does evil deliberately; a wicked or evil person

All practitioners, from the lowest levels of training up to and including independent practice, have encountered patients who lie, fake symptoms, disrupt office routines, make demands, and otherwise attempt to manipulate the therapeutic encounter to their own ends, which may conflict with that of the caregiver. Some seem to be clearly attempting to avoid work and other social responsibilities; some are attempting to obtain narcotic medication (a mainstay of legit-

Table 4 Factors contributing to the role of crock

Patient	Physician
Dysfunctional personality	Unsubstantiated fear
Hypochondria	Misguided suspicion
Depression	Educational deficit
Psychophysiologic (psychosomatic) illness	Inaccurate information
Manipulative behavior	

Table 5 Examples of the role of criminal

Patient	Physician
Drug diversion	Drug diversion
Prescription forgery	Practice standard violation

imate pain treatment programs) for recreational purposes, to feed their addiction, or to use as a product that provides a source of income. Even among honest patients who are genuinely suffering, noncompliance and simple failure to meet the physician's expectations contribute to physician frustration, making it tempting to lump all such conduct together and interpret it as deliberately evil.

Physicians are certainly not invulnerable to accusations of villainy. In the area of acute and chronic pain management, studies have documented a disparity in quality of care delivered to certain ethnic or socioeconomic populations.[9] The elderly, racial minorities, women, and patients with a history of previous or current substance abuse are all more likely to receive suboptimal care. Understandably, frustrated patients in this cohort often interpret physician behavior as indicative of a conscious choice to dismiss their concerns as trivial or too time- and effort-intensive to warrant attention.

Crock: One whose ideas or convictions are considered nonsense or irrational

A pejorative term with scatological origins, the label "crock" has unfortunately become part of the medical lexicon. Most often used by healthcare providers to describe patients whose convictions or perceptions defy their own sense of logic and understanding, this label can actually encompass a variety of specific clinical behaviors with recognized management strategies. In the chronic pain drama, some patients simply lack the vocabulary or facility of expression to describe their symptoms coherently. Those with dysfunctional personalities or who display clinical characteristics of anxiety, depression, or psychophysiologic (psychosomatic) disorders have all been known to fall under this rubric. Frequently, however, use of this term represents the provider's own failure to understand the nature of the patient's subjective experience. Especially for professionals trained in the scientific tradition of supporting clinical decisions with objective, reliable evidence, it is tempting to dismiss these patients as impossible to help in any definitive way.

Physicians may also harbor unsubstantiated fears or perpetuate unreasonable, irrational, or simply uninformed convictions. From a current knowledge-base perspective, medical school curricula as well as postgraduate residencies have been criticized for allowing physician training to fall woefully behind the scientific advances made in the management of chronic pain. Surveys consistently cite physicians' fear of reprisals from adversarial licensing and disciplinary authorities as an impediment to the delivery of appropriate care to patients with chronic pain. However, since the 1997 publication (and 2004 revision) of the consensus statement on pain management issued by the Federation of State Medical Boards,[10] the role of these regulatory bodies has become significantly less adversarial and more supportive of physicians making genuine, responsible, and well-documented attempts to deal with this disadvantaged patient population. Despite this advance, many physicians persistently exhibit nonproductive, defensive behavior that disadvantages their chronic pain patients.

Criminal: One who violates the law

In any patient population, although perhaps more prevalently in the chronic pain cohort, there are inevitably prescription forgers, drug diverters, and people who otherwise attempt to subvert the therapeutic encounter toward illegal ends.

Likewise, some physicians deliberately fail to meet standards of care, knowingly ignore recommended documentation standards, or blatantly disregard the law by irresponsibly providing prescriptions for controlled substances, thereby further impeding appropriate care delivery to the pain population.

Revising the scripts

The complex relationships involved in the professional encounter between health care provider and chronic pain patient underscore the challenge of altering the dynamics to optimize care. However, in any drama, resolution of the conflict and altering the outcome of the interaction can be accomplished by revising the scripts of the characters. It is indeed encouraging to find that, in the chronic pain drama, even small changes in the players' scripts can enhance health care delivery to a disadvantaged population.

Victim scripts

Patients—Empowerment and realistic goal setting

One of the health care provider's professional responsibilities is to help patients modify any behaviors that may be detrimental to attaining the shared goal of restored health. In light of the numerous ways in which patients feel victimized, the most fundamental behavior change can be realized with empowerment. For the pain population, this begins with the establishment of a supportive doctor-patient partnership, an essential part of which involves education. Compliance with almost any therapeutic regimen is enhanced when patients understand their specific condition. For this reason, educating the chronic pain patient about what is known and unknown about the cause, impact, and prognosis

Table 6 Differential diagnosis of aberrant drug behavior

- Addiction
- Drug diversion
- Pseudo-addiction (inadequate analgesia)
- Other psychiatric diagnosis
  - Encephalopathy
  - Borderline personality disorder
  - Depression
  - Anxiety

of his/her condition is crucial to establishing a productive relationship. To optimize a sense of control, the value of negotiating a set of realistic, shared goals in the pain management program can hardly be overestimated. Chronic pain sufferers need to acknowledge that complete pain relief may not be a reasonable treatment target. Instead, therapeutic goals need to focus on optimal life enjoyment, specifically addressing pain reduction (not elimination), and improvement in personal relationships, socializing activities, sleep, mood, leisure time activity, and possibly an enhanced potential for being engaged in meaningful work.

Physicians—an explicit exit strategy and meticulous documentation

A crucial tool to reduce the physician's sense of victimization is the negotiated pain management contract or agreement. This document, examples of which can be found online,[11,12] explicitly describes the responsibilities and expectations of *both* parties. Ideally, the agreement includes an explicit exit strategy that describes the consequences of failing to achieve a desired outcome. For example, it may be prudent to agree up front that a documented lack of pain reduction and/or functional improvement will require a reassessment and renegotiation of the initial therapeutic plan.

The best defense against a sense of victimization at the hands of professional regulatory or disciplinary bodies (e.g., state medical boards) is a familiarity with the recommended documentation guidelines for chronic pain management. Although each state medical and/or pharmacy board has its own set of standards, a review of these will usually confirm that they simply represent best practices in documentation of any goal-specific management plan.

Villain scripts

Patients—Differentiating aberrant behaviors and identifying pseudo-addiction

A quick review of patient "villainous" behaviors (Table 2) will confirm the value of a well-constructed pain management contract/agreement that describes the consequences of what has been termed "aberrant drug use behavior." Such behavior carries with it, like other disease states, its own relatively short differential diagnostic list (Table 6).

The category of pseudo-addiction deserves some explanation. This term, which appears frequently in literature devoted to the discussion of chronic pain, refers to patients' behavior that contains all the elements characteristic of addictive behavior but is actually the result of inadequate pain control. Characteristically, these patients are demanding, disruptive, unreasonable, and noncompliant. They may hoard medications, display compulsive and obsessive behaviors surrounding obtaining medication, and sometimes even lie or engage in criminal actions to obtain medication. However, in this subcategory of patients, once their pain is controlled to an acceptable level (recognized by many to be a 3 on a severity scale of 1-10), the aberrant behavior stops and they become respectable partners in the collaborative pain management effort. Unfortunately, all too often, signs of pseudo-addiction are missed, or no effort is made to investigate it as a possible cause of aberrant behavior, with the consequence that the patient is labeled noncompliant or a "drug seeker" and sequentially dismissed from one potential source of care after another.

The remaining causes of aberrant behavior in the list have specific recommended therapeutic management strategies. Addicts need specialist referral and compliance with an addiction therapy program may be a specified requirement of the pain management agreement. In such an instance, it is important to emphasize that referral does not necessarily preclude continuing the provider-patient relationship. Psychiatric diagnoses (depression, anxiety, personality disorders, etc.) all have identified management strategies. Likewise, drug diversion (obtaining a prescription for controlled substances with intent of selling or trading for another substance of choice) should be dealt with through legal means.

Physicians—reflective examination of beliefs and behaviors

To avoid being cast as a villain, the health care provider must distinguish between discriminating professional judgments and subjective moral judgments. On a personal level, this may require considerable reflection, discussion among colleagues, consultation with a trusted mentor, or even professional counseling. Ideally, the process of regularly examining and addressing motives, convictions, biases, and prejudices is an integral part of any physician's professional renewal exercise. In this area, one aspect of doctor-patient dynamics warrants closer examination. When it becomes necessary for a physician to disengage formally from a professional association by terminating the relationship, it is incumbent upon the provider to ensure that it is initiated in the best interests of the patient. To avoid lending support to allegation of patient abandonment, severing the relationship

must never be (or interpreted to be) punitive or the result of an arbitrary or capricious decision. The rationale for such an action—e.g. breach of trust in the relationship, unacceptable failure to comply with reasonable routines, or a lack of progress in the management plan as negotiated—should be explained to the patient and documented explicitly in the chart to eliminate any question about its validity and intent.

Crock scripts

Patients—Appropriate diagnosis and treatment and supportive listening

Patients cast in this role are arguably among the most challenging. Difficulty in understanding is often accompanied by a similar struggle in empathizing. Physicians must guard against the inclination to dismiss these patients offhandedly as being impossible to help or, worse, unworthy of any further expenditure of resources because of the likely futility of the effort. Accurate diagnosis and treatment of concurrent conditions (Table 6) is crucial in this regard. Appropriate primary care management (or, if necessary, specialist referral) for psychiatric and substance abuse conditions is frequently the appropriate response to these patients. Again, setting explicit realistic goals, may contribute to a much more gratifying provider-patient interaction. Ultimately, the conscientious physician may need to frame the conflict in terms of a genuine (although lamentable) inability of the profession to address the patient's needs rather than condemning the patient for having needs that cannot be met. Supportive listening, validation of the subjective experience, and acknowledgment of the frustration associated with feeling victimized are all strategies that the primary care provider can use to ameliorate the hurt and isolation associated with being labeled "crock."

Physicians—Self-directed, lifelong learning

The physician's best defense against "irrational" or "incomprehensible" behavior is the consistent use of evidence-based medicine by following established clinical practice guidelines and published standards of care. Education—through formal training or self-directed study, or under the guidance of specialist consultation—is crucial to avoiding allegations of substandard treatment. Recognizing the support of the Federation of State Medical Boards (FSMB)[13] and taking advantage of the educational resources provided by professional pain societies[14-17] will ensure that physicians consistently offer their patients the most rational, up-to-date diagnostic and therapeutic care.

Criminal scripts

Patients—electronic safeguards

Illegal behavior (forged prescriptions or suspicion or evidence of selling or trading prescriptions) must be reported to appropriate authorities whose responsibility it is to investigate and initiate any necessary criminal proceedings. To help physicians remain conscientious guardians of the public welfare, several tools have been developed. The Drug Abuse Warning System (DAWN)[18] is a public health surveillance system that monitors and reports on drug-related emergency department visits and drug-related deaths to identify trends associated with prescription and nonprescription substance use/abuse. Support services such as the Ohio Automated Rx Reporting System (OARRS)[19] allows provider access to patient's prescription histories, immensely simplifying the verification of patients' reports of prescription medication use.

In this regard, it is important to remember that the physician's responsibility is "to heal sometimes, to comfort frequently, to care always." In the arena of criminal activity, the physician must be conscientious and circumspect, while scrupulously attempting to avoid becoming suspicious and accusatory. We have an obligation to cooperate with law enforcement authorities and to report potential criminal abuses. We must never forget, however, that our primary commitment is to provide health care to those who need it.

Physicians—conscientious monitoring

As part of the profession of medicine, all practitioners accept the responsibility of maintaining a behavioral standard that is irreproachable. In the area of pain management, violating established legal standards can best be avoided by committing ourselves to excellent documentation. Likewise, physician must demand excellent documentation from colleagues by establishing and maintaining practice standards.

Summary

Achieving a mutually satisfying conclusion to the "Chronic Pain" drama is contingent upon resolving the conflicts that create barriers to optimal patient management. These conflicts are intricately woven into the "roles" the players assume as the therapeutic encounter unfolds. Examining and restructuring these roles—"revising the scripts"—provides opportunities to change behaviors and alter the interactive dynamics. Strategies for success include establishing a genuinely collaborative physician-patient relationship with an emphasis on education of both patients and physcians, realistic goal setting, meticulous documentation, effective reassessment routines, and a clearly defined exit strategy.

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