Family Practice Grand Rounds

Pain and the Difficult Patient

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DR. ALAN DAVID (*Assistant Professor, Department of Family Practice*): The conference today is entitled, Pain and the Difficult Patient. The patient and physician share, in effect, discomfort when certain pain-like symptoms are difficult to diagnose or alleviate. Although this discomfort is shared, it is also different for each of them.

The participants in today's discussion are: Dr. John Neill, Assistant Professor in the Department of Psychiatry; and Dr. H. Thomas Weigert, Chairman; Dr. E. C. Seeley, Associate Professor; Dr. John Patterson and Dr. Peter Powers, third year residents, all of the Department of Family Practice.

There are two major goals for today's discussion: first, to increase the awareness of how we, as physicians, feel and react to patients in whom we have difficulty finding organic or physiologic reasons for their symptoms; and second, to better understand the approach and management of the difficult-to-diagnose painful patient. Two case histories will be presented.

First Patient

The first patient is Ms. B.W., a 25-year-old woman, who called one day complaining of pain in the dorsal part of her hand, wrist, and forearm. She had banged it on a door frame two days earlier. She is an attractive, unmarried secretary who has a history of marked adolescent adjustment reaction with depression. She lives alone and goes to college part-time. Her family history is remarkable only in that her mother has chronic physical complaints which have failed to resolve despite the efforts of numerous physicians. She was seen and examined that day by her personal physician who found no bruising, swelling, erythema, or point tenderness. The range of motion of the wrist was complete. There was no numbness or tingling of the fingers. She was told that it was a mild bruise. Initial treatment consisted of immobilizing the wrist with an ace wrap.

Over the next several days she reported several episodes of severe right hand and wrist pain. She appeared in my office about five days after the initial visit requesting an "x-ray." This was normal. The range of motion was again completely normal. No evidence of tender painful tendons, bruising, discoloration, or warmth was found. At this point I asked a colleague to examine the patient. He confirmed the absence of positive physical findings. Both of us then discussed the possibility that this might be functional in light of the patient's marked overconcern about her problem. She was placed on an analgesic and an anti-inflammatory agent, reassured, and sent home.

She called about three hours later, crying. The pain was so intense she "[didn't] know what to do—[she couldn't] stand it." She was given instructions to use alternating cold and hot baths for the hand. If that did not help she was to come into the office within an hour. She called back several hours later stating that the pain was better but not completely gone. Two days later the patient was again seen because of intermittent episodes of intense pain. I then suggested to her that she might be focusing excessively on the hand even though the pain was real. Perhaps her concern was making it worse than it really might be. She seemed to

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accept this without anger or hesitation. She was reassured that things would get gradually better within four or five days. When she was next seen five days later, the hand was better. The wrist splint was off and she was able to resume her normal activities.

Second Patient

The second case history concerns Mrs. G.R., a 36-year-old woman, who came to the Family Medical Center complaining of sudden epigastric burning pain upon awakening. She had been divorced and remarried, and she had three sons by her first marriage. She has had difficulty holding any job which brings her into contact with many people. Her brother was recently killed in an accident which left her with a reactive depression for about two months. There was neither acute stress nor food that she could relate to the pain. No other symptoms (fever, vomiting, diarrhea, chills, or malaise) were noted. She had continued to eat during that day although her appetite was poor. She related a history of having recurring "gall bladder" attacks even though her gall bladder had been removed several years previously. She had "migraine" headaches approximately every two months. The physical examination was entirely unremarkable. She was placed on a regimen of antacids and a six-meal-a-day bland diet. The initial impression was that she probably had mild gastritis or a hiatal hernia with esophagitis.

She called back 48 hours later complaining she was not better. Her symptomatology had not changed. She was then re-examined and no remarkable findings were noted. She was placed on increased pain medication, Tylenol 3, plus Gaviscon and Librax. Two or three days later the patient returned with no apparent relief. Several diagnostic studies were ordered. Therapy was unchanged. An upper GI, barium swallow, SMA-12, and complete blood count all returned within normal limits. The patient, on discovering that her laboratory tests were normal, related that buttermilk occasionally seemed to help relieve her symptomatology. At this point I reviewed with the patient the entire course of her illness and the diagnostic studies that had been undertaken. I explained that I was not sure of the etiology of the pain but that I believed that it was real and uncomfortable. She was continued on the Librax four times a day and was placed on a bland diet with buttermilk three times a day. I assured her that her symptoms would get better within a reasonable length of time but that progress would be slow. After that, the patient did not contact the office nor was she given a return appointment. She was seen approximately a month later in relation to an episodic visit for her son. Her epigastric pain was inquired about and she said that it was gone most of the time.

Comment

Both cases involved fairly short-lived episodes of pain. In both situations no organic pathology was found on physical examination, x-ray examination, or laboratory data. Both resolved with a certain amount of time and "understanding." The patient did not leave; the patient-physician interaction was not terminated. Both patients seemed to respond to reassurance but it is not clear exactly why. Both patients were a source of moderate frustration to me as their physician because of my inability to make a pathologic diagnosis and my uncertainty as to how to deal with each problem. These, then, are examples of the "painful patient."

DR. JOHN NEILL *(Assistant Professor, Department of Psychiatry)*: It seemed that when I was talking with Dr. David about this, there were two possible directions to take. The more standard approach is for me to stand up and talk to you about anxiety, neurosis, depression, hypochondriasis, and hysteria-conversion. The more subversive direction, which I decided to take with his encouragement, looks at what I call the physician-patient transaction.

Let's see if we can understand the best way to manage someone for whom you are not able to make a diagnosis. First, meeting with the patient is a *transaction*. There are expectations of things being given and received. Secondly, there is a sense of organized and unorganized illness. At the outset, the patient offers symptoms. Before a diagnosis is made, it is an unorganized illness. Later in the process, the physician makes a diagnosis and from this decides on management. In so doing, the illness becomes organized, and the

patient's behavior is dictated by the management decided upon by the physician. This is the "apostolic function," a concept derived from Michael Balint's work.[1] When a diagnosis is not made, the illness remains essentially unorganized, and an unorganized illness disturbs the physician for he is not sure how to proceed in terms of behavior, management, or cure.

Most importantly, however, is that the physician, whether he knows it or not, dispenses out a "dose" of himself as he organizes illness or clarifies unorganized illness. It may be peculiar to think simply of yourselves as being therapeutic and as having a definite effect. Each of you might try to imagine yourself as being a sort of lozenge, and imagine what color or flavor you would be for this person. You are, in fact, part of the treatment from the first moment that you begin the doctor-patient interaction.

Let's go back to Ms. B.W., who injured her hand. What were your reactions when she returned for her second visit regarding her pain?

DR. DAVID: When Ms. B.W. arrived at the office that day and said, "Well, I am here for an x-ray, my hand has been hurting worse," I thought maybe I had missed a small fracture. I felt slightly guilty, but I was glad she returned to get an x-ray. After I looked carefully at the x-ray film and found it negative, I wanted to get someone else to look at the patient because then I was beginning to feel frustrated. If there was nothing wrong, then what was I going to do with the patient? Why was the patient here?

DR. NEILL: So a few hours later you got to the point at which she has a panic attack and you told her to come back into the office if it was not better in an hour. Strangely enough, things got better when you said, "You can come in and see me right away."

Even though it may not have been clear at that moment, you satisfied all her needs with one simple formulation. You made it clear: "Your pain is real and I believe you. You can come and see me about the pain again today. You are afraid of the pain, but you needn't work so hard reminding yourself how bad it hurts. It *will* get better." It almost has the quality of a hypnotic suggestion. It seems to have turned, like a lock with a combination.

DR. DAVID: People need to have the reassurance that they can come back without becoming much worse or deathly ill. In the case of Ms. B.W., I did not give her a specific time to return. I simply said the hand should be better within four or five days. What kind of risk, if any, do you take in giving a patient with an unorganized illness such as pain a return appointment? Our society has pretty well ingrained in us that you have to be ill in order to go to the physician.

DR. NEILL: There is little risk in having them back if you understand your feelings and the reason to have them back. What should push you to bring the patient back is the feeling you get in your gut when you look out and see that person in the waiting room or see their name on the appointment list. You say to yourself, "Oh no! What am I going to do this time?" When that feeling arises about a person with a short-term unorganized problem, it is appropriate to schedule a return appointment in order to structure the situation. When you feel harassed or terrorized, schedule a return appointment. In so doing you will help the patient avoid the need to become greatly worse before he/she can justify seeing you again for reassurance or whatever.

Let's return to the first encounter with the patient for a moment. Initially, I would have let some negotiation take place. She offers the pain and you make the response, "We'll give you the Ace bandage and I don't see anything wrong." I probably would not have suggested to her that she could come back for an x-ray. Instead, something might have been said like, "I'm quite sure you have the pain but I am not worried about what's going on." This came up again, I think, in your eloquent and possibly spontaneous formulation in the second case. "I don't know exactly what's wrong, what's causing your pain, but I am not worried and it will get better."

DR. H. THOMAS WIEGERT *(Chairman, Department of Family Practice)*: I would like to take issue with that. You may be dealing with a hairline fracture of the navicular or other small bones in the wrist. You can not really tell during the first few days. There is a point in getting an x-ray one week or ten days later. It would seem to me that it is better to go ahead and have that degree of structure for the patient to understand what is going to happen. This keeps you honest with yourself as well as with the patient. If you reassure them prematurely and then six days later there is something found on the x-ray film, you lose credibility.

DR. NEILL: All right, as you point out, I was not familiar with the latency of appearance of a hairline fracture.

DR. E. C. SEELEY *(Associate Professor, Department of Family Practice)*: I think had the patient been told at her first visit that the pain was functional, she would have been turned off. She might never have returned.

DR. DAVID: To follow upon Dr. Seeley's observation, I would like to discuss several different approaches that have been listed as unsuccessful.[2] First, we are convinced sometimes that we are going to be the physician who is going to cure this patient. Consequently, we try very hard to diagnose and treat the patient with numerous tests or medications. This usually fails. Secondly, we sometimes make a concerted effort to convince the patient that there is nothing wrong. We review the laboratory tests and x-ray and ECG findings very carefully with the patient. This may result at best in a temporary remission of symptoms. Finally, we sometimes have the patient seen by multiple consultants. I might have asked an orthopedic surgeon to see Ms. B.W. All these paths are stopgap measures which do not meet the patient's needs. How do we ascertain why the patient is really here—what does the patient really want?

DR. NEILL: There is a danger in referring people to multiple consultants. There is a diffusion of responsibility. No one takes charge of the patient or the problem. Secondly, it might be helpful to find out the affective meaning of the symptom. A simple active listening statement might be, "I noticed this really got you upset." You might find that prior to injuring the wrist she had an argument with her boyfriend. That would point to a more conversional genesis of the pain. As you widen your scope of investigation, you will soon come across something that will be meaningful.

DR. PETER POWERS *(Third year resident, Department of Family Practice)*: The case of Ms. B.W. is a good example of trying to satisfy your scientific or intellectual inquiry, for example, to make absolutely sure there is not a hairline fracture or something missed. Therefore, you are genuine, concerned, and reassuring to her whether or not she has pain that is "functional." That is probably one element essential to success. Maintaining your scientific inquiry could also be reassuring to the patient whatever the etiology.

DR. DAVID: These two cases raise the issue of how we reassure ourselves and the patient that we have been complete and reasonable in our evaluation in which nothing has been found. This process was described several years ago in an article, "Reassurance Therapy" by Sapira[3] in *Annals of Internal Medicine*. Six steps in reassuring a patient are described. First, one has to elicit a detailed description of the symptoms. Secondly, one needs to elicit the affective meaning of the symptoms—what this means in terms of the patient's life. Examining the patient is the third step. For example, if you surmise that the patient has a functional bowel problem but you did not lay your hands on the abdomen, then the patient may go away with the feeling that his visit was not complete. The fourth step is making a diagnosis. The fifth step is explaining the symptoms to the patient in words appropriate for that patient. The sixth step is reassurance. This is most important. We must let the patient know that we believe his problem is real, but that it is not serious, lethal, or harmful.

If we understood more of what patients want from us and how illness fits into their lives, then we would have a greater understanding of these patients. Perhaps, we might then focus less on making the diagnosis and more on meeting the patient's needs.

DR. NEILL: It would be easier to know what the patient needs from you if you lived in a small town 40 or 50 years ago and saw the family at church and so on. Now it is not so clear. You really *do* need to talk more with the patient, to schedule more time directly or indirectly and look at the more affective meaning of illness with the patient at some point along the way. When you realize that this may be a long-term relationship, you might say at some point, "You know it seems to me that you just have a body that's not put together right." The patient may then say, "I thought so, it's just like my mother, (or my grandfather, or grandmother); I've just got their nerves. I was always told that I was going to have this, that, and the other thing."[4] You might reply, "Well now, you know Mrs. Smith, it looks like we are going to be working together for a long time. I think the problem for us is going to be learning to live with these illnesses, with this migraine, with whatever it is in your abdomen that is going on." I wager she will be relieved initially to find that you are not going to cure her. In spite of its being hard

to fathom, people are relieved to find out that you are *not* going to cure them. It means they do not have to struggle anymore.

DR. JOHN PATTERSON *(Third year resident, Department of Family Practice)*: I saw a lady today whom I have seen for the past 1½ years. She had had, during that time, recurrent facial pain that has been evaluated by an otolaryngologist at least once, by two other family physicians, and by me. Her problem list fills the page. She invariably brings in a minimum of three to four clippings on the newest approach to various medical problems, not necessarily related to her problem. I saw her having facial pain often for a period of two or three months. Only after a hospitalization did I realize just how necessary it was for this lady to have some reason not to have to work. She needed to be able to say, "My pain is so bad, how can I do a good day's work when I feel so bad?" Well, I gently challenged her and offered her a daily visit with me and perhaps another physician, a psychiatrist. She politely cancelled out on that, but on a subsequent visit continued to have pain, so I boldly injected her face without any expectation that I was doing anything physiologic, anatomic, or appropriate. She had no pain for weeks and I did not see her for months, until today, in fact, when she returned for an upper respiratory tract illness. She again told me about this facial pain that was always there. When I suggested that we needed to approach this pain again in some way, she said, "Oh, well, yes, but an ice pack really does help and once it goes away with an ice pack it doesn't return for three or four weeks." I used to wince when I saw her in the waiting room or saw her name on the list. The first step for me has been accepting the fact that I am going to have to carry the burden of her need to come and check in. I finally had to say that if I reacted in any way but giving her acceptance for coming in, then I was going to defeat my purpose and hers. Her pain justifies her not working and not being a social person.

DR. NEILL: That is what I was talking about—the physician's version of the "apostolic function." He really wants to convert all his patients to his way of thinking about how much they should be hurting, with what kind of illness, and what they should do about it. What Dr. Patterson was describing was the renunciation, at least temporarily or intermittently, of the "apostolic function." He is listening to what the patient is saying, what she was asking for. She came back again, and you seem to have some satisfaction in this. It is curious. You have not cured anything, have you?

DR. DAVID: I think it has become clear in this discussion that the goal in dealing with patients of this type is not necessarily to cure them but to control their symptoms and to respond in an acknowledging way. Often the symptoms that patients present to us are unconscious solutions to problems in their living, and the case of facial pain that Dr. Patterson described is certainly an appropriate example. Our role, then, is to establish a therapeutic relationship, which will take time. We have to acknowledge the pain and symptoms as real. They are just as real as the pain of a laceration of the arm. I agree with Dr. Neill's point that setting up regular appointments eases the patient's need to behave in the sick role. To make a regular appointment suggests to the patient that he/she does not have to be worse to come in—you want to see them regardless. It is important to acknowledge that we probably cannot alleviate all suffering. Some of these people may be cured, while some may come in less often and may not need regular appointments. But until we get to know them, we need to take this kind of approach. We will probably be more successful and much less angry.

DR. NEILL: The maxim, "What can't be cured must be endured," applies both to the patient and the physician! It sums up this discussion quite well.

References

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