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Stories from doctors of patients with pain. A qualitative research on the physicians' perspective

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Abstract *Goal of work:* .The aim of this study was to explore the physicians' internal representation of the doctor–patient relationship in the dramatic field of the patient with pain. *Methods:* Using an open narrative format, 151 physicians were asked to "Tell us about an episode during your professional experience in which you found yourself in difficulty whilst confronting a patient who was in pain". The narrations were examined in accordance with a clinical-interpretive method. *Main results:* Three "perspectives of observation" were identified, namely: the biological perspective, the professional perspective, and the personal perspective. The biological perspective is about the biological model and the "depersonalization" of pain. In the professional perspective, the narrative concerns the patient as a "person" and the reattribution of the pain to the suffering person. The personal perspective is about the emotional-relational explosion within the meeting between the doctor as human being and the patient as human being. Most of the narrations did not strictly connect to one or another of the perspectives, but each story seemed a journey without peace back and forth among the perspectives. *Conclusions:* The professional perspective seemed to be the only place in which physicians could "stop", a space not extreme in which they seemed to express the need for education about the management of the professional relationship with the other person.

Keywords Pain · Qualitative research · Physicians' representation · Physician–patient relationship

Introduction

The medical literature of the last few years is characterized by an increasing experimental focus on the nontechnical and nonbiological aspects of disease. This has been particularly helped by a substantial increase in research into the communicational-relational aspects of the clinical consultation [22, 26]. In previous research the issue has also been explored in dramatic fields such as that of oncology. The well-known proposal by Buckman suggests a six-step protocol to manage the interaction with the cancer patient and, in general, in the context of giving bad news [5]. In an experimental study, doctor–patient interactions in oncology have been found to be characterized by disease- and doctor-centred styles: Despite the fact that consultations concerned life-threatening disease and often contained information regarding toxic treatment which is known to provoke psychological dysfunction, the number of questions relating to patients' psychological health were few [13]. The fact is that a patient-centred interaction [17] could be fundamental in order to improve clinical outcomes.

Communication should be viewed as a core clinical skill: after a good encounter with doctors patients show better compliance with the therapy and better psychological adjustment to a cancer diagnosis [9]. That is why an increasing amount of literature is concerned with skills training for doctors' communication in the oncological context (see for example references 1 and 11). Alongside these studies and slightly following them in time, progressively increasing attention has been paid to the dimension of the patient's experience of the disease. Some contributions have demonstrated the importance that the patient's perspective has in the healing process [2, 16, 24]. Studies about patients' perception of the quality of the care they receive, in particular in oncology treatment, have revealed that insufficient quality of health-care provision could constitute an additional load on patients and could undermine treatment effectiveness [3]. A study exploring how women with breast cancer experience the patient–doctor communication of the diagnosis has shown the importance of a comprehensively patient-centred working relationship [20].

In this context of increased attention to the doctor–patient interaction and the patient's experience of healing, the perspective of the physician seems still to be understudied, and in particular, provider attitudes and emotions are much neglected [15]. Only recently, and with experimental contributions still scarce, has a new source of nonbiological research been opened: that of the experience of the doctor during the meeting with the patient [27]. A recent review suggests that many doctors find unpleasant talking with patients about distressing subjects, such as giving bad news, and that also physicians experience problems handling their emotions and feelings [10]. The present study is a contribution to this field of work, that of the inner life of the physician [21] in the particularly dramatic area of the patient with pain. The upsetting view of patients living with pain has been identified in previous well-known research. In particular, in her classical work, Saunders described the concept of "total pain", that included the physical, social, emotional and spiritual elements [7]. In this perspective, pain is explored as a lived experience of illness, and patients are involved in the research with the goal of comprehending the pain "through the eye of the patient" [6, 18]. On the contrary, little is known about the doctor's perspective with regard to the patient with pain. The cognitive and emotional construction of health professionals has been studied as it could influence the communication with the patient in pain [4].

The aim of this study was to explore the pain "through the eye of the doctor" and in particular to reach a view on the doctor's internal mental representation of the clinical relationship with the suffering patient. Because of the explanatory nature of the study oriented at comprehending subjective aspects and internal representations, written narrations were used as a tool to collect data and the clinical-interpretive method was used to explore the narrations.

The use of qualitative research is increasing in medicine [19, 23] as a means to explore subjective aspects of an experience that cannot be reduced to quantitative measures such as number or frequencies. In particular, in respect of the clinical interview, the study of narratives offers the possibility of developing an understanding that cannot be arrived at by any other means [14]. Narratives allow the researcher to approach the participant's experiential world in a more comprehensive way, this world itself being structured [12].

Methods

In order to obtain the experience of physicians involved in clinical consultations a written narrative format was used (for the use of this tool to collect material, see for example references 12 and 14) which asked the participant to "Tell us about an episode during your professional experience in which you found yourself in difficulty whilst confronting a patient who was in pain". The written assignment was given to the participating physicians at the beginning of a series of courses dedicated to the communicational-relational aspects of the clinical meeting with the patient in pain. The decision to introduce this narrative task at the beginning of the training was made because the proposed assignment could have provoked feelings of an emotional nature and the course offered the opportunity to discuss with the participants a first-glance analysis of the narrations.

The narrated experiences were to be anonymous, and the assignment was formulated in such a way as to leave the maximum possible freedom for the participants to express themselves. The assignment, however, constituted an identical stimulus for each participant. No further information was added. Each participant had around 20 minutes to complete the assignment. The written material collected constituted a variation of a fairly standard approach to qualitative analysis previously used by our group [27]: we had a high number of participants (unusual for qualitative research) but a short time was given to produce the texts so that more direct and instinctive stories would be encouraged rather than long narratives. In addition to the narration, some sociodemographic data were collected from the participants (also anonymously).

The narrations were examined in accordance with a clinical-interpretative method [12] in which the objective is to reconstruct the internal representation of the medical profession (rather than of an individual physician) with regard to the relationship with the patient in pain. The clinical-interpretative method, as a variant of the grounded theory, may be described as an inductive process of identifying analytical categories as they emerge from the data with the intention of developing hypotheses from the ground rather than defining them a priori [19, 23]. The method foresees a series of reading phases [23]. Initially, the stories were read in an atheoretical, analytical way with the aim of identifying repeated themes or a singular theme critical for the comprehension of the internal meaning of the stories. During the course of the first reading, a series of narrative strategies used by the physicians were included in the analysis as evidence of the modality in which a physicians' experience of a patient was fixed in their memory. The aspects collected in the first reading were therefore explicitly told or implicitly suggested by the expressive modality used. A second reading involved the defining of an exhaustive map of the aspects collected from the first reading. The map consisted synthetically not so much of "facts" but rather of prototypical concepts, themes or thematic areas and links which would consolidate a relationship among these. A third and final reading allowed verification of the efficiency of the narratives' reconstruction obtained by means of the map and of the exhaustiveness of it. The final reading also allowed identification of fragments of stories which were particularly representative at the final presentation of the results.

The analysis was carried out by two researchers (E.V. and E.M.), a psychologist and a physician, with training in analysing clinical psychological texts. The analysis was discussed in detail by the team.

Results

The participants comprised 151 doctors of whom 63 were female and 88 were male with an age range of 27–67 years. Of the 151, 44 were specialists in anaesthesia and resuscitation, 25 were specialists in oncology, 22 were specialists in internal medicine, 15 were specialists in orthopaedics, 13 were specialists in pain therapy and palliative treatment, 9 were general practitioners, 7 were specialists in gynaecology, 3 each were specialists in physiatrics and in emergency surgery and neurosurgery, 2 were specialists in geriatrics, and 1 each were specialists in otorhinolaryngology, ematology, radiotherapy, nephrology, pharmacology, sports medicine, psychiatry, and child neuropsychiatry.

The content analysis of the experiences showed the following distribution: 84 related to meetings with oncology patients, 26 with patients affected by muscular pain, 18 with patients affected by headache or neuropathies, and 23 with patients affected by other clinical pathologies (e.g. arthritis, systemic sclerosis, etc.). The inductive process of analysis suggested three thematic perspectives through which the stories could be read: the biological perspective, the professional perspective, and the personal perspective. Each perspective seemed to cross the narratives and to be determined by pieces of different stories more than by a group of stories.

In the following paragraphs we discuss these perspectives. The Appendix presents a more in-depth insight of a theme within each perspective. Pieces of the narrations are used as examples to describe the content of the three perspectives. Since the analysis includes a reflection on the doctor's expressive style, the layout characteristics of the narratives are maintained as much as possible. Any abbreviations, acronyms or graphic signs relate directly to the doctor's written text (and are, where necessary, explained within square brackets). The identification codes for the fragments of the narrations are indicated.

The biological perspective: the pain of the disease

The first perspective consists of fragments which have the particular characteristic of depersonalizing the pain; here the biological story is narrated.

> P. [patient] 32 years old. Comes to A&E [Accident and Emergency Department] with violent chest and lumbar pain. Presents dyspnoea and cyanosis. EOT [objective examination of the thorax] normal, EOA [objective examination of the abdomen] normal for abdominal quadrants. The Giordano [a kidney examination] result was ++ dx [diagnosis], nondysuric. Admitted and treated with pain killers (acetylsalicylate and anti-inflammatories + cortisone) without improvement of the subjective symptoms. On a subsequent examination of the Rx thorax [thorax following treatment], there was an increase in the cardiac area. The echocardiogram showed pericarditis. [MD10]

> ... the difficulty was in understanding whether or not this involved two distinct pathologies (low back pain + postsurgery inguinal neuropathic pain) or a single pathological feature (low back pain L2-L3). [MD120]

In these narrations, there is a subtractive component, the pain is "taken away" from the patient and the subject takes on a passive role, marked by sentences expressed in a linguistically passive form, not usual in the Italian language. It is as though the patient does not exist as the entity of a person but exists only as a function of the painful symptoms of which he/she is complaining.

> A 70-year-old patient was mastectomized and underwent a lymphoadenectomy for cancer. [MD26]

> The patient presents abdominal and rachiolumbar pain due to a tumor of the pancreas. Besides the pain, there are features of asthenia and anorexia. [MD121]

In this view, two more in-depth issues are found. The two issues can be termed "medical successes" and "the leaking sieve".

Medical successes. The first issue underlines the indisputable protagonist of this perspective: the science of medicine which confronts, breaks up and resolves biological pain. In this imaginary section we find stories which tell us about the successes and the achievements of medicine in the face of disease and bodily pain.

> A patient (male) of about 30 years old, loves life, fun and motor racing. ... Every time he had to make a journey of any type, he came to Palliative Treatment Surgery where he had built up an excellent relationship with the doctors; he had another infiltration and ... the world was again at his feet! [MD30]

> ... but the proposed treatment had an excellent effect and after 30 days the patient was able to walk without a stick. He had stopped thinking about death and spent his days (almost) serenely. He had even taken up cooking and watching TV again. [MD16]

The leaking sieve. Here the stories told are "full of holes". This is only apparently in contrast to the previous in-depth issue. Here stories talk about the "chess piece of biological pain" or about those situations in which the founding concept of this perspective enters into crisis. The doctor seems to take part in a pain which is not sufficiently understandable in biological terms. This leaves the doctor with a conceptual void which is unfathomable in the language of this view.

> What makes me crazy is the control of the pain incident which is not classifiable in many components, not only organic but also psychic. [MD139]

> All of a sudden, the efficiency of the therapy is lessened. The patient complains of serious sleep disturbance and recrudescence of the polyathralgia, with the onset of lumbosciatica Dx [diagnosis]. These symptoms do not correlate with any one clinical feature and cannot be highlighted with clinical exams. [MD143]

> ... for mere curiosity, I administered a dose of placebo. The patient did not want to give up taking this therapy because it gave him enormous relief from the pain up until the end of the therapy a week later. I still cannot explain what happened in the body and the mind of that young patient. [MD8]

The professional perspective: the pain of the sick man

In the second view, the other person "emerges". Here the narrations describe the patient as a "person".

> Among the patients whom I have followed, I remember a particular patient, Giuseppe whom I treated at his home. I was part of a palliative treatment team. Giuseppe was an elderly patient of over 70 years old and lived at Zen [a poor district] in Palermo where he had lived for more than 20 years after being transferred by the local housing department. [MD33]

> I remember the story of Enrico T., 42 years old, married with two children, lorry driver, affected by cancer of the colon with peritoneal and hepatic metastasis ... [MD64]

The pain is no longer distinguishable from the person who suffers and has, in these stories, a first name. The doctor is witness to the complexity of the person's experience of pain: the patient as a subject decides and gives importance to that which happens to him. The main character of these stories is the patient, "keeper and owner" of his/her pain and illness, an active and conscious actor in the process of treatment. As a consequence the doctor has to convince and "win over" the patient in order to carry out a diagnostic and therapeutic programme.

> ... in the same way as she had managed her own illness, she had also decided to manage her pain. [MD21]

> In fact, she wanted to know everything and chose what she wanted ... so she had to be convinced that the drugs would have helped her. [MD71]

The patient's pain requires a more complex explanation in which the body and its biology are only a part and it is from this comprehensive view that the patient lives with it.

> Once the situation had been analysed and the connection between the onset of the headache and the external negative stimuli had been identified, I advised him to distance himself from negative situations at weekends (when the pain worsened) and slowly, with the help of pain killers which eased the pain and with the elimination of the problems, the patient was able to (even though partly) resolve the problem of the headaches. [MD12]

> On analysing the contents of her case history, it was found that the problem was based on an interior conflict (the lady was about to lose her home due to repossession). When the patient was confronted with the possible cause of her pain, her symptoms clearly improved. [MD78]

With this perspective, one in-depth theme was identified, a theme that could be termed "the vocabulary".

The vocabulary. In the view of "the pain of the sick man", a specific reflection is dedicated to the new professional reality. Doctors seem to attribute new meaning to their clinical work which is at times disorienting; they seem confused about this new meaning and do not know how to deal with it. The vocabulary of the profession is enriched by terms and sometimes by acts in an apparently unexpected and confusing way.

> My ethical vocabulary did not, at that time, recognize a suitable modality to hear his cry for help. Only when I was faced with his suicide attempt (which was totally unexpected) did I understand what the patient was trying to tell me. [MD64]

> It's clear that the doctor's therapeutic goal could not be "technical", if not in part, the relational aspect of an empathic nature became preponderant where reciprocal emotions and words became the beginning of a bidirectional esteem which would have accompanied the patient until his death (which came after a few months and was faced with courage and serenity). [MD61]

> To summarize briefly: the global pain of the patient was accepted and an attempt was made to hypothesize about solutions for the 'pieces' known about her suffering. The help and the sharing of the project with the team was fundamental but above all with the patient and her family members. [MD140]

The personal perspective: the hurt healer

These stories are characterized by a blending of the theme of pain. The focus seems no longer to be on the medical pain or on the pain of the patient but on human limits, of which pain is a symbolic example. In this perspective, the emotional-relational aspect explodes in the meeting between the doctor and the patient but above all between human beings. The patient is no longer just a "you", "the other"; the doctor as human being identifies himself with the suffering of the patient as human being.

> In that moment, one associates the feeling of being sorry for the patient with the frustration of seeing 'failure' in one's own role of 'healer'. [MD89]

> After a week ... all of a sudden, the correct feeling is established, a relationship of trust is born. I am able to understand what Lucio is looking for.
>
> We examine the pain, we calm the anxiety together and the drugs slowly begin to work ... .
>
> Where is the problem?
>
> Are we becoming too ... friendly?
>
> I have recently suffered the loss of my mother; for obvious reasons I treat the patient at his home; I identify myself with him; I see his children, his family; I become almost a distant cousin.
>
> When he died (of pneumonia) at 5 a.m., they called me at home, I went, I lost ... the distance.
>
> His death is a loss, not a sad observation. [MD136]

A strong process of identification brings the doctor and the patient onto the same existential level. As evidence of this, the stories relate to close relatives of the doctors themselves.

> That man was my FATHER. [MD54]

> Patient of 58 years old, affected by scleroderma. It is not a typical case of professional experience because the patient was my aunt. [MD144]

The only case that springs to mind is that of my father who was affected by bladder cancer. In the last years of life he suffered atrociously with the pain but demonstrated immense dignity and was able to withstand all the therapeutic interventions, putting great faith in the doctors who were treating him...". [MD20]

In this view, two in-depth issues are identified, which we term "the hero patient" and "the escape". They both seem to constitute different attempts on the part of the doctor to face his or her own condition of the "hurt healer".

The hero patient. These are stories of the good, handsome patient, who suffers deeply. In the doctor's experience, this patient is an exceptional person and is dignified in an uncommon way. In the case of the hero patient, a process of idealization seems to be being acted out in order to heal the state of profound frustration which the doctor as human being is in.

> Let me start by saying that Mrs. G. is an exceptional woman with a high level of culture as well as being a woman of enormous spirit and patience. [MD15]

> In her early 50s, characterized by an indescribable gentleness, she has never complained, even though the illness slowly overwhelms her and her face expresses the physical, but above all the psychological, suffering she is experiencing. The dignity with which she has coped with the fear of death has left an immeasurable impression on me. [MD17]

> He was a splendid man, full of humanity and richness of soul and as with all sad stories, the end came too soon and too painfully. [MD54]

The escape. In order to face the condition of "hurt healer", alongside the attempt to distance the patient by idealizing him, there are stories about the doctors' attempts to distance themselves. When faced by a situation of total emotional involvement, an escape route is searched for, either by denial and displacement, or by physical acting out. The detached descriptions of physical pain can be considered within this perspective as the extreme effort to repress one's emotional involvement. The following are escape examples through denial, displacement and acting out.

> A 45-year-old patient came to my surgery about a month ago affected by double symptoms: (1) chronic back ache, (2) inguinal pain. Case history records an inguinal hernia operation (2001) and furthermore, the diagnostic investigations highlight the presence of a herniated disc L4-L5 which compresses the hard matter (= lumbosacral NMR scan). [MD120]

> What has hit me the most is the total lack of sensitivity of the laws regarding pain therapy and the lack of culture with regards to the doctors. It is difficult to prescribe central drugs (e.g. morphine) and doctors obstinately prescribe pain killers (e.g. FANS [antinfiammatori non steroidei, NSAIDS], paracetamol) because of the problems in prescribing morphine and its derivatives. This complete ignorance is possibly the fault of the medical schools, of alternative methods of administration (see the transdermic method) and due to the fact that doctors are scarcely informed. In my opinion, medical schools should be responsible for teaching this subject and should dedicate more time to it. At least in cases where recovery from an illness is not possible, a patient should be allowed to die in a painless and serene way. [MD14]

> Despite all attempts (and not just my own), it was not possible to alleviate such pain which is now only a component of Carla's global suffering. Every time I go to see her I look at my watch and I cannot wait to leave. I feel embarrassed. I keep quiet and I limit what I listen to. If I could, I would leave. [MD109]

Discussion

Pain is one of the main themes in medicine, a frontier for research and clinical medicine, a symptom and even an illness. The subject of pain is approached in medical literature from many different perspectives. Recent contributions introduce a more subjective perspective of pain, that of the pain experienced by the patient who is suffering [6, 18]. Our work followed the attempt to enrich medicine from this "subjective" angle on pain, but in our case, studying from the point of view of "he/she who heals", or is "responsible" for healing pain. Few previous papers have discussed the doctor's pain in reflective rather than experimental terms [8]. The aim of this work was to clarify doctors' experiences when they are faced with a patient who is suffering. This topic is a very complex one and is a part of the wide reflection about the inner life of physicians [21]. Contributions in this field are increasing in the medical literature and they include multidisciplinary and borderline issues such as ethics, psychology and philosophy [25]. Our contribution is a reflection on the topic via a possible oversimplification that should be a reflective stimulus and should not mislead the reader as to the complexity of the topic.

In particular, in a dramatic field such as that of the patient with pain, the emotional and subjective involvement of doctors in the process of care is crucial, but this involvement is still under-studied. This perspective was collected by means of a qualitative methodology which is becoming more popular in medical science in order to explain mental representation of caring [23]. The results highlighted the physicians' difficulties in terms of three possible perspectives.

The first perspective, that of "the pain of disease", is about the biological model and the depersonalization of pain. This level of extreme simplification gives rise to a physicians' cultural dissatisfaction: the biological model "enters a crisis" every time the solutions to a difficult pain are not found within its theories and explanations. Critically, this simplification offers a poor and inadequate understanding of pain.

In the second perspective, that of "the pain of the sick man", stories of the patient as a "person" are narrated and the pain is reattributed to the person. With this perspective, the meeting is not just with the body's pain but with another person who is suffering. In this view the critical issue is that a new, unknown and uncertain professional space is opened beyond the disease.

The third perspective, that of the "hurt healer", is about the emotional-relational explosion within the meeting between the doctor as human being and the patient as human being. The doctor's threatening identification with the patient's suffering is suggested. The critical issue is due to the doctor's continuous and risky fluctuation between the idealization of the patient and the way in which he/she defensively distances him/herself from that patient.

In a comprehensive general view, a kind of clarifying map of doctors' difficulties is detected. Nevertheless, the map does not exhaust the value of the stories. The narrations do not seem to be located at a point on the map but to flow within it. The reading of an entire narration (presented in the Appendix) may be particularly useful to see the way in which the doctor moves across the map. This continuous journey from one perspective to another suggests that the doctor does not seem to find a peaceful place. The encounter with the patient in pain seems to be experienced as a place where the doctor feels unable to cope. The stories seem to be characterized by a material lack of a way through which the physician is enabled to cope with the patient in pain.

In particular, in the first perspective the physician does not seem to find what is necessary: the more technical and biological aspect of the physician's competence is inadequate in facing pain. The first perspective is culturally unacceptable. In the third perspective, the doctor seems to declare that the emotional involvement is "too much" and therefore the only solution is denial and an escape route. The third perspective is emotionally unacceptable.

The crossing through the second perspective is different. The second perspective, that of meeting with the other as a person, seems to be a place of crossing where doctors seem paradoxically not to experience contradiction. Physicians suffer somewhat from professional incompetence. In this journey without peace, doctors seem to indicate this as a place in which they may be able to "stop", a space not extreme in which they are able to experiment professionally.

It is possible that the acknowledgement and a better comprehension of the difficulties at the level of internal representation of care could favour a better consciousness of the professional acting and a chance to face up to the difficulties. The results seem to suggest the need for education in a perspective that physicians themselves feel is possible: that of the management of the professional relationship with the other person—which is not about the dynamics of the doctor's work, but is not further technical/biological training either.

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Appendix

The following story exemplifies the three doctors perspectives with patients in pain. The "biological" perspective is clearly evident at the very beginning of the story. The meeting with the other as a person as described in the "professional" perspective is unequivocal, for example, with the use of the patient's first name. The last sentence exemplifies the personal perspective, that of the "hurt healer". This story is also an example of the continuous journey of the doctor within the three perspectives. The original layout characteristics of the text have been maintained.

> 50 years ♂ ALS
>
> Disease's (very fast) progression with acute respiratory failure—hypercapnia—admission to the emergency unit—ETI—mechanical ventilation, tracheostomy and then discharged to his home with ventilatory support.
>
> NB tetraplegic patient
>
> He is sent to our unit (the patient had been treated at another intensive care unit) and I am appointed to provide specialist support at the patient's home (reanimative support to ventilation and analgesia for associated pain). He is not my first patient; on the contrary all these patients are of my competence.
>
> SURROUNDING—at the beginning opposed; the intensive care in which at first he was treated was "perfect"; it's a pity that they refused some informations to the patient on the course of the disease, prognosis and progress; we are seen as incompetent but (?) "I'm quite young. How could my time be up?".
>
> The patient is going bad and bad ...
>
> He refuses the PEG or a nasogastric tube for feeding and prefers feeding by OS (patient with dysphagia) with consequent inhalations ... and then, the pain ... piercing, dull, unceasing, shooting.
>
> He's not exactly happy.
>
> (Who knows why?!)
>
> After a week ... all of a sudden, the correct feeling is established; a relationship of trust is born; I am able to understand what Lucio is looking for.
>
> We examine the pain, we calm the anxiety together and the drugs slowly begin to work ... .
>
> Where is the problem?
>
> Are we becoming too ... friendly?
>
> I have recently suffered the loss of my mother. For obvious reasons I treat the patient at his home; I identify myself with him; I see his children, his family; I become almost a distant cousin.
>
> When he died (of pneumonia) at 5 a.m., they called me at home; I went; I lost ... the distance.
>
> His death is a loss, not a sad observation
>
> [MD136]

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