Airing Pain Programme 15: Effective communication: patients and professionals

Better communication for doctors and patients and how to make the most of medical appointments.

*Communication is fundamental to the relationship between patient and healthcare professional. In this programme **Airing Pain** looks at this issue from both the patient and doctor's point of view. Psychologist David Craig of Glasgow comments on his communication skills training DVD for chronic pain professionals. GP Mark Ritchie explains how depression and chronic pain can be linked, and gives advice on how patients can prepare for medical consultations, using the memory aid: Ideas, Concerns, and Expectations. And finally, we hear from a number of patients about how they effectively broke down any communications barriers with health professionals in order to gain the most that they could from their consultations.*

Paul Evans: Hello, and welcome to ***Airing Pain***, a program brought to you by Pain Concern, a UK charity that provides information support for those of us who live with pain. Pain Concern was awarded first prize at the 2009 NAPP Awards in Chronic Pain, with additional funding from the Big Lottery Funds Awards For All Program, and the Voluntary Action Fund Community Chest. This has enabled us to make these programs.

Ron Parsons: I'm of the age where, as a young person, I went to the doctor and listened to every word he said. Didn't dare argue with him.

Mark Ritchie: The average GP out there needs to be looking for pain, obviously, and looking for ongoing pain and deciding where his level of expertise ends and when he needs to refer on or when he needs to ask for help.

Marion Beatson: You're frightened to actually say to doctors, 'No, you're wrong,' whereas we should be more open to say to the doctor, 'I'm not happy with what you've told me.'

Michael Morrison: When I go in to see the doctor, the doctor is the medical man. He knows about the drugs, etc. I'm the one that knows about my pain.

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Paul Evans: I'm Paul Evans, and in this edition of ***Airing Pain*** I'll be looking at the key relationship between patient and medical professional. And the key point is communication. For those of us with chronic pain, if we can't convey how the pain is affecting our lives, then the practitioner can't help. It leads to frustration, anger, depression – all things that make the pain worse. So in this program I'll be getting advice from patients and professionals on how to get the best from that relationship. Firstly let's listen to an example of a consultation performed by actors. You see if it rings any bells.

GP: Is the pain in your back?

Patient: Yeah.

GP: Is it going down your leg?

Patient: No.

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GP: Good, that sounds like straightforward mechanical back pain. Are you getting out of the house much?

Patient: Well, yeah, but... it's not the same.

GP: Are you taking any pain drugs?

Patient: Yeah, but they're no helping as much as they did.

GP: Well, you doing any back exercises?

Patient: Uh, no.

GP: Really? *[sigh]* Well, you should be, so, here's a wee something with these exercises on them. If it doesn't get any better, why don't you come back and see me, okay?

Evans: Now you judge for yourself whether you thought that consultation went well or not. It was an extract from *Chronic Pain Communication Skills*, a training DVD resource for health professionals primarily in pain management. And it was produced by members of Glasgow's New Victoria Hospital Pain Clinic and is presented by Drs Peter Mackenzie and David Craig. Now, my thought is that clinicians are highly educated people; they've been through years and years of training, so why on earth should they need to be taught how to communicate? I put this question to psychologist Dr David Craig.

David Craig: I think that it's the usual suspects. Sometimes we need communication skills. It's having the time to listen, but I think that even when clinicians do have that time, it's perhaps doing little bit more to convey to the patient that they are listening. I think we're all used to listening, shall we say, to friends and colleagues without necessarily properly listening or conveying to that individual that we are actually listening.

Evans: So I come through your doors as a patient. Your computer screen and your computer keyboard are there. I come in. You're sitting at your keyboard. You say, 'take a seat, Mr Evans.' You don't look around, and you say, without looking up, 'Now, what can I do for you, Mr Evans?'

Craig: I mean, you give a good example there of the sorts of things that we're trying to do and they're not just about the verbal aspect of communication, but making sure that the basics are in place as the patient comes in to a consultation. And it's the usual suspects, the obvious things, such as engaging the patient with eye contact, but also perhaps more subtle things about conveying what psychologists sometimes call a curious interest; but also a degree of genuineness and warmth, which is not always easy to do, doesn't always come naturally to some clinicians. But I think that even before we open our mouth as clinicians, the ability to convey that with nonverbal communication is obviously very important.

Evans: So going through my scenario now, I could tell you how I think you should have changed it. They may not be practical things to do. Well, the first thing I would say would be to get rid of that computer screen. Stand up when I come into a room. Be friendly. And, actually, try not to be professional. Does any of that ring a bell?

Craig: I think so. Although I think when we talk about those sorts of issues, there's a danger of losing clinicians when we're talking about a sort of a training program. And I think, particularly with psychology, we run the risk of forgetting the clinician's point-of-view here. Well, of course, we're desperately keen to make sure that the patient's viewpoint is communicated well. When we're thinking about training packages, they're only going to be helpful if they appear to be valid to the clinician. So while I think your example of standing

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up, and the idea of being less (sort of) professional in terms of being stiff, shall we say, in presentation – probably very important. I think on the other side we have to recognize that patients themselves very often wish a degree of, or a sense of, the clinician being professional and knowing what they're doing in that, and no more so than in pain management. And I think with so much of the conversation to do with communication skills, it's about getting a balance.

Evans: David Craig. Now I assume that we all agree that the scenario acted out earlier was not effective. So let's hear how effective it could have been.

GP: I'd really like to get a sense of how you experience your pain. How would you describe it?

Patient: Well, most of the time, it's in my back. It's like a burning and gripping feeling. It feels very tight, like something's going to break at any minute.

GP: Can you tell me anymore?

Patient: Well, it's really hard, because some days the pain's really, really bad and other days I can deal with it. It just really hits you sometimes and I never get any warning. I can't even plan to do things, because the next day, I could be laid up in bed. It's like it decides how bad I'm going to feel. And on the good days, it's still there but I can get so much more done that I get to hoping that it'll stay like that. And then the next day, I'm on my back again. Just seems so unfair. And then I start to wonder if I'm doing it to myself.

GP: Hmm. It's really frustrating. And how are you left feeling when you think that maybe you've done something to your back?

Craig: There are a number of different strands to the communication skills project at the moment. The first thing is for us to properly evaluate it and what we're aiming to do is to have a few of the doctors involved in a package that doesn't just include the DVD, but also includes us actually videoing some of the sessions and providing some informal feedback to the clinicians based on what they've learned in the DVD, but also just from our own experiences so that it becomes a little bit more valid and real to them. One of the difficulties that we sometimes find with sort of standalone training packages is that they don't always transfer readily into the sorts of habits that people develop in their day-to-day clinics.

Evans: That's right. I've been seeing a video of yourself in a consultation.

Craig: Yes.

Evans: It can be quite sobering.

Craig: Absolutely, and I think that that's hopefully where it's going to show its effectiveness – not so much actually in the DVD but in being able to see there as a clinician some of the things that you're doing very well, as I said, and to get some reinforcement, all of what you're doing, which can be valuable in its own right; but also seeing the way that they are in the session – they might have done things a little bit differently. And I think bringing it home like that is probably more powerful than just simply watching the video itself.

Evans: David Craig of New Victoria Hospital, Glasgow. And their training DVD, *Chronic Pain Communication Skills*, is available from the pain clinic itself or I'd recommend that you download it from numerous sites on the Internet. Just type 'Chronic Pain Communication Skills' into your search engine. I've even found it available from my mobile phone.

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Now, let me just remind you that whilst we believe the information and opinions on ***Airing Pain*** are accurate based on the best judgments available, you should always consult your health professional on any matter relating to your health and well-being. He or she is the only person who knows you and your circumstances and, therefore, the appropriate action to take on your behalf.

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So we've heard the doctor's viewpoint on how best to manage a consultation, but what happens when that communication breaks down? Marion Beatson has lived with chronic pain since having a work place accident some ten years ago.

Beatson: Well, I was angry at the fact that nobody was willing to help me and the fact that I didn't know where to turn. Had I had the information at hand, I would have known to go to my doctor and say, 'This is not good enough. I want a second opinion and I want answers.' But you're frightened to actually go and say to doctors, 'No, you're wrong,' whereas we should be more open to say to the doctor, 'I'm not happy with what you've told me.' If they don't have the answers, it's them having the ability to find the answers and where to tell us to go to get them and that's the big issue: the patients finding out where to go next.

Evans: So are you still a shrinking violet when it comes to speaking with doctors?

Beatson: No.

Evans: How do you speak to them?

Beatson: I write down what I want to say first. And if I'm not happy, I'll tell them I'm not happy. And I actually tell them what I want rather than them telling me what they want. It's taken eight years, but each of the doctors in my local surgery now know me and know that I walk in coming in with what I want to say. They don't get to talk until I'm finished. And then they'll say, 'Great! Well, let's look at what's been happening.' And I'll say, 'Right, okay.' So I'm in control of what happens in my doctor's surgery.

Evans: So when your appointment comes up on their appointment book, they know they've seen you, do they take a day's leave to avoid you or do they welcome you?

Beatson: No, no, because they know I'm there to help myself and I'm not aggressive. I'm not. I just want to speak to you, I'll speak to them like how I'm speaking to yourself and I'll say, 'this is what's been happening, and what's wrong? What is going on?' And they know that I'll take my medication sensibly. But if it's a new doctor, that's where I'll say, 'Who am I seeing? What doctor is it I'm seeing?' And I'll say, 'Well, no, I'd rather have another doctor that is used to seeing me.' And that is what I'll usually do if I can't get my own specialist doctor in the surgery, whereas he knows my case inside out. But I will make appointments for him most of the time, and I'll wait for the appointment.

Evans: He knows you, and you know him.

Beatson: Yes, he knows when I come in that everything is going to be, 'Alright, okay. Okay, Mary. Right, then. We'll try this first, and if that doesn't work, we'll then put you to the pain clinic.' And that's what happened.

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Mark Ritchie: The average GP out there needs to be looking for pain, obviously, and looking for ongoing pain and deciding where his level of expertise ends and when he needs to refer on or when he needs to ask for help.

Evans: That's Mark Ritchie who's a GP in Swansea with a special interest in pain management. He's clinical lead for Abertawe Bro Morgannwg Community Pain Service in South Wales. I put to him that many ***Airing Pain*** listeners feel let down by their GPs.

Ritchie: I think that to a large extent they may well be right and it's not because general practitioners have done anything wrong. It's because up until very recently, there's been no undergraduate training in chronic pain at all. The principles of managing pain are still based on the World Health Organization's pain ladder, which starts with simple analgesia and works up to opiates like morphine. Either, when you look at where that ladder came from, it came from trauma and acute injury, battlefield-type things or motor accidents, etc.

It didn't come from a person having chronic, unremitting, ongoing pain. And the problem with that is that when we talk about pain, we talk about simple pain pathways from periphery to the brain and we follow this down the line: use this drug at this point, use drug number 2 at that point, and use drug number 3 at another point. And that'll solve the pain. What we're not accepting at that stage is the multiplicity of causes and cause and effect that goes on between the periphery and the brain, in other words, how the pain is modified, etc. And, therefore, the average general practitioner has not had the benefit of appropriate training in dealing with chronic pain.

Evans: When I come to a GP on my first appointment because I feel I'm suffering pain and this that and the other... the GP will go through a step process. He has this, so we do that. That didn't work; we will do this.

Ritchie: The pathway I might follow, given that you've now come in and you've got pain in your hip or something: take a history first, then I'd examine you and I'd have a look at where that pain's coming from and I would try to come up with a diagnosis. If that diagnosis is something that is imminently treatable, with drugs or with physiotherapy or with exercise, then obviously, those are the pathways we could go down. But often in the case of a chronic pain situation, you can isolate where the original injury might have been, but you are now long past the time of repair and yet the person still has pain. The pain is real. It is a real pain that has been generated, but it's not been generated from a current injury. It's been generated by a cascade, maybe called the electrical impulse cascade, which is continuing sending these signals by neurotransmitters to the brain.

And the brain is then interpreting that as a current injury or a current problem. In actual effect, the problem might have been over a year ago, two years ago, five years ago. But the cascade is still functioning, so it's still sending the impulses down that pathway. And this is the difficult part, because a fundamental, basic, primitive brain associates pain with danger. And therefore, the fact that you're now receiving pain, the body worries about this; the brain worries about this and says, 'I've got to do something. I've got to pull away from this. I've got to protect myself…' so as to protect its function.

Evans: So the systems, they are in place and working but actually working against themselves.

Ritchie: In a way, yes, and modifying them incorrectly. If we can divide the pain pathway from the periphery to the brain into sort of three or four sections, the first section is from any point on your body, the peripheral point of the body, to the spinal cord, which an area called the dorsal root ganglia. It's not important, but it's in the spinal cord. From there, you then have a pathway up to the brain and various different modification areas within the brain. And

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you have a pathway down again, to wherever it entered the spinal cord, and then out to the periphery. So you've got these different segments, spots, and anywhere along there, firstly, the pain can be added to, modified, both up and down, so there are modifications within the area that will decrease pain. And there are modifications there that can increase pain. So the problem is how do we turn these on and off? And these can be turned on and off by a whole host of things.

So for instance, you take somebody who's depressed. They have lost a loved one. They will feel more pain than somebody who is not depressed. Does that mean they're making it up? Definitely not. It simply means that because they're depressed, they could be suppressing or adding hormones into the system. Actual enzymes. They can turn them on or turn them off. And by those enzymes then not being available, they can then maybe reduce the pain or they might actually be adding to the pain, exacerbating the pain, simply by what enzymes or hormones are currently being produced.

You produce natural painkillers. You produce things called endorphins and cephalins. These things you produce when you go for a jog; when you actually work up a sweat, you produce these natural painkillers. And with the word 'endorphin', if you knock off the first few letters and put an 'm' in the front, you've got 'morphine' or morphines. These are morphine-type or opiate-type enzymes. Your body makes them. But it doesn't make them to the same extent when you're depressed as to when you're in a happy mood. So it's a case of simple things, like mood can now modify the whole pain from top to bottom.

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Beatson: Towards the end of 2008 they realized that I actually had psychological problems as well, and they referred me to a psychologist. And it was the psychologist that actually helped me more than anybody else. Because he made me realize that, to stop feeling guilty about everything that's happened and that it wasn't my fault. Because a lot of patients think it's their fault and it's not their fault. And stop feeling guilty.

Evans: So how did he do that?

Beatson: He let me talk. He just sat and listened. And I told him things that I didn't even remember, from when I was young right through to the accident and the way I was treated after the accident. He said because I never got closure, that's what was making me so angry. And that nobody would pay attention to me; that it was there from the first doctor that treated me.

I had so much anger for this doctor that I didn't realize until I actually told him about it. But it was the way I told him about it. My whole personality changed. I didn't notice, but he picked this up. And it was him that told me, that the fact is that, 'Oh, you're an angry young lady!' And I was like, 'No, I'm not.' He says, 'Oh, yes, you are.' And I'm like, 'No, you're right.'

And he let me get off my chest what I wanted to say. He says, 'Right, if I was the doctor, what would you say to me?' He says, 'Without hitting me,' he says, 'tell me what you want.' And he just let me go for it.

Things like that made the big difference because you don't tell anybody in the family how you feel, and you don't tell any friends how you feel. So this is all bottled up inside you and you don't realize.

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Ritchie: Two years ago at the British Pain Society there was a Professor Jane from the United States, and he's actually a psychologist or psychiatrist. He did a whole lecture on how pain and depression and anxiety interact. He basically said if you take somebody who has pain but they're not depressed and they're not anxious, the chance of that becoming chronic pain is a lot lower than if the same person has the anxiety and depression.

He described this by adding these different components together as being cataclysmic: if you have depression and pain, you're more likely to go down the line of chronic pain. If you have anxiety and pain, you're more likely to go down the line of chronic pain. And what's interesting is which came first. Is the pain causing the depression, or did the depression lead to an exacerbation of the pain? And that's, of course, the million dollar question. As to the outcome, it doesn't really matter from the treatment point of view. From the treatment point of view, we need to recognize the fact that this person is a person as a whole, not just this one piece. Therefore, we need to treat all these elements, not just the pain.

Evans: ...which brings us back to where we started, in the GP's consultation. Now you see a patient at the very beginning, or at least, perhaps not the beginning of the pain, but at the start of them recognizing that they need help. Quite often, the real help doesn't come until the very end of the chain. How could you as a GP nip that circle of pain and depression in the bud at the very beginning?

Ritchie: Certainly, the largest area of illness in the country at the moment is actually depression. And depressive illnesses are highlighted now through many areas of QOF – the Quality and Outcomes Framework – and so on. We are looking for depression a lot sooner than we used to, and there are certain screening questions that you tend to ask every patient, not just those who come to you with pain.

So for instance, under the diabetic heading now, you also end up asking people about depression. And the reason I'm going to speak to diabetes just for a second is not because it's directly linked to pain, but because it's another chronic disease. It's funny how chronic diseases lead to depression. So a person with chronic asthma, chronic ischemic heart disease, chronic diabetes… they are the ones who seem to also end up depressed. And pain is no different. People with chronic pain end up depressed. So firstly, we need to look for it sooner. That we're already doing, so that's some really good points that I think has come out of the Quality and Outcomes Framework.

As to how quickly we can move down the pathway, a lot of this does come down to recognition. And certainly longer time in front of the doctor would be nice. I don't know how the government would budget for that, but it certainly would be nice to have longer appointment times. Sometimes there is a case of having to bring them back for three or four evaluations to truly get to where you're going, because not everything is necessarily as it seems when the person walked through the door.

So the reason for encounter needs to be extracted and people who have depression; people who have chronic pain; people who have a chronic condition, don't always tell you everything in that first encounter. There is a case of evaluating initially, listening carefully, moving through to extracting more facts by surreptitious questioning, shall we put it that way, or around-the-point questioning to see whether there's more to the picture than just what the person is initially telling you. But another part of it is the patient can actually prepare for this. The patient can actually take 5 or 10 minutes of their time before they come and see the doctor and write down, if necessary – if they have 50 problems – write them all down. But then divide them into ones that really are affecting their lives right now.

And realizing that we're going to need to answer them one at a time, we're going to need to move through the list. The classic example, which we have in general practice, is the group

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of patients whom we refer to as heart-sink patients. They come in, and they say to you, 'I've got a pain in my leg.' And you're still answering them on that and they say, 'Well, I've also got a pain in my thigh.' And before you could even answer that, they've decided they are depressed. And before you give them an answer to that, they move on to the next: 'And while I'm here, Doc...' By the time you've finished, you haven't answered anything because they haven't given you the chance to. Now whether it's because they don't want to get better, whether it's because they are frustrated by all these problems and don't know where to start, or whether it's the fact that they haven't actually got them in any order of importance is difficult to ascertain from that sort of consult. But that patient gets nothing out of the consult.

Evans: Or it may be none of those problems.

Ritchie: Correct. It may be none of those at all and it might be something underlying. All I'm saying is, if the patient – just as the doctor prepares by having studied and learned different medications, different treatment strategies, just as he's done that preparation, the patient needs to spend 5 or 10 minutes preparing what they're going to say to the doctor.

Evans: So that's the advice: prepare for your appointment.

Ritchie: Absolutely.

Evans: Write a list of what you want out of the appointment and write down what is worrying you.

Ritchie: Absolutely. In other words, get your ideas into some form of order. Having said this, this isn't going to apply to every single appointment: a person who is depressed, for instance, there's no way they're going to prepare in the same way. But then they're going to come in saying they're down, they've got no energy, nothing's going right and they don't want to do anything. That already paints a picture for me. It shows me that now I need to explore that a little bit. So that's slightly different.

But the person who's been in pain for 20 years, they usually know that they've been in pain for 20 years. And they know that they would like to get on top of this. They often don't understand why they've got pain. They have fears. Tell me what your fears are: 'I've had back pain for 20 years. Have I got cancer underlying that?' It's important because if I don't know that's worrying them, I can't address it. And if I do know it's worrying them, I can address it, so that I can get it out of the way in probably seconds. A quick examination, a clear explanation of why this wart isn't cancer in this particular case and now we can move on to the rest of it.

So fears are just as important. I can describe how they should prepare really in ideas, concerns and expectations: what their ideas are that are going on, what their concerns are, what they expect to get out of their appointment. The mnemonic 'ICE'. And they could actually use that to set out what they want to bring to the doctor.

Evans: Dr Mark Ritchie, and that memory aid for preparing for your appointment once again, ICE. I-C-E: ideas, concerns and expectation.

This is ***Airing Pain***. So as we've heard, patients and doctors can have a fruitful relationship when both parties are able to communicate. Ron Parsons and Michael Morrison are from the Aberdeen area. Ron Parsons first:

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Parsons: I'm of the age where as a young person, I went to the doctor and listened to every word he said. Didn't dare argue with him. Took the pills and went back to see him again if necessary.

Evans: Doctor knows best.

Parsons: Oh, yes. Oh, yes. That's what it was like when I was a schoolchild. It has only been, I would say, in the past 15 years or so that that has begun to change. Doctors are expecting to have comment from their patients, discussion with their patients. And when I do that, I get so much more out of a consultation.

Evans: So tell me, how do you speak to a doctor?

Parsons: I'll be a little pushy at times if I'm not being listened to, so I'll demand that. But I've got to remember that I have no medical training at all. I'm just a layperson. He is the medical expert. Sometimes people will say to me, 'No, but you're an expert in your own condition,' and such like. Nevertheless, he is the guy in the best position to treat me, so I will take his advice. If I don't agree with his advice, I'll ask if I can discuss it a little further by taking that sort of approach with him. I've seen a number of GPs over the years. I've never had any difficulty in speaking to somebody.

Evans: And that's because you're going to your GP surgery prepared?

Parsons: Yes, I do. I always go to my doctor with a list. There is never just one thing that I want to talk to him about. There can be half a dozen. And I'll say to him at the outset: 'There's my list. That's what I want to go through today. If you have time, let's have a go at it.'

Morrison: One thing that changed was when the patient was able to get hold of his records and see what the doctor was writing about him in his medical papers. I think that's when the patient-doctor connection changed. Personally, anyway, when I go in to see the doctor, the doctor is the medical man. He knows about the drugs, etc. I'm the one that knows about my pain, how it's affected me, how I think it should carry on from here, if we need to change drugs or increase or whatever.

But I'm the expert in my pain and every time I see the doctor, we normally have a good chin flap about what's happening now, and what should happen next: 'Right, do this for the next four or five weeks and come back and see me.'

Evans: Michael Morrison and, before him, Ron Parsons.

And that's the end of this edition of ***Airing Pain***. You can download this and all the previous editions from our website at painconcern.org.uk – and if you'd like to put a question to our panel of experts or just make a comment about the program, then please do so via our blog, message board, email, Facebook, or even pen and paper. And you can find all the contact details at our website.

I'll leave the final words to Marion Beatson:

Beatson: Please don't suffer alone. There are people out there that feel the same way as you do. Even if you're phoning your local voluntary centre: Pain Concern is the one I contacted. And I've heard back and constantly phone them and they tell you the information that you need to know. So please don't suffer. Don't sit there suffering alone. Do something about it.

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Contributors

* Dr David Craig - Chronic Pain Communication Skills

* Dr Mark Ritchie – Depression and chronic pain

* Marion Beatson – Speaking to a psychologist

* Ron Marsh – Relationship with health professionals

* Michael Morrison – Relationship with health professionals

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