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The Pain Practitioner is published by the American Academy of Pain Management, 13947 Mono Way, Ste. A, Sonora, CA 95370, Phone 209-533-9744, Fax 209-533-9750, Email: aapm@aapainmanage.org, website: www. aapainmanage.org.

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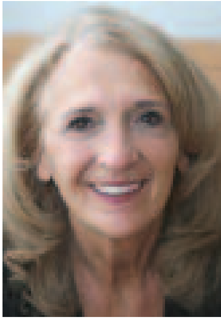

LENNIE DUENSING
Editor-in-Chief

Communicate!

BY LENNIE DUENSING, MEd, EXECUTIVE DIRECTOR AND EDITOR-IN-CHIEF OF *THE PAIN PRACTITIONER*

This practical issue of *The Pain Practitioner*, entitled, "Communicate!", focuses on the importance of effective communication between the clinician and the patient. It explores the barriers to it, and offers some suggestions for bridging this all too common gap.

The importance of effective communication in the clinician-patient relationship cannot be underestimated. While working on this issue, and speaking with both clinicians and patients, the words: "What we've got here is a failure to communicate." kept running through my head. Most of us are familiar with this famous line from *Cool Hand Luke* which, at different times in the film, was spoken by both the prison warden and Luke, a prisoner. As uttered by the prison warden, the statement was intended to underscore the difference in social status and power between the two men; however, most people use it, as did Luke, to refuse to agree with someone who has control—someone in a more powerful position (either perceived or actual). Both interpretations are significant when we examine the role and the importance of communication between the pain practitioner and the patient.

Communication can break down in the relationship between the clinician and the pain patient for several reasons. One barrier to communication is that patients and clinicians speak in voices that are different, which leads to a loss of mutual understanding and a sense of connection. Typically, the voice of the clinician is characterized by clinical terms and objective descriptions of physical symptoms that all too often lack an empathetic quality (the ability to embrace the patient's point of view and convey a sense of understanding of the patient's experience and caring). The voice of the pain patient, on the other hand, is characterized, most often, by the subjective experience of pain and its effect within the context of daily life.

Another related reason is the inherent imbalance of power in the relationship. Clinicians are usually in command when it comes to structuring the interaction, and as a result, pain patients often feel that reports of pain are not being heard or believed, and that they are stripped of personal meaning. In addition, people with chronic pain often feel vulnerable, frightened, and depressed when they enter the relationship, which can influence their ability to coherently express both very significant clinical and personal aspects of their pain. This puts them at a clear disadvantage.

Either the way, a failure to communicate is not only unacceptable, it can be harmful to the patient's health.

We now know that effective communication between the clinician and the pain patient matters. In the past, improving communication was viewed as "soft science," yet there is a growing body of evidence showing that when the communication gap between the clinician and patient is bridged, and there are significant clinical benefits including: reduced stress levels, improved adherence to treatment, and greater satisfaction with the clinician. Effective communication between the clinician and patient also reduces risks of misdiagnosis, improper treatment, and other undesirable outcomes. There are even fewer malpractice lawsuits.

Developing good communication skills and establishing therapeutic relationships with patients, have become so important, in fact, that they have been identified as priorities in both medical education and practice. For example, the 2004 Institute of Medicine report, *Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula*, states that "physicians must be equipped with

> **Did you know that…?**
> Clinicians allow patients only 18 seconds to describe their illness before interrupting, and only two percent of those patients ever get to finish their stories.

the knowledge and skills….needed to recognize, understand, and effectively respond to patients as individuals, not just to their symptoms," and that by improving communications skills, physicians will be better able to build therapeutic relationships with their patients and increase the likelihood that patients will follow their advice and adhere to their treatment plans (1).

On the other side of the communication equation, patients are becoming more knowledgeable about their conditions and treatment options. The paternalistic model (e.g., the prison warden) is increasingly giving way to one that encourages patients to be actively involved in their healthcare. In the paternalistic model, the clinician decides what is best for the patient without exploring such things as the patient's values, beliefs, cultural perspectives, desires, or lifestyle needs—information that is likely to be germane to treatment. In fact, "exploring" is not part of that model at all. Clinicians who favor this model are most likely to want only brief descriptions of physical symptoms, which they can then plug into tidy diagnostic categories. Although this type of relationship may work well for older patients, who remain convinced of their healthcare providers' god-like powers, it is unacceptable for most in the Boomer generation and younger. And it is certainly not acceptable—or useful—for those with complex pain conditions who require a combination of approaches.

Andrea Cooper, a person with pain who was interviewed for this issue, reminds us to: "Recognize that effective treatment outcomes rely on a good working partnership and open communication between the healthcare professional and the patient. This partnership, similar to any other relationship, requires compromise, mutual understanding, trust, and respect."

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