I have discussed the importance of this elsewhere in my articles 'How to get the best out of your doctor', and STEPS. In an emotionally charged situation such as the discussion of psychological problems, this doctor-patient relationship needs particularly to be one in which there is mutual trust and respect.

The Doctor-Patient relationship brings with it roles and responsibilities on both sides of the consulting table.

Those of the doctor might include (from the patient's point of view):

- being supportive towards the patient
- being informative
- being open
- making a diagnosis or ruling out certain conditions
- referring to specialist as necessary
- being patient's advocate
- using a holistic approach
- admitting shortcomings/areas of poor knowledge

Those of the patient (from the doctor's viewpoint):

- telling the truth
- being precise (not too long-winded)
- being realistic
- reporting accurately
- not trying to be a 'good patient', second-guessing how the doctor expects him to behave
- not waiting until the last minute of the appointment to raise important issues
- not expecting the doctor to ?read' him
- not expecting the doctor to understand ALL of the pain experience
- remembering he is only one of many patients so the doctor's time and resources are limited

McCracken et al. ([1]) have stressed that patient satisfaction is especially important for patients with chronic pain, suggesting that the intractable problems associated with unrelieved chronic pain confer a greater likelihood of dissatisfaction with healthcare.

In 1997, they found that trust and confidence in the doctor were the best predictor of treatment satisfaction. More recently ([2]) they found that a thorough evaluation, felt by the patient to be complete, and clear explanations from the doctor were the most important factors.

In either case, it is clear that the strength of the doctor-patient relationship is of prime importance in the efficacy of pain management.

COMMUNICATION: THE WATCHWORD OF A GOOD ALLIANCE

Remember: Communication is a two-way street. It is up to both parties to be realistic (doctors are not magicians, patients are not merely moaning minnies) and to co-operate in the full sense of the term.

Patients who ask the question, "What can I do to help myself"

are likely to achieve a more satisfactory outcome than those who persist in asking the doctor

"How can you help me, doctor?"

As I have explained before, a therapeutic alliance is a joining of forces to combat the problems brought about by chronic illness.

THE 4 E's: The Bayer system teaching communication skills

1. **ENGAGE**
2. **EMPATHISE**
3. **EDUCATE**
4. **ENLIST**

Engagement: the doctor introduces himself and listens to the patient (note that the average time of clinicians not interrupting in the first consultation is about 20 seconds!).

The idea is for the doctor to promote a helpful environment: he must take on board as much information as he can so that he can note down key points which he can show the patient in order to discuss them: making sure there are no misunderstandings.

The doctor may need to direct the flow of information in order to gain the information he needs to know.

The patient meanwhile needs to project him/herself effectively: keeping it simple and to the point, with a non-accusative approach (not "You haven't/don't...help/understand, but "I don't feel understood/ I am having difficulty, I feel there is no progress).

The next step is **Empathising**: rather than jumping in to save the drowning man and drowning with them (sympathy) the doctor needs to try to put himself in the patient's shoes and see things from the other perspective if possible.

Failure to do so, or appear to try at least, may cause a block in the therapeutic relationship.

The patient needs to keep in mind that the few minutes of consultation may be the most important part of that day to him/her, but are only a small part of the doctor's working day, full of consultations in which every other patient also considers his/her problems to be of most importance; not only that, but sadly, the NHS does not allow much consultation time these days.

Thirdly, **Education:** what does the patient need and want to know? It is vital to provide information that can be understood, remembered and retained, preferably with a source of information to revisit at a later date if necessary (a booklet to read at home, for instance). Medicine can be like a foreign language so jargon must be avoided.

This brings to mind an old Chinese saying which goes something like this:

Tell me and I may forget, show me and I may remember, involve me and I will understand.

The patient needs to be ready to admit when he/she doesn't follow what the doctor has said; better to clear up misunderstandings now rather than later.

A patient's misconceptions need to be recognised by the clinician and pointed out to the patient so that he/she can understand them and discard them, so that they are replaced by accurate information and understanding. The same could of course be said about the doctor's misconceptions!

A doctor needs to teach the patient (and after all, the word doctor means teacher) so that he/she has an understanding of the realistic choices available.

The final stage is **Enlistment,** which refers to getting the patient to take on board the suggested management the doctor proposes. It is no good prescribing something the patient will fail to comply with.

Without enlisting the patient's co-operation, he/she cannot benefit. Of course the converse is also true, the patient needs to enlist the doctor's support and continued involvement.

HIT OR MISS COMMUNICATION?

The 7 **MIS**-SES PATIENT

- **MIS**perception: the brain is mis-reading pain signals (NOT at a conscious level); for instance, allodynia is pain felt from a non-painful stimulus like light touch (clothing)
- **MIS**conception: *pain=damage:* chronic pain tends not to equate to ongoing damage
- **MIS**direction: conceal emotions in an effort to appear stoical and avoid being labelled as psychosomatic or malingering.
- **MIS**understanding: information from the doctor may not be fully comprehended; information is not the same as insight.
- **MIS** interpretation: doctor not interested, doesn't care; doctor doesn't believe pain.
- **MIS**trust: loss of trust in doctor
- **MIS**take: *non-compliance*: not taking medication appropriately, not following instructions about lifestyle (exercise)

DOCTOR

- **MIS**perception: 'heartsink patient': can't be helped
- **MIS**conception: no diagnosis= no problem
- **MIS**direction: conflicting medical advice (especially from different staff)
- **MIS**understanding: information from patient, impact of problems not fully understood
- **MIS** interpretation: bias towards psychological problems as predominant/malingerin
- **MIS**trust: patient's motives suspected: malingering? Seeking drugs? Litigation?
- **MIS**take: ineffective pain management

As we can see, these problems put up barriers to effective doctor-patient communication.

Note that by 'doctor' I actually refer to any medical/paramedical staff who are involved in pain management, and by ?patient' I also refer to family/carer/advocate.

What if the therapeutic alliance completely breaks down? Firstly, I recommend taking an advocate with you to the next consultation with the aim of addressing the problems calmly but firmly. Should that fail, then the second option is to seek out a different doctor.

Healthcare personnel should always bear in mind that competence must be married with

compassion in treating people with chronic pain.

HUMAN WARMTH by Antoine de Saint Exupery:

The one thing the sufferer longs for,

and which we can all give,

is human warmth.

Kindness and human sympathy

are often more important than any medicine.

people are ready to forget any torments

for one kind word.

The care of a patient,

the welcome given to a fugitive,

forgiveness itself,

are only worthwhile

because of the smile that goes with them.

---

[1] McCracken LM, Klock PA, Mingay DJ, Asbury JK, Sinclair DM *J Pain Symptom Manage* 1997; 14: 292-299 Assessment of satisfaction with treatment for chronic pain.

[2] McCracken LM, Evon D, Karapas ET *European Journal of Pain* 2002; 6: 387-393 Satisfaction with treatment for chronic pain in a specialty service: preliminary prospective results