

## Annotated Bibliography

# Communication in Pain Management



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Banja J. (2008). Toward a more empathic relationship in pain medicine. *Pain Medicine*, 9(8): 1125-1129.

Specialists in pain medicine commonly experience psychological assaults on their self-esteem, especially from patients who seem unreasonably demanding, overly critical, or threatening. This article will discuss how these challenges can trigger a professional's self-protective and defensive coping mechanisms that, in turn, can provoke decidedly unempathic responses. Situations that compromise empathy, however, can be particularly worrisome in health delivery practices like pain medicine that are highly relational and that seek to use relationships therapeutically. The article will therefore conclude with two sets of strategies that might be useful in managing these uncomfortable situations more empathically. The first set will focus on certain pragmatics of empathy skill development. The second will discuss the Eastern notion of "bare attention" as an ideal form of empathic engagement that can also counteract an unhealthy degree of defensiveness when self-esteem is threatened.

Barkin RL (2010, April). Treatment challenges of acute and chronic pain: Current concepts. *Advanced Studies of Pharmacy*, 7(1): 11-17.

Recent approaches to pain management have increasingly emphasized the use of individualized treatment strategies that are based on the patient's specific and patient-centered physiologic and psychologic analgesic needs, the underlying pathophysiology of pain, the use of new analgesic polymodal medications and combinations, the application of pharmacokinetic and pharmacodynamic drug profiles, and the prevention of drug-seeking or other aberrant behaviors. A thorough pain assessment is the foundation of an individualized treatment plan. Clinicians must know the right questions to ask when reviewing the patient's medical, surgical, and psychiatric history, but they must also be able to listen carefully to the patient's responses and to those who accompany the patient. Assessment of pain should go far beyond the typical 10-point rating scale to include an evaluation of the pain quality and intensity. Thorough periodic assessment of patients who are being treated for pain is required to confirm treatment efficacy and effectiveness and to identify adverse events. Confirmatory drug testing using ultra-high pressure liquid chromatography and mass spectroscopy is preferred to ensure that patients are utilizing and metabolizing pharmacotherapies as prescribed. Nonsteroidal anti-inflammatory drugs and acetaminophen are widely used for the treatment of pain and are available in many prescription and nonprescription products. However, these agents are associated with clinically significant adverse events, and careful patient selection is required to ensure that they are utilized safely. Two new opioid agents have recently entered clinical practice. Tapentadol is a  $\mu$ -opioid agonist and a monoamine reuptake inhibitor (primarily norepinephrine); oxycodone is a specific  $\mu$ -opioid agonist. Both agents are metabolized primarily by phase II metabolism and do not produce toxic metabolites that various older opioids, most of which are metabolized by phase I metabolism, produce. It is important to understand the distinction between addiction (a pattern of impaired compulsive drug use control with a careless disregard for harm to self and others, usually with the goal of achieving drug-induced euphoria) and pseudoaddiction (a pattern of escalating analgesic demands in response to inadequate pain relief). Finally, effective pain management necessitates effective ongoing bilateral communication between the pharmacist and the prescriber(s) to ensure adequate pain control while reducing the risk of adverse effects and medication misuse, abuse, or diversion.

Canaday BR (2009). A day in the life: Pain management strategies for frontline pharmacists. *Advanced Studies of Pharmacy*, 6(2): 37-44.

Analgesics are among the most widely prescribed of all medications, yet many patients continue to experience poorly managed pain. Studies of patients with chronic or acute pain have demonstrated that many are unsatisfied with the pain relief that they are able to achieve, and that approximately 20% of all hospitalized patients report inadequate pain control. Misuse or diversion of pain relievers is a significant problem, especially among adolescents and young adults. Concerns about opioid dependence, addiction, or nonmedical use often create barriers to effective pain management. Opioid abusers have developed several techniques to compromise controlled-release mechanisms. Tablets may be crushed and swallowed or snorted, or the active ingredient may be extracted in a solvent and taken by mouth or injected. Newer abuse-resistant technologies are being developed to make it more

difficult for substance abusers to misuse opioid medications. However, the risk of opioid misuse is low among patients with chronic pain who do not have preexisting substance use disorders. The US Food and Drug Administration is developing new strategies that will be required of manufacturers of opioid analgesics to help prevent drug misuse. Pharmacists have a dual role in management of pain as both caring clinicians and as professionals who are responsible for meeting legal and ethical standards for dispensing controlled substances. It is necessary to maintain some degree of vigilance regarding the potential for medication misuse, yet it is also important to avoid stigmatizing our patients with chronic pain. Communication between the patient, pharmacist, and prescribing physician is essential to avoid misunderstandings and prevent inappropriate medication use. Pharmacists must also be able to counsel patients about the expected benefits of treatment, possible adverse effects, what to do in the event of a serious adverse event, and strategies to mitigate some of the predictable adverse events of opioid therapy. The effective medical management of pain requires the consideration of many different patient-related and medication-related factors, including the intensity of pain, risk or history of substance abuse, medication dose and route of administration, and equianalgesic conversion for patients who are transitioning from one opioid to another. Pharmacists are ideally positioned to significantly improve the effectiveness and safety of pain management.

Clarke, K.A., Iphofen, R. (2008). The effects of failing to believe patients' experience of chronic pain. *Nursing Times*; 104: 8, 30-31.

BACKGROUND: Some patients with chronic pain complain that they feel they are not believed.

AIM: To explore the effects of healthcare professionals not believing patients with pain.

METHOD: This study (n=8) adopted a multi-method approach involving a low-structured interview coupled with patients' diaries and a follow-up interview. It is based on a hermeneutic analytical approach within a phenomenological framework.

RESULTS: The themes identified were: 'I am in pain'; 'I don't believe you'; 'When you feel that you are not genuine'; 'Alienation'; and 'Being believed'.

CONCLUSION: This study highlights that healthcare professionals can show they believe patients by simple means. These are: active listening; being non-judgmental; and accepting the pain experience as credible as recounted by patients, thus showing them that the relationship is based on caring and empathy.

Frantsve L, Kerns RD (2007). Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision-making. *Pain Medicine*, 8, 25-35.

OBJECTIVE: This article reviews the literature on patient-provider interactions among patients with chronic pain conditions with an emphasis on shared medical decision making.

RESULTS: Key findings suggest that: 1) patients with chronic pain and health care providers are likely to have opposing attitudes and goals, with patients seeking "to be understood as individuals" and struggling to have their pain concerns legitimized while their health care providers may place a greater focus on diagnosis and treatment than quality of life concerns; and 2) female patients may face additional challenges when communicating their pain concerns with providers. Increased emphasis on communication training and efforts to promote a shared decision making process are proposed as possible mechanisms to improve patient-provider interactions.

CONCLUSIONS: Treatment of chronic pain is often complex and may be further complicated when patients and health care providers have differing goals and attitudes concerning treatment. Difficulties in engaging in collaborative treatment decision making may result. Efforts to enhance patient-provider communication as well as to systematically examine nonspecific treatment factors are likely to promote effective management of chronic pain.

Green CR, Anderson KO, Baker, TA, Campbell LC, Decker S, Fillingim RB, Kaloukalani DA, Lasch KE, Myers C, Tait RC, Todd KH, & Vallerand AH. (2003). The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain. *American Academy of Pain Medicine*, 4(3): 277-294.

CONTEXT: Pain has significant socioeconomic, health, and quality-of-life implications. Racial- and ethnic-based differences in the pain care experience have been described. Racial and ethnic minorities tend to be undertreated for pain when compared with nonminorities.

**OBJECTIVES:** To provide health care providers, researchers, health care policy analysts, government officials, patients, and the general public with pertinent evidence regarding differences in pain perception, assessment, and treatment for racial and ethnic minorities. Evidence is provided for racial and ethnic-based differences in pain care across different types of pain (i.e., experimental pain, acute postoperative pain, cancer pain, chronic pain) and settings (i.e., emergency department). Pertinent literature on patient, health care provider, and health care system factors that contribute to racial and ethnic disparities in pain treatment are provided.

**EVIDENCE:** A selective literature review was performed by experts in pain. The experts developed abstracts with relevant citations on racial and ethnic disparities within their specific areas of expertise. Scientific evidence was given precedence over anecdotal experience. The abstracts were compiled for this manuscript. The draft manuscript was made available to the experts for comment and review prior to submission for publication.

**CONCLUSIONS:** Consistent with the Institute of Medicine's report on health care disparities, racial and ethnic disparities in pain perception, assessment, and treatment were found in all settings (i.e., postoperative, emergency room) and across all types of pain (i.e., acute, cancer, chronic nonmalignant, and experimental). The literature suggests that the sources of pain disparities among racial and ethnic minorities are complex, involving patient (e.g., patient/health care provider communication, attitudes), health care provider (e.g., decision making), and health care system (e.g., access to pain medication) factors. There is a need for improved training for health care providers and educational interventions for patients. A comprehensive pain research agenda is necessary to address pain disparities among racial and ethnic minorities.

Gunningberg L, & Idvall E. (2007). The quality of postoperative pain management from the perspectives of patients, nurses and patient records. *Journal of Nursing Management*, 15, 756–766.

**AIM:** To study the quality of postoperative pain management in a university hospital. Method Paired patient and nurse assessments of the patient's pain management were conducted in two departments, complemented with audit of patient records. The Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire was answered by 121 patients and 47 Registered Nurses.

**RESULTS:** Of 14 items in the Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire, four items in general surgery and five items in thoracic surgery reached the threshold for high quality of care. No significant differences were found between the assessments in the two departments, but the patients in general surgery experienced more pain than the patients in thoracic surgery. In general surgery, the patients assessed their worst pain significantly higher than the nurse did. The patients who experienced more pain than expected were less satisfied with the quality of their care and experienced higher pain intensity levels. For 25 (41.0%) patients in general surgery and four (6.7%) patients in thoracic surgery, pain intensity was documented according to hospital quality goals.

**CONCLUSION:** In both departments, areas for improvements could be found in all subscales of the Strategic and Clinical Quality Indicators in Postoperative Pain Management questionnaire, i.e. communication, action, trust and environment. It is important to discuss what information the patient needs, as well as how and when it should be given. Furthermore, considering earlier pain experience and the goal of pain relief for the individual patient may facilitate an adequate assessment of the patient's pain. In future, electronic health records have the potential to support the use of clinical guidelines.

Haskell SG, Brandt CA, Krebs EE, Skanderson M, Kerns RD, & Goulet JL.(2009). Pain among Veterans of Operations Enduring Freedom and Iraqi Freedom: do women and men differ? *Pain Med.* 10(7):1167-73.

**OBJECTIVE:** To evaluate sex differences in the prevalence of overall pain, moderate-severe pain, and persistent pain among Veterans of Operations Enduring Freedom and Iraqi Freedom seen at VA outpatient clinics, and to evaluate sex differences in pain assessment.

**DESIGN:** The observational cohort consisted of Veterans discharged from the U.S. military from October 1, 2001 to November 30, 2007 that enrolled for Veterans Administration (VA) services or received VA care before January 1, 2008. We limited the sample to the 153,212 Veterans (18,481

female, 134,731 male) who had 1 year of observation after their last deployment.

RESULTS: Pain was assessed in 59.7% (n = 91,414) of Veterans in this sample. Among those assessed, 43.3% (n = 39,591) reported any pain, 63.2% (n = 25,028) of whom reported moderate-severe pain. Over 20% (n = 3,427) of Veterans with repeated pain measures reported persistent pain. We found no significant difference in the probability of pain assessment by sex (RR = 0.98, 95% CI 0.96, 1.00). Female Veterans were less likely to report any pain (RR 0.89, 95% CI 0.86, 0.92). Among those with any pain, female Veterans were more likely to report moderate-severe pain (RR 1.05, 95% CI 1.01, 1.09) and less likely to report persistent pain (RR 0.90, 95% CI 0.81, 0.99).

CONCLUSIONS: As the VA plans care for the increasing numbers of female Veterans returning from Iraq and Afghanistan, a better understanding of the prevalence of pain, as well as sex-specific variations in the experience and treatment of pain, is important for policy makers and providers who seek to improve identification and management of diverse pain disorders.

Jacobsen R, Møldrup C, Christrup L, & Sjøgren P. (2009). Patient-related barriers to cancer pain management: a systematic exploratory review. *Scandinavian Journal of Caring*, 23:190-203.

The aim of this review was to systemically explore the current evidence regarding patient-related barriers to cancer pain management to find new areas that might be important for better understanding of patient barriers' phenomenon. The method used in this study was a computerized literature search, carried out in Cochrane Library, Medline (through PubMed), Web of Science and EMBASE databases for the period 1994–2005. Thirty-seven studies, dealing with cognitive, sensory and affective patient-related barriers, as well as studies, describing patients' pain communication and their adherence to analgesic regimen were included and analysed. The dominant part of articles studied cognitive patient-related barriers to cancer pain management, while affective, sensory barriers, as well as pain communication and pain medication adherence were studied in much less extend. However, the findings from different studies regarding relationships between between cognitive barriers and pain intensity were not consistent. On the contrary, the quality of pain communication was consistently found to be not satisfactory in some key areas. The associations between more expressed attitudinal as well as sensory barriers and less optimal adherence were also consistent. In conclusions suggestion for the new research areas on patient-related barriers to cancer pain management are made. Firstly, further research is needed to differentiate the role of cognitive, affective and sensory factors with respect to their impact on pain relief, pain communication and medication adherence. Besides that, validated instruments to assess patients' pain communication and adherence to analgesic regimen are lacking.

Kerns RD & Dobscha SK. (2009). Pain among Veterans Returning from Deployment in Iraq and Afghanistan: Update on the Veterans Health Administration Pain Research Program. *Pain Medicine*, 10(7): 1161-1164.

In November 1998, the former Undersecretary for Health for the Department of Veterans Affairs (VA), Dr. Kenneth Kizer, launched the Veterans Health Administration (VHA) National Pain Management Strategy establishing pain management as a national priority. The overall objective of the national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness. Among the key elements of the strategy, a need to “expand basic and applied research on management of acute and chronic pain, emphasizing conditions that are most prevalent among Veterans,” was articulated.

Kerns, R.D., Booss, J., Bryan, M., Clark, M.E., Drake, A., Gallagher, R.M., Green-Rashad, B., Markham, R., Rosenberg, J., & Turner, A. (2006). Veterans Health Administration National Pain Management Strategy: Update and future directions. *American Pain Society Bulletin*, 16, 1-15.

The focus of the Bulletin's innovations column is often some form of new assessment, diagnostic technique, or treatment strategy. Another important type of practice innovation involves fundamental changes in the healthcare system and day-to-day behaviors of healthcare providers, that is, how clinicians and teams coordinate and deliver high-quality pain management to all patients across all

settings. In July, APS published updated recommendations for improving the quality of acute and cancer pain (Gordon et al., 2005). A critical message in these recommendations is that all care settings should formulate a structured, multilevel system approach (sensitive to the type of pain and setting of care) that ensures safe, high-quality pain management to all patients. A shining example of dedication and innovation to making this type of systematic change is the ongoing effort of the Department of Veterans Affairs (VA). This article provides an update on the VA's impressive quality initiative.

Lew HL, Otis JD, Tun C, Kerns RD, Clark ME, & Cifu DX. (2009). Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: polytrauma clinical triad. *J Rehabilitation Res Dev.* 46(6):697-702.

This study examines the prevalence and coprevalence with which returning Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans were reporting symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS). The medical records of 340 OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network Site were comprehensively reviewed. Analyses indicated a high prevalence of all three conditions in this population, with chronic pain, PTSD, and PPCS present in 81.5%, 68.2%, and 66.8%, respectively. Only 12 of the veterans (3.5%) had no chronic pain, PTSD, or PPCS. The frequency at which these three conditions were present in isolation (10.3%, 2.9%, and 5.3%, respectively) was significantly lower than the frequency at which they were present in combination with one another, with 42.1% of the sample being diagnosed with all three conditions simultaneously. The most common chronic pain locations were the back (58%) and head (55%). These results underscore the complexity of the presenting complaints in OIF/OEF veterans and support the importance of a multidisciplinary team approach to assessment and treatment.

Mangione MP, & Crowley-Matoka M. (2008). Improving Pain Management Communication: How Patients Understand the Terms "Opioid" and "Narcotic". *Journal of General Internal Medicine*, 23(9): 1336–1338

**BACKGROUND/OBJECTIVES:** Pain specialists often advocate discontinuing use of the term "narcotic," with the negative connotations it bears for many patients, in favor of the term "opioid." To contribute empirical data to this argument, we elicited and compared patient understandings of the terms "narcotic" and "opioid."

**DESIGN/PARTICIPANTS:** Brief, anonymous surveys were administered to 100 outpatients. Respondents were asked to describe what a narcotic/opioid is, give example(s), explain why someone would take a narcotic/opioid and describe long term consequences of use.

**RESULTS:** Of the 100 outpatients, 86% responded "don't know" to all four opioid questions. Only 12% did not know what a narcotic was (< .001). While 50% of patients related "narcotics" to pain management, more than a third cited addiction or abuse. Of the 100 outpatients, 78% feared an adverse outcome from long-term narcotic use, with 66% of those answers citing "addiction."

**CONCLUSION:** Most patients were unfamiliar with the term opioid, while a substantial percentage identified a narcotic as an illegal drug and most reported adverse consequences as the outcome of long term use. Our findings, while preliminary, suggest that "opioid" is a more unfamiliar term, but raise questions about whether simply using different terminology would affect patient fears about this class of medications.

Matthias MS, Parpart AL, Nyland KA, Huffman MA, Stubbs DL, Sargent BA, & Bair MJ. (2010). The patient-provider relationship in chronic pain care: provider's perspectives. *Pain Medicine*, 11: 1688-1697.

**BACKGROUND:** Pain is the most commonly reported symptom in primary care and is a leading cause of disability. Primary care providers (PCPs) face numerous challenges in caring for patients with chronic pain including communication and relational difficulties.

**OBJECTIVE:** The objective of the study was to elicit providers' perspectives on their experiences in caring for patients with chronic pain.

**DESIGN:** The design used was a qualitative study using open-ended, in-depth interviews.

**PARTICIPANTS:** Twenty providers (10 men, 10 women) from five different clinics were

interviewed at the Roudebush Veterans Affairs Medical Center.

RESULTS: Three broad themes emerged from the analysis: 1) providers emphasized the importance of the patient–provider relationship, asserting that productive relationships with patients are essential for good pain care; 2) providers detailed difficulties they encounter when caring for patients with chronic pain, including feeling pressured to treat with opioids, believability of patients’ reports of pain, worries about secondary gain/diversion, and “abusive” or “difficult” patients; and 3) providers described the emotional toll they sometimes felt with chronic pain care, including feeling frustrated, ungratified, and guilty.

FINDINGS: Findings were interpreted within a model of patient-centered care.

CONCLUSIONS: The clinical implications of these findings are two-fold. First, PCPs’ needs cannot be ignored when considering pain care. PCPs need support, both instrumental and emotional, as they care for patients with chronic pain. Second, improving PCPs’ patient-centered communication skills—including demonstrating empathy and encouraging shared decision-making—holds promise for alleviating some of the strain and burden reported by providers, ultimately leading to improved patient care.

McHugh G (2001). Living with chronic pain: the patient's perspective. *Nurs Stand.*18;15(52):33-7.

AIM: The aim of this study is to investigate patients' perceptions and experiences of chronic pain management before and after attending pain services.

METHOD: A sample of 245 patients with chronic pain, who attended specialist pain services in 11 UK hospitals, were interviewed using a structured questionnaire. Patients' ages ranged between 23 and 86 years (median 51 years), and the duration of pain ranged between six months and 57 years (median five years).

RESULTS: Patients reported that pain had had a profound effect on their lives, restricting daily living and leisure activities. 33 per cent (81) were classified as medically disabled. Patients' perceptions and attitudes to the management of chronic pain varied. Their main concern was that, although they wanted a specific diagnosis, they were often not given a reason for their chronic pain.

CONCLUSION: Pain management requires a significant amount of input by health professionals. Patients wanted advice on the best techniques to help them cope with chronic pain. Most patients had previously tried many different pain treatments to obtain short-term pain relief. One third of patients had waited up to four months for their initial pain assessment at the pain service. Once referred to specialist pain services, patients were satisfied with their care. Almost half (47 per cent, 115) of the interviewees reported that their pain had improved. As chronic pain has a profound effect on patients' lives, it is important that early diagnosis, treatment and referral to appropriate specialists is given high priority. This study has raised the awareness and understanding of an important, but often misunderstood area.

Merril JO, Rhodes LA, Deyo Richard A, Marlatt GA, & Bradley KA. (2002). Mutual mistrust in the medical care of drug users. The Keys to the “Narc” cabinet. *J Gen Inter Med*, 17: 327-333.

OBJECTIVE: Caring for patients who are active drug users is challenging. To better understand the often difficult relationships between illicit drug-using patients and their physicians, we sought to identify major issues that emerge during their interactions in a teaching hospital.

DESIGN: Exploratory qualitative analysis of data from direct observation of patient care interactions and interviews with drug-using patients and their physicians.

SETTING: The inpatient internal medicine service of an urban public teaching hospital.

PARTICIPANTS: Nineteen patients with recent active drug use, primarily opiate use, and their 8 physician teams.

RESULTS: Four major themes emerged. First, physicians feared being deceived by drug-using patients. In particular, they questioned whether patients’ requests for opiates to treat pain or withdrawal might result from addictive behavior rather than from “medically indicated” need. Second they lacked a standard approach to commonly encountered clinical issues, especially the assessment and treatment of pain and opiate withdrawal. Because patients’ subjective report of symptoms is suspect, physicians struggled to find criteria for appropriate opiate prescription. Third, physicians avoided engaging patients regarding key complaints, and expressed discomfort and uncertainty in their approach to these patients. Fourth, drug-using patients were sensitive to the possibility of poor



medical care, often interpreting physician inconsistency or hospital inefficiency as signs of intentional mistreatment.

CONCLUSION: Physicians and drug-using patients in the teaching hospital setting display mutual mistrust, especially concerning opiate prescription. Physicians' fear of deception, inconsistency and avoidance interacts with patient's concern that they are mistreated and stigmatized. Medical education should focus greater attention on addiction medicine and pain management.

Mitchinson AR, Kerr EA, & Krein SL (2008). Management of Chronic Noncancer Pain by VA Primary Care Providers: When Is Pain Control a Priority? *American Journal of Managed Care*, 14:77-84

OBJECTIVE: To examine how primary care providers (PCPs) prioritize management of chronic pain in patients with multiple chronic conditions and to determine PCP perspectives on chronic pain management and pain treatment resources.

STUDY DESIGN: Survey mailed to a random sample of 500 Department of Veterans Affairs (VA) PCPs at VA medical centers and community-based outpatient clinics.

METHODS: After reading a vignette describing a patient with multiple chronic conditions and chronic pain, PCPs were asked to identify the 3 most important issues to address during the visit. The survey also asked about the availability of services, and level of confidence and satisfaction with chronic pain management.

RESULTS: A total of 279 eligible PCPs (57%) responded to the survey, 77% of whom identified pain control among the top 3 treatment priorities. PCPs who did not choose pain control were more likely to indicate that chronic pain patients should see a specialist (54% vs 35%,  $P = .006$ ) and were less confident about using opioid analgesics (52% vs 72%,  $P = .002$ ). Of the respondents, 86% reported psychology or mental health clinics were available at their clinic site; 71%, physical therapy; and 20%, multidisciplinary pain clinics. Most PCPs (74%) were satisfied with the quality of care they provide for patients with chronic pain but only 30% were satisfied with access to pain specialty services.

CONCLUSION: Additional training opportunities for PCPs and more effective use of ancillary services may be needed for further improvements in care for chronic pain patients.

Murinson BB, Gordin V, Flynn S, Driver LC, Gallagher RM, & Grabois M. (2013). Recommendation for a new curriculum in pain medicine for medical students: toward a career distinguished by competence and compassion. *Pain Medicine*, 14: 345-350.

OBJECTIVE: The education of physicians is a fundamental obligation within medicine that must remain closely aligned with clinical care. And although medical education in pain care is essential, the current state of medical education does not meet the needs of physicians, patients, or society. To address this, we convened a committee of pain specialist medical student educators.

METHODS: Tasked with creating systematically developed and valid recommendations for clinical education, we conducted a survey of pain medicine leadership within the American Academy of Pain Medicine (AAPM). The survey was conducted in two waves. We asked AAPM board members to rate 194 previously published pain medicine learning objectives for medical students; 79% of those eligible for participation responded.

RESULTS: The "Top 5" list included the awareness of acute and chronic pain, skillfulness in clinical appraisal, promotion of compassionate practices, displaying empathy toward the patient, and knowledge of terms and definitions for substance abuse. The "Top 10" list included the major pharmacological classes as well as skills in examination, communication, prescribing, and interviewing. The "Top 20" list included the pain care of cognitively impaired populations, those with comorbid illness, and older adults. With the survey results in consideration, the committee produced a new recommended topic list for curricula in pain medicine. We strongly recommend that adequate resources are devoted to fully integrated medical curricula in pain so that students will learn not only the necessary clinical knowledge but also be prepared to address the professional, personal, and ethical challenges that arise in caring for those with pain.

CONCLUSIONS: We conclude that improved medical education in pain is essential to prepare providers who manifest both competence and compassion toward their patients.

Newton BJ, Southall JL, Raphael JH, Ashford RL, & LeMarchand K. (2013). A Narrative review of the impact of disbelief in chronic pain. *Pain Manag Nurs*, 14(3): 161-171.

Although the experience of being believed is frequently alluded to in chronic pain literature, few studies have specifically explored this phenomenon and even fewer reviews have been offered. This narrative review sought to explore the wider social context in which individuals with chronic pain may experience disbelief toward their pain. Articles were obtained through a search of eight databases and a hand search of the references of full-text papers. Key results within the articles were noted and integrated to form three main themes: stigma, the experience of isolation, and the experience of emotional distress. The experience of stigma can occur in a number of ways. It may be through actual or perceived encounters with others; it can be through the use of psychologic explanations of pain; it can come through a perceived challenge to one's integrity and subsequently affect an individual's identity; and such stigma may be influenced by negative female stereotypes. The loss of relationships associated with being disbelieved can lead to the experience of isolation. This may be self-initiated, particularly when an individual has been given a contested diagnosis. Finally, disbelief can lead to emotional distress. This can take the form of guilt, depression, and anger. Throughout the article, implications for health care professionals, working with individuals living with chronic pain, are discussed.

Nicolaidis C. (2011). Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. *Pain Medicine*, 12: 890-897.

How we frame our thoughts about chronic opioid therapy greatly influences our ability to practice patient-centered care. Even providers who strive to be nonjudgmental may approach clinical decisionmaking about opioids by considering if the pain is real or they can trust the patient. Not only does this framework potentially lead to poor or unshared decision-making, it likely adds to provider and patient discomfort by placing the provider in the position of a police officer or a judge. Similarly, providers often find themselves making deals with patients using a positional bargaining approach. Even if a compromise is reached, this framework can potentially inadvertently weaken the therapeutic relationship by encouraging the idea that the patient and provider have opposing goals. Reframing the issue can allow the provider to be in a more therapeutic role. As recommended in the American Pain Society/ American Academy of Pain Medicine guidelines, providers should decide whether the benefits of opioid therapy are likely to outweigh the harms for a specific patient (or sometimes, for society) at a specific time. This article discusses how providers can use a benefit-to-harm framework to make and communicate decisions about the initiation, continuation, and discontinuation of opioids for managing chronic nonmalignant pain. Such an approach focuses decisions and discussions on judging the treatment, not the patient. It allows the provider and the patient to ally together and make shared decisions regarding a common goal. Moving to a risk-benefit framework may allow providers to provide more patient-centered care, while also increasing provider and patient comfort with adequately monitoring for harm.

Paulson M, & Dekker AH. (2005). *Healthcare Disparities in Pain Management*. Journal of the American Osteopathic Association, Supplement 3, 15(6): S14-S17.

Despite efforts targeted at physicians for improving the way in which they manage pain, discrepancies still abound in how they treat certain patients for this condition. Special populations of patients such as racial minorities, women, and substance abusers are victims of deficiencies in pain management and suffer needlessly. Healthcare providers need to be aware of disparities that may not be readily apparent. To provide appropriate care, physicians need to follow pain management guidelines; however, they receive contradictory information on how to treat patients in pain, and they may be apprehensive about prescribing opioids. Recognizing that pain is one of the most frequent reasons a patient may see a physician, it is important to recognize the healthcare disparities in managing pain as well as the barriers to providing appropriate treatment for pain. Only when physicians acknowledge disparities and barriers can they begin to evaluate and improve on their own practices of pain management.

Rosenberger PH, Kerns R, Jokl P, & Ickovics JR (2009). Mood and Attitude Predict Pain Outcomes Following Arthroscopic Knee Surgery. *Annals of Behavioral Medicine*, 37:70-76.

BACKGROUND: Decreased pain represents a clinically important outcome following arthroscopic knee surgery. However, little is known about preoperative mood and attitudinal factors and their potential relationship with pain outcomes.

PURPOSE: This prospective, longitudinal study investigated the influence of preoperative depression, stress, and optimism on pain severity and interference with functioning, controlling for relevant demographic and clinical factors 1 year postoperatively.

METHODS: Participants (N=180, mean age=48.2 years) completed scales assessing pain severity and interference both preoperatively and postoperatively. Demographics, depression, stress, optimism, and body mass index were assessed preoperatively. Physicians assessed extent of knee osteoarthritis during surgery.

RESULTS: Hierarchical regression analyses controlling for relevant demographic and clinical variables revealed that optimism and stress were significant predictors of pain severity at 1 year but not pain interference. Extent of osteoarthritis predicted pain interference.

CONCLUSIONS: These findings support that optimism and stress are important predictors of patient-rated pain severity. They do not, however, predict the extent to which pain interferes with daily functioning.

Schwartz TM, Tai M, Babu KM, & Merchant RC. (2013). Lack of association between Press Ganey emergency department satisfaction scores and emergency department administration of analgesic medications. Presented at the American College of Emergency Physicians *Scientific Assembly Research Forum*, October 2013, Seattle, WA.

STUDY OBJECTIVE: We explore the relationship between Press Ganey emergency department (ED) patient satisfaction scores and ED administration of analgesic medications, including amount of opioid analgesics received, among patients who completed a patient satisfaction survey.

METHODS: We conducted a secondary data analysis of Press Ganey ED patient satisfaction surveys from patients discharged from 2 academic, urban EDs October 2009 to September 2011. We matched survey responses to data on opioid and nonopioid analgesics administered in the ED, demographic characteristics, and temporal factors from the ED electronic medical records. We used polytomous logistic regression to compare quartiles of overall Press Ganey ED patient satisfaction scores to administration of analgesic medications, opioid analgesics, and number of morphine equivalents received. We adjusted models for demographic and hospital characteristics and temporal factors.

RESULTS: Of the 4,749 patients who returned surveys, 48.5% received analgesic medications, and 29.6% received opioid analgesics during their ED visit. Mean overall Press Ganey ED patient satisfaction scores for patients receiving either analgesic medications or opioid analgesics were lower than for those who did not receive these medications. In the univariable polytomous logistic regression analysis, receipt of analgesic medications, opioid analgesics, and a greater number of morphine equivalents were associated with lower overall scores. However, in the multivariable analysis, receipt of analgesic medications or opioid analgesics was not associated with overall scores, and receipt of greater morphine equivalents was inconsistently associated with lower overall scores.

CONCLUSION: Overall Press Ganey ED patient satisfaction scores were not primarily based on in-ED receipt of analgesic medications or opioid analgesics; other factors appear to be more important.

Tait RC. (2008). Empathy: Necessary for effective pain management? *Current Pain and Headache Reports*, 12(2):108-112.

Empathy is a provider attribute that has been a topic of increased clinical interest, particularly as it relates to pain. This article examines various dimensions of the pain and empathy literature: definitions of empathy, research regarding the psychophysiology of empathy for pain, and research related to empathy in psychological and medical care. Research regarding topics broadly related to empathy is also reviewed, including communication skills and patient-centered care. Although this literature supports the clinical value of provider empathy and/or behaviors likely to reflect empathy, little research has explicitly examined empathy in the treatment of pain. Nonetheless, when

considered in the broader context, the evidence is sufficient to draw some conclusions regarding approaches to pain care that are likely to reflect and/or elicit provider empathy and are central to effective pain management.

Tait RC & Chibnall JT. (2005). Effect of treatment success and empathy on surgeon attributions for back surgery outcomes. *J Behav Med*, 28(4): 301-312

This study examined the effect of conservative and surgical treatment success/failure on attributions by surgeons for low back surgical outcomes. It also examined empathy as a moderator of these attributions. Forty surgeons attributed surgical outcome in a hypothetical patient to physical and psychological factors. Results indicated that surgeons were less likely to attribute the cause of surgical failure to physical factors when the patient had already failed conservative treatment for low back pain. Surgeons also were more likely to attribute failed surgery, relative to successful surgery, to patient psychological factors. An interaction effect indicated that the latter difference was significant only when the patient had previously succeeded at conservative treatment. Empathy moderated this effect: empathic surgeons were less likely to see the failed surgery patient as psychologically culpable. This self-serving attributional style, as moderated by empathy, is discussed regarding its potential impact on patient care and physician judgment processes.

Upshur CC, Gonzalo B, & Luckmann R. (2010). They don't want anything to do with you: patient views of primary care management of chronic pain. *Pain Medicine*, 11: 1791-1798.

OBJECTIVE: Chronic pain is one of the most frequent complaints of patients in primary care, yet both patients and providers report low satisfaction with chronic pain care. This study was designed to explore the views held by a diverse sample of patients with chronic pain complaints about their care experiences to identify ways to improve care.

DESIGN: Qualitative analysis of 17 patient focus groups (size 3-7 participants). Groups used structured questions and were tape-recorded, transcribed, and coded using qualitative software. Eleven groups were conducted in English, six groups in Spanish.

PATIENTS: Convenience sample of 72 adult patients (68% female, 44% Latino, mean age=48.1 years) recruited from four diverse primary care practices in Central Massachusetts.

RESULTS: Across all 17 groups, and all gender, ethnicity, and age groups, most patients reported suboptimal interactions with their providers when seeking care for chronic pain. Subjects acknowledged feeling disrespected and distrusted, suspected of drug-seeking, and having their symptoms dismissed as trivial and/or not warranting medical care. Patients reported more satisfaction when they felt a provider listened to them, trusted them, was accessible to address pain concerns between visits, and used patient-centered approaches to establish goals and treatment plans. Patients also recommended some management techniques related to the chronic disease management model to improve pain care.

CONCLUSIONS: Implementing patient-centered approaches in caring for individuals with chronic pain and using principles drawn from the chronic disease management model to improve care systems may improve both patient and provider satisfaction with chronic pain care.

Walid MS, Donahue, SN, Darmohray, DM, Hyer, LA, & Robinson JS. (2008). The Fifth Vital Sign—What Does It Mean? *Pain Practice*, 8( 6): 4417-422

Acute pain is reported as a presenting symptom in over 80% of physician visits. Chronic pain affects an estimated 76.2 million Americans—more than diabetes, heart disease, and cancer combined. It has been estimated to be undertreated in up to 80% of patients in some settings. Pain costs the American public more than \$100 billion each year in health care, compensation, and litigation. That's why pain was officially declared "The Fifth Vital Sign." Henceforth the evaluation of pain became a requirement of proper patient care as important and basic as the assessment and management of temperature, blood pressure, respiratory rate, and heart rate. The numeric pain scale certainly has a place in care and in pain management; however, it is important to assess the patient's communication and self-management style and to recognize that patients, like pain, are on a continuum with varied styles of communication and adaptation. It is easy to get lost in the process, even when the process is

initiated with the best of intentions. In the quest for individualized medicine, it might be best to keep pain assessment in the individualization arena.

Wasan, AD, Wootton J, & Jamison RN. (2005). Dealing with difficult patients in your pain practice. *Regional Anesthesia and Pain Medicine*, 30(2):184-192.

Pain patients can be difficult. They can provoke negative feelings of frustration and anger among clinicians and damage the doctor-patient relationship. This article helps practitioners to identify those pain patients who would be prone to difficult behavior and sheds light on some of the reasons behind the behavior, and chronic noncompliance are discussed. Specific recommendations are also given of the best ways to manage patients with difficult behavior.

Wiedemer NL, Harden PS, Arndt IO, & Gallagher RM (2007). The Opioid Renewal Clinic: A Primary Care, Managed Approach to Opioid Therapy in Chronic Pain Patients at Risk for Substance Abuse. *Pain Medicine*, 8(7): 573-584.

OBJECTIVE: To measure the impact of a structured opioid renewal program for chronic pain run by a nurse practitioner (NP) and clinical pharmacist in a primary care setting.

PATIENTS AND SETTING: Patients with chronic noncancer pain managed with opioid therapy in a primary care clinic staffed by 19 providers serving 50,000 patients at an urban academic Veterans hospital.

DESIGN: Naturalistic prospective outcome study.

INTERVENTION: Based on published opioid prescribing guidelines and focus groups with primary care providers (PCPs), a structured program, the Opioid Renewal Clinic (ORC), was designed to support PCPs managing patients with chronic noncancer pain requiring opioids. After training in the use of opioid treatment agreements (OTAs) and random urine drug testing (UDT), PCPs worked with a pharmacist-run prescription management clinic supported by an onsite pain NP who was backed by a multi-specialty Pain Team. After 2 years, the program was evaluated for its impact on PCP practice and satisfaction, patient adherence, and pharmacy cost.

RESULTS: A total of 335 patients were referred to the ORC. Of the 171 (51%) with documented aberrant behaviors, 77 (45%) adhered to the OTA and resolved their aberrant behaviors, 65 (38%) self-discharged, 22 (13%) were referred for addiction treatment, and seven (4%) with consistently negative UDT were weaned from opioids. The 164 (49%) who were referred for complexity including history of substance abuse or need for opioid rotation or titration, with no documented aberrant drug-related behaviors, continued to adhere to the OTA. Use of UDT and OTAs by PCPs increased. Significant pharmacy cost savings were demonstrated.

CONCLUSION: An NP/clinical pharmacist-run clinic, supported by a multi-specialty team, can successfully support a primary care practice in managing opioids in complex chronic pain patients.

Wilson D, Williams M, & Butler D. (2009). Language and the pain experience. *Physiother. Res. Int*, 14: 56-65

BACKGROUND AND PURPOSE: People in persistent pain have been reported to pay increased attention to specific words or descriptors of pain. The amount of attention paid to pain or cues for pain (such as pain descriptors), has been shown to be a major factor in the modulation of persistent pain. This relationship suggests the possibility that language may have a role both in understanding and managing the persistent pain experience. The aim of this paper is to describe current models of neuromatrices for pain and language, consider the role of attention in persistent pain states and highlight discrepancies, in previous studies based on the McGill Pain Questionnaire (MPQ), of the role of attention on pain descriptors. The existence of a pain neuromatrix originally proposed by Melzack (1990) has been supported by emerging technologies. Similar technologies have recently allowed identification of multiple areas of involvement for the processing of auditory input and the construction of language. As with the construction of pain, this neuromatrix for speech and language may intersect with neural systems for broader cognitive functions such as attention, memory and emotion.

METHOD: A systematic search was undertaken to identify experimental or review studies, which specifically investigated the role of attention on pain descriptors (as cues for pain) in persistent pain

patients. A total of 99 articles were retrieved from six databases, with 66 articles meeting the inclusion criteria. After duplicated articles were eliminated, the remaining 41 articles were reviewed in order to support a link between persistent pain, pain descriptors and attention.

RESULTS: This review revealed a diverse range of specific pain descriptors, the majority of which were derived from the MPQ. Increased attention to pain descriptors was consistently reported to be associated with emotional state as well as being a significant factor in maintaining persistent pain. However, attempts to investigate the attentional bias of specific pain descriptors highlighted discrepancies between the studies. As well as the diversity of pain descriptors used in studies, they were inconsistently categorized into domains of pain. A lack of consistent bias towards certain pain descriptors was observed, and may be explained simply by the fact that the words provided are not those which subjects themselves would use.

CONCLUSION: These findings suggest that the multidimensional and individual nature of the persistent pain experience may not be adequately explained by pain questionnaires such as the MPQ. Personalized pain descriptors may communicate the pain experience

Yee Tse MM & Ho SSK. (2014). Enhancing Knowledge and Attitudes in Pain Management: A Pain Management Education Program for Nursing Home Staff. *Pain Manag Nurs*, 15(1):2-11.

The aim of the study was to examine the effectiveness of a pain management program (PMP) in enhancing the knowledge and attitudes of health care workers in pain management. Many nursing home residents suffer from pain, and treatment of pain is often inadequate. Failure of health care workers to assess pain and their insufficient knowledge of pain management are barriers to adequate treatment. It was a quasiexperimental pretest and posttest study. Four nursing homes were approached, and 88 staff joined the 8-week PMP. Demographics and the knowledge and attitudes regarding pain were collected with the use of the Nurse's Knowledge and Attitudes Survey Regarding Pain—Chinese version (NKASRP-C) before and after the PMP. A deficit in knowledge and attitudes related to pain management was prominent before the PMP, and there was a significant increase in pain knowledge and attitudes from  $7.9 \pm SD 3.52$  to  $19.2 \pm SD 4.4$  ( $p < .05$ ) after the 8-week PMP. A PMP can improve the knowledge and attitudes of nursing staff and enable them to provide adequate and appropriate care to older persons in pain. PMPs for nurses and all health care professionals are important in enhancing care for older adults and to inform policy on the provision of pain management.