Conversations That Matter:
Addressing Challenging Topics in the Exam Room
Discussion Guide

Opening remarks by LAURA COOLEY, PhD (10 Minutes)

- Good morning, thank you for joining us today for a panel discussion to explore communications in pain care.
- I am honored to be here today working with Teva Pharmaceuticals and to be part of an event that aims to help foster more open communication in the exam room between healthcare providers and those living with pain. As we all know, pain management is complex, which can complicate the dynamics in the exam room and hinder productive dialogue. Dialogue between a healthcare professional and a person living with pain particularly regarding the impact of pain, the risk of prescription drug abuse and the role of abuse deterrence technology are not easy topics to cover.
- In fact, results from a recent survey, conducted by Teva in collaboration with the American Academy of Pain Management and U.S. Pain Foundation, showed that healthcare professionals and people affected by pain recognize their personal responsibility in helping address prescription drug abuse, but acknowledge conversations about the issue can be uncomfortable.[1]
- As the Director of Education and Outreach at the American Academy on Communications in Healthcare, I hear about these issues on a daily basis. While there are challenges surrounding open dialogue in many healthcare sectors, the pain care landscape faces additional complexities that need to be addressed for effective communication.
- Fortunately, there are many tools to help guide these conversations. The same survey I mentioned earlier that reported discomfort in conversations about pain also found that over 70 percent of both healthcare professionals and people affected by pain agree that information and resources are critical to helping address the issue.[1]
- Pain Matters is an educational initiative created by Teva Pharmaceuticals to provide tools and resources to help the pain community navigate the pain management landscape. This Pain Awareness Month, Pain Matters is proud to announce Design for Dialogue.
- Design for Dialogue is a program that challenges the pain community to rethink the exam room experience and design a space, from the wall color to the furniture to the resources available, that they feel would help address the discomfort around these conversations and complex issues and allow them to more openly communicate with each other.
- Today at this symposium, we want to bring Design for Dialogue to life through a panel discussion about challenges to productive patient/provider conversations and role-play scenarios in which myself and my fellow panelists examine the complexities and some opportunities to foster more meaningful discussion.
- At this time, I would like to introduce my fellow panelists.
    - Bob Twillman, executive director and director of policy and advocacy at the American Academy of Pain Management
    - Paul Gileno, founder of the U.S. Pain Foundation
    - Dr. Richard Payne, Esther Colliflower Professor of Medicine and Divinity at Duke Divinity School at Duke University, medical director for the Pain Action Alliance, and John B. Francis Chair in Bioethics at the Center for Practical Bioethics
- In the interest of full disclosure:
    - This afternoon's event is brought to you by Teva Pharmaceuticals.

- All of today's participants, as well as myself are working with Teva to raise awareness of the Pain Matters initiative. The panelists and I are being compensated for our time and/or travel costs to participate in today's symposium.

- So without further adieu, let's begin the discussion.

Panel discussion moderated by LAURA COOLEY, PhD

Section A: Identifying Challenges in Communication (15 minutes)

LAURA: Let's start by examining some of the challenges that exist that can make open, meaningful conversation more difficult, especially in pain care. From the stigma surrounding the condition alone to the prescription abuse in this country, the challenges no doubt are real and complicated. Let's dig a little deeper into these issues with our panel of experts.

- **BOB,** let's start with you. As someone with a background in both pain management and psychology, what do you think are the biggest challenges to productive and open dialogue in this space?
  - High pressure situation where people might forget what they intended to say
  - Patients may feel intimidated, want to appear okay
  - Limited time

- **PAUL,** you serve as an advocate for people living with pain and also live with it yourself. What's your perspective on the challenges from a person living with pain:
  - Patients feel like they aren't being heard
  - Patients feel like they can't bring up certain topics without sounding like an addict or abuser
    - According to the survey, 20 percent of patients worry that asking about abuse would suggest they have a problem[1]

- **RICHARD,** during these often difficult conversations, what would you say are the doctor's concerns?
  - Don't want to sound accusatory
  - Don't want to lose trust; 40 percent of HCPs say discussions of abuse may damage relationships with patients[1]
  - Limited time
  - Recognition (conscious or subconscious) of potential conflict in putting the best interest of the patient first vs. a "public-health" responsibility to watch costs of health care; to address misuse and abuse of controlled substances, etc.
  - Recognition that resources and services that the patient really needs, i.e., access to an inter-disciplinary, rehabilitation-focused chronic pain clinic is not possible

- **LAURA:** Thank you all for your insight into the communication challenges from your perspective. Now onto finding solutions. The American Academy on Communication in Healthcare has quite a few tools they offer to physicians and patients that focus on an ideal we refer to as "relationship-centered care". With this focus, we can better ask and listen to patient concerns, respond more empathically to patient emotions, and share in the decision-making process.

- **PAUL,** communication has been a focus of your advocacy work in the past as well. What do you remind people living with pain to do when they meet with their physicians?
    - Write down important points you don't want to forget
    - Feel confident in your story
    - Don't be afraid to discuss abuse and misuse

- **RICHARD,** have you found any particular practices that are helpful on the provider side?
    - Familiarize yourself with simple communication protocols and practice them (e.g, sit down; turn off pager or cell phone; don't fiddle with digital devices or multi-task)
    - Practice the skills of empathetic listening
    - Use simple technique of repeating back and "getting to yes" so that your patient feels that you have really heard their concerns
    - Give your patients the time they deserve to tell you their whole story—or make it appear so!

Section B: Enhancing Healthcare Communications Techniques (20 minutes)

- **LAURA**: Those are some great insights. I particularly appreciate Dr. Payne's point of not interrupting. Interestingly, clinicians often interrupt patients during their initial monologue when most patients would talk for up to 90 seconds if uninterrupted. Only 23 percent of patients feel they finish sharing their concerns with their clinicians.[2,3] This is one challenge to effective dialogue that is best demonstrated through role play.

  [Script for interrupting exam room convo]

  Richard as clinician: How are you feeling today? [NOTE: The clinician should also be fiddling with digital device, and multi-tasking throughout the scene]
  Paul as patient: Begins to describe his pain for roughly 15 seconds.
  Richard [interrupting]: Well it sounds like you are doing better then. How are your medications?
  Paul: They're okay. I'm not really sure if the dosage is working so I've been trying some alternative treatments because as I was going to say before my pain has really increased...
  Richard [interrupting]: What alternative treatments?
  Paul: I tried acupuncture but I don't think it helped.
  Etc. showing that Richard isn't letting Paul finish explaining his pain.

- **LAURA:** Notice how as soon as the clinician interjects, Paul not only loses his train of thought but also feels less confident in sharing the remaining details of his story. At AAHC, we remind clinicians to listen with intentional presence which means listening in a way that shows you are non-verbally attentive and that your thoughts reflect the speaker's words.

- **LAURA**: Another point that Dr. Payne mentioned is the importance of empathy. Once your patient has finished sharing their full story, the way in which you respond is crucial to the future of that dialogue.

- Responding with empathy means making statements that show support, understanding and partnership.
- However, we have found that empathetic conversations actually lead to increased efficiency in the exam room. Internists who made empathetic statements saw exam room visits that were an average of 2 minutes shorter than those who did not use empathy.[4]
- Let's take a look at an empathetic conversation.

[Script for empathetic /intentional presence exam room convo highlighting non-verbal attention, reflecting the speaker's words with your own and using statements. In this scenario, we should be attentive to the SPIKES protocol and make it obvious to the audience. The clinician should be shown turning off his cell phone and not looking at his iPAD:

Richard as clinician: How are you feeling today?
Paul as patient: Describes his pain and gets to the end of his full statement
Richard: So your pain has gotten worse. I can imagine how frustrating that would be for you.
Paul: Yes, it has been frustrating since I've been taking my medications exactly as prescribed.
Richard: Absolutely. Most people in your position would feel the same way. Can you tell me about your morning routine? Are you still able to perform daily tasks such as walking to the mailbox?
Paul: It really depends on the day... *continues to explain*
Richard: I'm sorry to hear how difficult this is. So, if I am understanding what you're saying, your are not getting the results and the pain relief from the medications that we thought? Is that correct? Let's see if we can come up with a plan together.

Section C: Communication in Pain Management- Discussing treatment with prescription opioids and Abuse Deterrence Technology (15 minutes)

LAURA: As we all saw in those demonstrations, healthcare communications can be difficult. It takes a lot of trust from both the healthcare professional and the patient to have a productive and open dialogue. Dialogue in the pain management space can seem particularly difficult due to the complexities of the pain care landscape. The nuances involved in managing the effects of pain and the risks of prescription drug abuse and misuse can lead to people feeling uncomfortable in the exam room.

- **Paul and Bob**, both of your organizations were involved in the Teva sponsored survey which found that 31 percent of physicians feel uncomfortable talking to their patients about prescription drug abuse and 29 percent of people affected by pain worry that asking about abuse and misuse would indicate that they have a problem.[1]

- **LAURA: Dr. Payne**, do you echo those same sentiments?
  - **DR. PAYNE:** I do. I feel like the lack of open dialogue can impact a patient's treatment plan and ultimately lead to them to not having all of the information they need to manage their pain. Our failure to acknowledge the complexity of experiencing chronic pain, and our challenges in managing chronic pain also lead to difficulties with our patients.

  - We have to communicate that chronic pain requires multiple approaches to management—major efforts on both the part of the patient-sufferer, and the clinician. We have to state that rarely, if ever, is pain totally eliminated, and that an expectation of total pain relief, especially with the use of medications like opioids is a set up for failure and frustrations, even though there is a role for opioids in chronic pain management.
- **LAURA:** That's an interesting point and actually also is supported by this patient/provider survey. 71 percent of healthcare professionals and 75 percent of people affected by pain believe that providing more information and resources is the best way to deal with opioid abuse.[1] And one thing that we haven't touched on yet but that both parties indicated as something they are interested in is more information on abuse deterrence technology. Two thirds of healthcare professionals and half of patients see abuse-deterrent formulations as being a good way to address problems of opioid abuse.[1]

- **Dr. Payne,** what are your thoughts on improving understanding and communications surrounding these new formulations?
  - Speak to how ADT formulations are important additions to our tools to management pain
  - Be honest in that although they are useful and may help deter abuse, the patient may have to take on additional out-of-pocket costs because sometimes insurance providers will not pay for them

- **Paul,** do you think patients are interested in learning more about abuse-deterrent technology? How can prescribers best talk about treatment options that include this technology without insinuating that there may be an abuse problem?
  - People with pain should be aware of all their treatment options, including those with ADT
  - Given the sensitive nature of the conversation, I would encourage prescribers to speak about ADT as an option that represents a positive step toward addressing the opioid abuse problem overall because you never know who else may have access to the medication. In fact, more than three out of four people who misuse prescription pain medications do so by using medication prescribed to someone else.[5]
  - According to the survey, many (82 percent) feel a strong responsibility to educate patients about abuse-deterrent formulations.[1]

Thank you and closing by LAURA COOLEY, PhD

- Thank you all for your time and your valuable perspectives. My organization is committed to improving communication in the healthcare space and I am honored to have been part of today's session brought to you by Teva Pharmaceuticals. I hope the discussion today proved to be meaningful for our audience and that you are able to take some of the learnings here today back with you to your practices.
- As I mentioned earlier, today's session is part of Design for Dialogue, a program under Pain Matters offered by Teva that is specifically helping to address some of the challenges of communication in pain care. Please take a moment to visit painmatters.com and join the pain community as we

rethink the exam room experience and design a space to help address the discomfort around these complex issues.

- So that we can continue providing practical tools and resources to the pain community, we invite you to provide your feedback on today's program and our initiative through the questionnaire found on your seat.
- Our panelists will be available for a few minutes after the program today if you have any individual questions for them.
- On behalf of Teva Pharmaceuticals, thank you all for spending your afternoon with us.

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[1] Data on file: Versta Research. Survey on Pain Matters, Report of Findings from the Chronic Pain and Abuse Deterrence Technology Surveys of Patients and Healthcare Professionals. 2015.

[2] Rabinowitz, I, Tamir, R, Reis, A. Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter. *British Medical Journal*. 2004;501-502.

[3] Beckman HB, Frankel RM. The effect of physician behavior on the collection of data. *Annals of Internal Medicine*, 1984;692-696.

[4] Levinson W, Forawara-Bhat R, Lamb J. A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings. *JAMA* 2000;1021-1027. Available at: http://www.hadassah-med.com/media/2003614/10PatientscluesandMDresponses.pdf. Accessed August 4, 2015.

[5] Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health: volume 1: summary of national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2011. http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.pdf. Published September 2011. Accessed November 14, 2014.