

Pain Management Doesn't have to be a Pain: Working and Communicating Effectively with Patients who have Chronic Pain

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Introduction

More than 60 million Americans suffer from some type of persistent or recurrent pain sufficient to substantially affect their lives.¹ Although effective treatments are currently available, at least 40% of patients treated in the routine practice setting fail to achieve adequate relief from primary pain.² In a recent survey of Kaiser Permanente (KP) members with various chronic conditions, patients with chronic pain fared the worst in terms of quality-of-life burden, diminished functional status, and lost productivity.³

One reason why this population is difficult to treat is the inadequate communication between clinician and patient regarding treatment and self-management of chronic pain. Communication is the most powerful tool between clinician and patient—a tool that needs to be strengthened by the medical community.

Enhancing communication with a patient who has chronic pain can be daunting because so many aspects of the patient's life are affected by the pain. Clinicians never seem to have enough time to discuss all the relevant issues in addition to addressing coexisting health conditions or presenting problems. An approach that makes that task seem possible—and even accomplished

successfully—is to realize that we do not need to do *more*; we instead need to do things *differently*.

To enhance our current abilities and possibly to acquire additional office-based tools and strategies for addressing chronic pain, this article—the first in a series—discusses the challenges and complexities of treating chronic pain. (Upcoming articles in this series will provide more in-depth discussion of pain assessment and management.) The more assured we feel about the direction to give the patient, the more likely the patient will be to follow this direction.

A Three-Step Approach

An effective approach for working and communicating with pain patients at an office visit can be conceptualized as consisting of three steps: measuring and assessing; planning the treatment; and delivering the treatment. To enhance communication with patients and to emphasize selected points, clinicians should feel free to use visual aids, such as pre-printed handouts and spontaneous drawings or notes.

Measure and Assess the Pain

To understand the “big picture” of measuring pain and assessing the impact of pain on the patient, you

must first “size up” what you are dealing with. This evaluation should be done in your office even before you order any tests.

Measuring pain has long been a difficult concept that nonetheless requires documentation in the medical record. The difficulty facing both the patient and the clinician is that pain is entirely subjective and is often described by a number that proves useless because neither the patient nor the clinician really knows what specific therapeutic action is required by the number. Patients often state that they do not know how to attach a number to their pain, and many patients tend to catastrophize by assigning to their pain a score of 10 or higher only because they suppose that doing so is the only way to bring acknowledgment and treatment. Clinicians have no treatment plan for a score higher than 10, and they are trained to interpret a score of 10 as indicating a need for hospitalization, which almost no chronic pain patient needs. You need the ability not only to detect trends in the patient's pain score but also to evaluate the patient's ability to function.

What is needed is a “pain language” that both the patient and clinician can use to effectively communicate with each other. The scale can be explained in functional terms:

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- A score of 10 indicates a need for hospitalization.
- A score of 8 or 9 indicates that the patient is missing work, canceling social activities, and stays in bed because of inability to function.
- A score of 5, 6, or 7 means that the patient is having a very difficult time functioning with existing responsibilities and that pleasurable activities are rare and concentration is impaired.
- A score of 1, 2, 3, or 4 reflects functional pain: Pain is definitely present—and may even require regular medication—but does not interfere with daily activities.

While acknowledging that the pain is real and does affect the patient's life, you both must understand where the patient really is in order to manage the pain effectively, both in and out of the office visit. Assessing the impact of the pain on a patient's life does not have to be a Pandora's Box. The impact can be assessed during your routine exam

by use of a mental checklist of "The Six Dysfunctional D's": distress, depression, deficits, disturbed sleep, disability, and deconditioning.⁴ For many patients with chronic pain syndromes, dysfunction is apparent in these six "D's":

- Distress: emotional distress manifesting as anxiety, conflicted feelings, anger, hostility, resentment, and alienation, possibly aggravated by family, school, or environment;
- Depression: varying degrees and forms (agitated, vegetative, refractory), possibly with psychological dysfunction (anxiety);
- Deficits: cognitive and behavioral deficits (eg, impulse control, assertiveness, attention, concentration, memory, judgment);
- Disturbed sleep: sleeping patterns disrupted by the distress and by the pain sensation;
- Disability: Varying degrees of perceived and actual disability, possibly influenced by family, environment, or both;
- Deconditioning: emotional,

intellectual, spiritual, and physical deconditioning resulting from lack of healthy function.

Recognizing these characteristics in your patient should alert you to the need for a more aggressive treatment plan.

Plan the Treatment

Many patients—and some clinicians—fail to realize that chronic pain is not just a prolonged version of acute pain.

Unlike a patient with acute pain, a patient with chronic pain should not focus on his or her pain. The goal of treatment is adequate pain control to allow improved function and independence. Poor pain control promotes further loss of strength, flexibility, and function. Hypersensitivity may have already developed and can lead to further change in the nervous system. Depression and anxiety are common. All these factors ultimately lead to more pain (Figure 1).

The KP Care Management Institute (CMI) has developed evidence-based guidelines⁵ for assessing and managing chronic pain in the primary care setting. These and clinician/member tools can be accessed at our National Clinical Library Web site, <http://cl.kp.org>.

One of the most effective treatment approaches is to acknowledge that the pain is real by explaining to the patient the biology of chronic pain:

- Pain and injury can alter sensory nerves, causing them to constantly send out false alarms.
- Pain signals become embedded in the spinal cord like a painful memory. This hypersensitization, called *windup*, results from changes in the neurotransmitters, receptor binding, nerve-firing threshold,

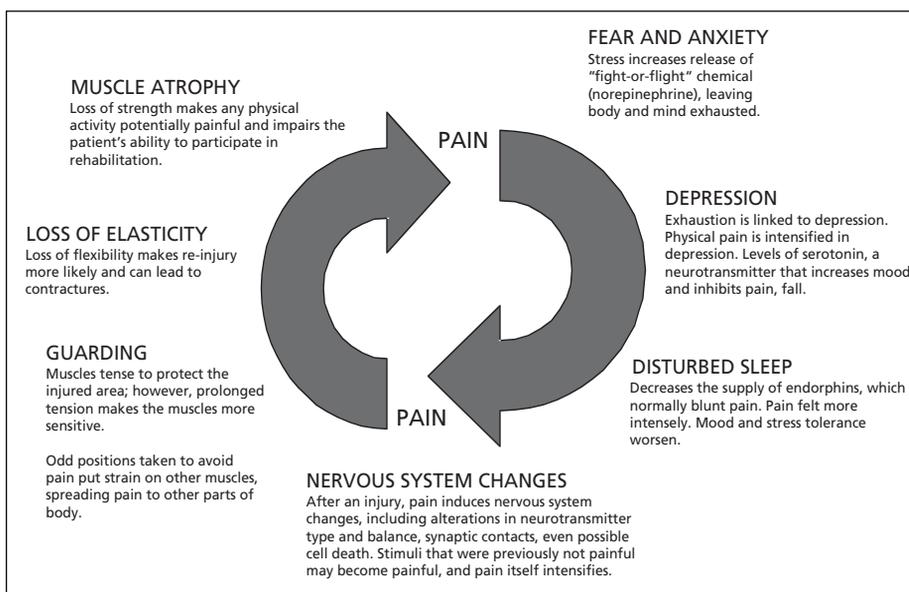


Figure 1. Illustration shows interaction (a "vicious cycle") between pain and its results. Pain causes physical and emotional phenomena that, in turn, cause additional pain.

and synaptic contacts.⁶⁻¹¹ Pain is then felt as more severe, and that which was not painful can become painful. In most patients, windup resolves as the injury heals. However, in some patients, these changes persist. The more severe the pain and the longer it persists, the more likely the change will become permanent.¹² We don't yet

know the exact combination of pain severity, duration, etiology, and genetic predisposition that leads to chronic pain, but adequate pain management for *all* pain is clearly needed.

In many cases, the patient thinks that a diagnosis will lead to a cure. If a diagnosis is made, then a treatment exists that will take the pain away. Most patients do not under-

stand that pain can become chronic for no reason; this concept therefore must be explained to them. Using a visual diagram or illustration of chronic pain is extremely helpful for validating the biological process, for making the diagnosis real, and for setting the stage for treatment—which, in fact, consists of long-term self-management. A simple, one- to

Table 1. Applying the recommended three-step approach to managing chronic pain: Examples of potential patient encounters			
"Doctor, there must be something wrong—you are missing it, or why can't you find it?"			
Key message	Measurement and treatment plan	Delivery	Tools
<p>"Pain is real and can malfunction for no reason."</p> <p>"We must change our treatment plan to manage the pain. This is what we are going to do first ..."</p>	<ul style="list-style-type: none"> • Measure, chart NRS^a • Explain that functional pain levels are your goal • Address medication and side effects • Focus on what the patient can do, such as exercise and pleasurable activities • Provide pain diary • Patient to report back at next visit 	<p>"I know that this is difficult for you. It's difficult for me as your doctor, because my job is to fix/cure you, but in this case, we have to work together to help you feel as best as you can with the pain. That will take a different kind of work than before, because for right now, chronic pain is not curable."</p>	<ul style="list-style-type: none"> • Visual materials on chronic pain • NRS • Pain diary • List of KP and community classes
"I can't ..." or "Yes, but ..."			
Key message	Measurement and treatment plan	Delivery	Tools
<p>"Sometimes, issues get in the way of a patient's ability to get better."</p> <p>"Are there other stressors in your life that affect your pain?"</p>	<ul style="list-style-type: none"> • Assess for complications • Measure, chart NRS • Explain again that functional pain levels are your goal • Address medication and side effects • Briefly assess for presence of depression, anxiety, or serious mental disorder • Focus on what the plan was for the patient and hold the patient accountable • Patient to report back at next visit 	<p>"Let's focus on what progress we have made and apply how we did that to what we are facing at this visit."</p> <p>"I am hearing that you think what I am saying is valuable and yet you are not able to follow through. What do you think that is about?"</p> <p>"Pain management is 90% you and 10% me, so it is not going to feel like our plan is working if you feel it is the other way around. So, let's take another look at the treatment plan and try to make it work better for you."</p> <p>"My job is not to give you what you want; it is to give you what you need."</p>	<ul style="list-style-type: none"> • NRS • Pain diary • One behavioral activity goal • One pleasurable activity while pacing
"My pain medications are not working. I need more ..."			
Key message	Measurement and treatment plan	Delivery	Tools
<p>"Medication is only one component of pain management."</p> <p>"Before we increase or change your medication, let's take a look at the treatment plan and what you are doing to self-manage your pain."</p>	<ul style="list-style-type: none"> • Measure, chart NRS • Assess for misunderstanding, undertreatment, pseudoaddiction, addiction • Briefly assess for presence of stress, depression, anxiety, or serious mental disorder that could be the cause of increase in medication usage • Explain again that functional pain levels are your goal • Address medication use • Focus on what the plan was and hold the patient accountable • Patient to report back at next visit 	<p>"I am concerned about your use of medication. Let's try to figure out what is going on. For us to work together, this daily diary of medication intake is critical to fill out. If changes need to be made, it will be after the next visit, when I can examine your completed diaries and get a clearer picture of what needs to happen next."</p> <p>"Do you ever find that during or after a stressful event, you feel you need more pain medication due to feeling more pain?" IF YES:</p> <p>"Our emotional pain can make our physical pain worse, but pain medication is not designed to address emotional pain. Let's take a closer look at what to do during stressful events, so you are not using pain medication as a response ..."</p> <p>"My job is not to give you what you want; it is to give you what you need."</p>	<ul style="list-style-type: none"> • NRS • Pain diary • Handouts on management of medications and side effects • Referral to Chemical Dependency clinic for evaluation if unsure

^aNRS = numeric rating scale.

five-minute explanation can be followed with, "Now that we are here, we need to talk about the management plan." Before entering the examination room, anticipate possible questions or problems the patient may have regarding self-management techniques, and assemble some strategic options for addressing these concerns (Table 1).

Promote Self-Management for Pain Control

Help your patient to set realistic treatment goals for improving function on the basis of objective physical limitations and not on the basis of perceived pain. Being 100% pain-free may not be a realistic goal. Tell the patient, "There will be better and worse days, but there are things you can do to feel better" and that you expect a trend of general improvement over time.

Restore physical conditioning gradually by giving clear, specific exercise prescriptions. For example, the patient may be instructed to walk ten minutes per day and to increase this daily duration by one minute each week (eg, walk 11 minutes daily for the second week) until the patient reaches a pre-assigned number of minutes daily. Many patients respond well to a "rehabilitation" analogy. Talk to the patient about "starting where you are—not where you think you should be—and increase from there." When confronted by the comment that it hurts to exercise, reassure the patient by saying, "gentle daily exercise may actually decrease (instead of increase) your pain. Gentle daily exercise strengthens muscles that help you become more active and independent and helps restore more normal balance in your nervous system."

An essential instruction is for patients to pace their activities. You may say to the patient, for example, "Pace yourself. Some days will be better than others, and you might tend to push yourself to do more. If you break up your activities into smaller tasks and take rest periods before the pain gets severe, you will decrease your discomfort and prevent your pain from flaring up." Discuss "flare-up" management *before* it occurs so that the patient has a plan to follow and can prevent the pain from further escalating out of control.

Address Patients' Attitudes About Medication

We sometimes blame the patient if treatment seems to fail. Resist this temptation by trying to "see through the patient's eyes." If the patient is not following instructions, ask the patient why. The answer could alert you that the patient does not expect success, has no incentive to change, or feels that the effort is too great. Do not assume that you know the answer without asking the patient.

If a patient's pain is poorly controlled, the first thing to ask is whether and how they are taking the medications you prescribed. Some people are afraid to take opioids, for example, for fear of becoming addicted to these drugs. Reassure the patient that addiction is rare—only about 5 in 10,000 people without an existing substance abuse problem become addicted—and that the patient is therefore unlikely to become addicted if the opioid medication is taken as prescribed.

Patients often do not understand the difference between dependence, tolerance, and addiction; explaining the difference may therefore be helpful. Using a commonplace example such as caffeine intake can often help to demystify these concepts:

- *Dependence* is a physiologic state characterized by *withdrawal* and is rare in patients treated for less than three weeks. You might say to the patient, "If you've taken any medication for awhile and suddenly stop taking it, you may feel withdrawal symptoms. For example, have you ever gotten a bad headache from suddenly stopping caffeine? That was withdrawal."
- *Tolerance* refers to the decrease in strength of the opiate effect with continued use of the drug. You might say, "When you first started drinking coffee, you felt more of a lift from one cup; after a few years, it took several cups to get the same lift. That's tolerance."

In the general population, the rate of addiction to prescription analgesic drugs is comparable with the rate of addiction to alcohol: about 5 in 10,000 persons. Despite potential or actual harm, patients may have a psychic compulsion to continue taking a prescribed analgesic drug on an ongoing basis for effects other than pain relief. To illustrate this dangerous behavior, you might say, "Using our caffeine example, the caffeine addict might continue to drink caffeine despite it causing significant medical problems, such as rapid or irregular heartbeat."

Many patients who receive an inadequate dose of opioid medication seek more pain medication to regain control of their pain. This behavior is called pseudoaddiction because it is often mistaken for the true drug-seeking behavior of addiction. The behaviors of pseudoaddiction resolve with improving analgesia, whereas true drug-seeking behavior does not.

Fear of actual or perceived side effects is also a major problem. Take

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the opportunity to open a dialogue with your patients on the best way to take the prescribed medication, and ask about specific worries. The specter of nausea, constipation, dizziness, and dry mouth keeps many patients—especially older patients—from starting or continuing to take medications as prescribed, although these patients might not always tell you that they have stopped or have not begun taking the medication. Always start the drug regimen at a low dosage and slowly titrate the medication. Tell your patients up front that most side effects from prescription medications can be managed and that you will slowly increase the medication dosage to allow the patient's body time to adjust. Tell patients that you will find the best dose for their comfort. Being frank with patients makes them your partner in optimizing their care.

Because thoughts, feelings, behavior, and symptoms all affect pain severity, you should help patients to become aware of factors exacerbating their pain. Use of a pain diary can help patients to provide you with key information on how the care plan is progressing and allows you to give feedback on what is proving effective and why. Patient diaries can include the following: daily numeric rating scale (NRS) scores; daily functional impairment scores; quality of pain (eg, “dull,” “sharp,” “throbbing,” “sore,” “tender,” “heavy,” “tight,” or “burning”); what factors decrease or increase the pain; how the pain has affected sleep, mood, and relationships; and side effects of the medication.

Consider Whether to Use Cognitive Behavioral Therapy

Some patients need more help to attain good self-management strat-

egies than you or a health education class can provide. Consider cognitive behavioral therapy (CBT) for patients for whom pain management is a challenge—whether or not they have poor social, occupational, physical, or psychological function. CBT is a psychotherapeutic approach that focuses on helping patients to modify the way they perceive pain and respond emotionally and behaviorally to the pain. The benefits of CBT are improved quality of life and, above all, more independence and self-efficacy with regard to pain management and the aspects of life affected by chronic pain. An important step is to let the patient know up front that using CBT does not mean that the pain is not real or that the patient has a psychological problem. Explain to the patient that all illnesses have psychological as well as physical components and that a comprehensive approach is more likely to help regain function.

Take Cultural Beliefs into Account

Cultural beliefs also can affect pain management.^{13,14} Without intending to convey any cultural stereotypes, a few examples of cultural responses to pain can be presented:

- Central American patients may view pain as a necessary part of life and sometimes as a consequence of “earthly misconduct” or “imbalance” of nature. Certain types of pain-related behavior—particularly moaning and crying—may be culturally acceptable to these patients.
- For African-American patients, expression of pain may be open and public. These patients commonly avoid pain medication because they fear the possibility of addiction.
- Chinese-American patients

might not complain of pain, so be alert for nonverbal cues. Some patients may use acupressure or acupuncture to treat pain.

- Muslim patients might refuse narcotic drugs as treatment for mild to moderate pain, because narcotics are forbidden in their religion. These patients may prefer home remedies to manage pain.

Published research¹⁵ shows that nonwhite patients experience a lower quality of health services and are less likely to receive even routine medical procedures than are white patients—regardless of insurance status, income, age, presence of comorbid conditions, and symptom expression. Understanding the role culture plays in health care beliefs and practices and adapting interventions accordingly can yield a higher quality of care and greater clinical effectiveness.^{16,17} You need to understand and work within the patient's cultural context instead of using your own culture-specific values.

Use tools such as the services of qualified medical interpreters and translated patient education materials, and ask about patient preferences for treatment. When appropriate, involve family members to improve the patient's trust and adherence to prescribed regimens.

Final Notes on Delivering Treatment

Remember: Patients need to tell their story. They also need to be believed. And they need direction and structure.

Many chronic pain patients have endured years of having their pain dismissed, and these patients often feel isolated and frightened. They may view any clinician with distrust. Comorbid psychological conditions (such as depression,

Use of a pain diary can help patients to provide you with key information ...

anxiety, lack of self-esteem) and inadequate coping skills can contribute to communication problems and to more pain. Simultaneously, clinicians may feel discomfort over their inability to provide a "cure." They may dread having yet another visit from the patient with multiple comorbid psychological conditions who is difficult to communicate with. This combination can lead to a particularly uncomfortable clinical encounter. Other examples of common challenging communication issues are shown in Tables 2a and 2b.

The patient should legitimately feel understood, cared about, and safe in the treatment environment; reluctance

on the part of the clinician will be detected by the patient, who will then become reluctant to accept and participate in the treatment. A helpful approach is to tell the patient that you recognize the impact that the painful condition has caused the patient and the patient's family.

Concentrate on progress, not problems. Focus the visit on ways to improve function—for example, increasing activity tolerance, work capability, and sleep. Point out and applaud progress, because patients sometimes have difficulty recognizing slow improvement. Small successes help patients to build larger ones.

If the visit is not focused and begins to stray, confront the patient

gently and always return to the treatment plan. Do not treat chronic pain as a medical emergency; by remaining calm and dispassionate yet supportive, you will help dispel errant beliefs and fears.

Continue to stay on task, and hold patients accountable for their own self-management under your guidance. Address any areas that did not receive follow-up from the patient, and gently remind the patient that this follow-up is a required part of the treatment plan. At the very least, try to identify barriers to progress.

To build adherence and trust, try initially to see the patient regularly, no matter how well or ill the patient feels. Collaboratively decide on

Table 2a. Exemplary communications when working with patients who have chronic pain		
"Yes, but..."	Poor communication	Psychological interference
Goals: Identify barrier Action-orientation	Goals: Effective communication Focused questioning	Goals: Psychiatric treatment Identify psychiatric component
<ul style="list-style-type: none"> • "I understand how difficult it is to change, and we are in this together. For me to be successful, you must be, too. How can I help you overcome [identified barrier(s)]?" • "Let's focus on your progress for a moment. Since our last visit, your diary shows/your reported pain level was/you have done...which shows that you CAN make progress." • "When you have pain all the time, it is common to think that you are not getting better. Let me point out the things we have been improving." • "Pain management is very tough, but it is just that: manageable. Let's try to come up with two additional techniques that you can practice until we see each other again. I am sure we can make more progress." • "I am hearing that you think what I am saying is valuable, yet you are not able to follow through. What do you think that is about?" • "I am hearing some resistance. Can you think of a better way of approaching our goals?" • "Sometimes issues get in the way of a patient's ability to get better. Do you have other stressors in your life that are affecting your pain?" 	<ul style="list-style-type: none"> • Ensure that no language or cultural barrier exists. • "Let's spend a few minutes using this pain scale so that we can better understand your pain together." • "Explain to me in your own words: What do you think is wrong with you?" • "In your own words, explain chronic pain and how to manage it." • "Sometimes it is difficult to express yourself. Next time, try writing down your concerns as if you are writing me a letter. We will go over it together." • "Let's both take a deep breath and try starting with what your pain feels like at this moment. Look at this scale with the word descriptions and tell me where you are on it." • "Communication is our best tool for working on your pain. What works best for me is ... What works best for you?" • "Next time, bring a family member in with you. They can provide valuable information." • "Sometimes expectations are unclear. What do you really expect regarding the treatment of your pain?" 	<ul style="list-style-type: none"> • "Pain takes an emotional toll on us. I can hear that you are deeply affected by your pain, and I sense some depression and anxiety. Let me talk to you about what we can do to help relieve those feelings." • "Pain can sometimes make us feel and act like a different person. It can isolate us and interfere with our abilities to relate appropriately. If this continues, it will cause more problems for you than just your pain. We need to address this by getting you additional help." • "When emotions are not stable, then pain will increase. We become more disabled. The good news is that we can treat the emotional part by trying this medication and getting you connected to our psychiatry department. The outcome is less pain, and the emotions are better controlled." • "Sometimes we are the last to see that our pain has affected us psychologically. As your partner in pain management, I see that you are not able to think clearly and that your emotions are not stable. Let me help you by getting you treatment that will help you deal with the physical pain better and feel more in control." • "Do you understand how emotions and pain are connected? Let me explain."

the time interval for visits, which may be spaced six to eight weeks at the start. Patients tend to respect your time if they perceive you as available; if they perceive you as unavailable, both the frequency and urgency of calls are higher. Routine follow-up visits reassure the patient of your continuing commitment, allow you to reinforce self-management skills, and provide an opportunity to avoid a pain flare-up.

Consistency is critical, because so many patients with chronic pain

are both confused and angered by inconsistent messages heard previously from many clinicians. Team members should have a common philosophy and must communicate regularly—both formally and informally—so that the plan is clear to all, including the patient. This strategy is especially important for a patient who tries to manipulate team members in an effort to obtain what the patient perceives as better care.

Sometimes, in a given moment,

you may be truly frustrated and unsure of what you have left to offer. At such times, try taking a deep, diaphragmatic breath or two, and do nothing. You might not need to order an additional test or change yet another prescription; you might just need to use the best tool you have: yourself. Just listen, validate, and show empathy. That approach can be the best medicine the patient needs. With your help, your patients with chronic pain will get their lives back. ❖

Table 2b. Exemplary communications when working with patients who have chronic pain

Fixation on pain	Noncompliance with treatment plan	Increased use of medication
Goals: Distraction Action-orientation	Goals: Acceptance of pain Compliance	Goals: Structure Appropriate use of medication
<ul style="list-style-type: none"> • "I know it is difficult for you to understand that you have pain that we cannot cure, but let's review exactly what chronic pain is and answer any questions you have about this condition." • "I understand that it is difficult to think about anything but your pain and how that affects you, but there are things we can do together to help you feel better." • "Let's focus on what we can do together, such as taking a closer look at the medication we're using and other approaches that could help." • "I believe that coming up with a management plan will help you feel like we are doing something about the pain that you feel. Let's start with discussing ..." • "To help me better understand what your pain is like when you are not in the office, I would like you to complete a pain diary between visits. That way, I can see any patterns and possible changes in our pain management plan that we need to make." • "I know that it is difficult to try and address everything about your pain that you are experiencing, so let's focus on what bothers you the most. What is that exactly?" • "What self-management tools or techniques are you using in addition to taking medication?" 	<ul style="list-style-type: none"> • "What are you doing to manage your pain on a daily basis in addition to taking the medication?" • "What prevents you from using additional pain management techniques that are clinically proven to reduce your pain?" • "Research indicates that medication alone does not manage pain effectively, so let's figure out what else you are going to do to help your condition." • "I realize that it is difficult to think differently about your pain in terms of trying new things, but we know that these things work. Let's come up with three nonmedication techniques that you will practice as part of your daily pain management. We will put them into your treatment plan, and at the next visit, we'll check in to see how they're helping." • "Is there anything that you don't understand that I can help explain to you that will help you to use additional techniques with your pain medication?" • "The person most affected by your pain is you. If you don't follow your treatment plan, neither your functioning nor your pain will improve. Increases in medication are not likely to help if you are not using additional techniques. Let's review the treatment plan again." • "Information about your daily living is critical to our management plan. If you don't fill out the diary, I cannot make any decisions about changes." 	<ul style="list-style-type: none"> • "I am concerned about your use of the medication. Let's try to figure out what is going on. For us to work together, this daily diary of medication intake is critical to fill out. If changes need to be made, it will be after the next visit—when I can examine your completed diaries." • "Medication is only one component of pain management. Before we increase or change your medication, let's look at what nonmedication pain management techniques you are using." • "Using pain medication is part of our plan, but it is very important that you take it as prescribed. Let's discuss a working agreement regarding your medication so that we are on the same page, with trust and understanding, working toward the same goal of higher functioning." • "Pain medication is a component of pain management. What concerns do you have about your medication? I have some concerns that I would like to talk with you about." • "Sometimes a patient may have stress that increases pain to a point of taking more medication. This is not effective pain management and can become a problem. Do you notice taking more medication when you are stressed? There are ways that you can deal with the stress differently so that your pain is not affected and you feel like you have to take more medication." • "Help me to understand how, when, and why you are taking the medications. I think we need to add some supportive techniques to your treatment plan, such as ..."

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Nobody Is Watching

Integrity is doing the right thing, even if nobody is watching.

— Jim Stovall, entrepreneur and organizational speaker