Pain, Compassion, and Motivational Communication

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"We speak more to each other with our features and bodies than we do with our mouths…Only if someone was in an extreme state, such as fear and anxiety, would you understand what they were feeling, whereas if you have a face and a body, you pick up on a whole range of subtleties…You can tell the difference between someone who is lying or exaggerating, someone who is bored, and someone who wants to go to bed with you."

– Robert Wilson, *The Hidden Assassins*, 2006.

On February 6th, 2015, at the CRA meeting in Quebec City, Dr. Monique Camerlain and Dr. Kim Lavoie presented a symposium on Motivational Communication to illustrate how these competencies can improve patient adherence satisfaction and treatment outcomes.[1]

The experience of pain is an overwhelming whole-person experience;[2] motivational communication based on compassion (from the Latin *com* and *pati*, meaning "to suffer with,") is at the foundation of finding solutions in a win-win approach to better patient care.[3] The literature also demonstrates that between 50% to 80% of the information transmitted by a health-care professional in a medical visit is immediately forgotten by the patient, and half of the retained information is incorrectly remembered. The problem is more important for the elderly population, those who are anxious, and those concerned about receiving bad news. Between 30% to 80% of patients' expectations are not met in primary-care visits while differences in agendas and expectations often are not reconciled.[4]

As noted by Doheny at a 2014 conference on compassion in healthcare, various studies suggest that compassion helps patients feel less pain and anxiety,[5] yet, only 12% of patients say that physicians have given them reason to hope.[6] There is an important need to improve doctor-patient communication to identify and eradicate the problems which hinder communication in order to bridge this gap and to establish an I-Thou relationship as described by Buber.[7]

Physicians, as communicators, tend to have a high education and learning culture, use regulatory and abstract language, thereby placing high importance on the hypothetico-deductive model of reasoning and on the use of print and technology. Less literate persons have low education and learn through life experiences. They seek evidence of caring and prefer practical, simple, concrete language as well as verbal and visual information. This information-frame mismatch can be the cause of a breakdown in doctor-patient communication and should be of concern to all who value a humanistic approach to health care. Our goal and challenge is to achieve a balance between the art of compassionate communication and evidence-based deduction. The aim of motivational communication is to elicit "change conversation" with the goal of resolving a patient's ambivalence about change. It is not a way of tricking people nor is it just one technique.

Compassionate Communication: How It Helps

According to a 1996 survey, 90 million Americans have significant literacy problems;[8] this figure is approximately 48% of Canadians. The failure to detect low health literacy is costing the health care system $93 billion annually in the US, putting one in three people at risk of poor health outcomes.[8] Health literacy refers to the ability to read, understand, and act on healthcare information.[9]

People with low literacy cannot properly read consent forms, medicine labels, inserts, or appointment slips. They have difficulty understanding health information for a variety of reasons including literacy, age, disability, language, and emotion.

Low literacy is difficult to detect because patients struggling to understand written and verbal information are often ashamed of this problem and hide it from everyone including their physician. Low health literacy affects people from all backgrounds but senior citizens, minorities and low income individuals are at higher risk. They are more likely to have chronic diseases and less likely to get the care they need. Numerous studies have demonstrated that they are more likely to be hospitalized and need emergency care. They have poorer health habits and are less likely to use preventive strategies to ward off disease.[10]

To improve communication and to motivate patients in the management of chronic diseases, the importance of compassion must be stressed.[7] Communication role enactment must respect motivational patterns and stages of change. It must be flexible and consider the total patient, his expectations and his level of health literacy for there is no single right way to approach patients.

Motivation is a force that energizes, maintains and controls human behavior. To initiate a change in attitude and behavior, one must take into account the existence of a continuum between the internal motivators which create a force behind human behavior based on an internal locus of control and the external motivators based on an external locus of control.[11] Deci and Ryan suggest that the internal process of motivation would be more likely to produce a lasting effect when compared with the one coming from the external. According to them, the feeling of being able to perform tasks to achieve a goal and the ability to self-regulate one's own behaviour are the foundation of autonomy and self-determination. This sense of self-determination would drive an individual to make the necessary efforts to achieve a goal, even in situations where external interventions are minimal, even nonexistent.[12]

Prochaska et al have also described various stages which may influence the conditions of change in their trans-theoretical model. According to their vision, people go through: pre-contemplation, contemplation, preparation, action, and maintenance.[13] This has been documented in 103 patients with rheumatoid arthritis (RA) and 74 with osteoarthritis (OA): 44% were in pre-contemplation, 11% in contemplation, 22% in preparation, 6% in action, and 17% in maintenance.[14]

We must remember however, that our patients are of the talk show and self-actualization books generation. They "want the microphone" and they consider that what they have to say is very important.[9] A previous study from a tertiary referral centre, characterized by a selection of difficult patients with complex histories, has shown that, if patients are asked to talk spontaneously about their complaints and to indicate when they are finished, the spontaneous talking time is 92 seconds on average. However, doctors tend to jump in and begin asking directed questions after only 22 seconds. Some recommend the 80/20 rule: listen 80% and talk 20% of the time.[9] It is also worth being aware of body language, which represents 55% of communication.[4]

Giving the patient a comfort zone to mention all complaints is a sign of compassion and respect. It may take less than two minutes, but it increases information gathering and both doctor and patient satisfaction. Since satisfaction influences outcomes it is a worthwhile investment.[14]

As Maya Angelou once said: "I've learned that people will forget what you said. People will forget what you did, but people will never forget how you made them feel." Farley also considers that "meeting a person in pain and staying with her becomes a spiritual experience."[10]

We contend, in conclusion, that the traditional review of systems and the standard patient history should be used as a safety net. An encounter should have three or four functions: gathering information, developing a relationship, communicating information, negotiating plans, and facilitation of the patient becoming active in his or her own care. This having been achieved, in the newer frameworks of total-care, emphasis should be put on improving doctor-patient communication to ensure patient empowerment and on creating an I-Thou relationship based on compassion as described by Martin Buber.[7]

Motivational communication is becoming a popular topic in medical education at all levels from undergraduate to continuing professional development, and in many different spheres of medical practice. If you get a chance to participate in motivational communication training, I would highly recommend it: your patients will thank you.

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References

1. Thompson A. Use of Motivational Communication to Better Patient Outcomes. 6 February 2015. Available at : *www.rheumreports.com/?report=163&title=Using_Motivational_Communication_to_Better_Patient_Outcomes.&c=2015_CRA_AHPA&r=%2F%3Fc%3D2015_CRA_AHPA.*
2. Ferrell B. Ethical perspective in pain and suffering. Pain Manag Nurs 2005; 6(3):83-90.
3. Covey SR, Merrill AR, Merrill RR. Priorité aux priorités. New York, New York: Simon and Shuster. 1995.
4. Camerlain M, Richard N, Trasler T. L'art de la Science: communiquer aux patients. Perspectives du College Royal 2005; 2(3):12-4.
5. Doheny K. Rx for Better Health Care: Kindness and Compassion. Health Day: News for Healthier Living. 24 November 2014. Available at: *www.consumer.healthday.com/mental-health-information-25/emotional-disorder-news-228/rx-for-better-health-care-kindness-and-compassion-693888.html.*
6. Camerlain M. Communique l'espoir. L'Actualité Médicale 2006; 24:25-7.
7. Buber M. I and Thou. New York, New York: Free Press. 1971.
8. Camerlain M, Myhal G. Health Literacy: Bridging the Gap. The Canadian Journal of CME 2004; 68-73.
9. Kirby MJL. The Health of Canadians: The Federal Role. Final Report. Volume Six: Recommendations for Reform. October 2002. Available at: *www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm.*
10. Farley M. Compassionate Respect. A feminist Approach to Medical Ethics and Other Questions. 2002 Madeleva Lecture on Spirituality. Mahwah, New Jersey: Paulist Press. 2002.
11. Long LW. Communication and Motivation. Normal, Illinois: Illinois State University. 2000.
12. Deci EL, Ryan RM. Intrinsic Motivation and Self-Determination in Human Behavior. New York, New York: Plenum Press. 1985.
13. Prochaska JO, Norcross JC, DiClemente CC. Changing for Good: The Revolutionary Program That Explains the Six Stages...Six Stages of Change and Teaches You How to Free Yourself from Bad Habits. New York, New York: William Morrow. 1994.
14. Keele FJ, Lefevre JC, Kerns RD, et al. Understanding the adoption of arthritis self-management: stages of change profiles among arthritis patients. Pain 2000; 87(3):303-13.