

Conducting Quality Consultations in Pain Medicine



This document defines the standards to optimise specialist pain consultations. It also provides supplementary practical guidance to enhance the therapeutic value of the consultation.

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Risks of failure to implement these guidelines

Patient safety	Increased risk of clinical error
Quality	Reduced standards of care; Decreased patient satisfaction; Increased patient complaint
Workforce	Increased stress amongst clinicians

Introduction

The patient-clinician consultation is a core component of delivering effective clinical care. This interaction between patient and clinician underpins assessment and management and so will impact on healthcare outcome. Indeed, Pendleton et al describe the consultation as the central act of medicine¹.

This document defines the standards required to optimise specialist pain consultations. It also provides the practitioner with supplementary practical guidance to enhance the therapeutic value of the consultation. Evidence is drawn from relevant consultation models and from other original research literature where available.

These standards will not necessarily be achieved within a single consultation but may require delivery via a series of consultations. In a multidisciplinary team, some aspects of the assessment and management may be undertaken by other suitably trained members within the team.

Standards of care are based on the requirements stipulated in the General Medical Council (GMC) document *Good Medical Practice*² and the Faculty of Pain document *The Good Pain Medicine Specialist*³. The specialist pain practitioner should consider the current document in conjunction with these other supportive regulatory documents. The relevant Good Medical Practice standards set are signposted.

The pain consultation

Maguire, a leading clinical communication researcher, indicates that doctors with effective communication skills identify patients' problems more accurately. The patients adjust better psychologically and are more satisfied with their care⁴. Doctors with effective communication skills also have greater job satisfaction and less work related stress.

Patients referred with pain related problems typically have complex presentations which require a thorough understanding of the consultation process. The consultation typically proceeds within a biopsychosocial framework. Therefore, the assessment is not only biomedical but will explore relevant psychological and social aspects. The doctor's responsibilities will include adopting a patient-centred approach and facilitating a shared understanding of the pain presentation.

Whilst the main aim of this document is to set standards for clinical practice, it is hoped that it will stimulate interest in this core clinical area and foster further practitioner development. Maguire states that the opportunity to practice key communication skills and to receive constructive feedback of performance is essential⁴. This document provides a framework for professional development.

Aim of the consultation

The Good Pain Medicine Specialist document defines the following standard for acceptable

practice within the clinical consultation³. The pain specialist must assess the patient, taking into account the medical, psychological, cultural, ethnic and social influences on the experience of pain. He/she organises and reviews appropriate investigations and devises an individualised management plan, (if appropriate, in consultation with other team members). The current document builds on this definition.

Standards

The *Good Medical Practice* April 2013 and *The Good Pain Medicine Specialist* documents serve to underpin this current publication. In setting these acceptable standards, the terms 'you must' and 'you should' are defined in the same way as that described in the GMC *Good Medical Practice* document. 'You must' demonstrates an overriding principle whilst 'you should' pertains to the provision of an explanation of how you will meet the overriding principle. 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance. In some cases within the consultation process 'you should' will be aspirational in nature.

You must provide a good overall standard of care to your patients

- You must provide a good standard of practice and care as defined in the Faculty of Pain Medicine document: *The Good Pain Medicine Specialist*.
- You must always act in the best interest of the patient (GMC 1).
- You must be honest and trustworthy in all your communication with your patients (GMC 1, 31, 68).
- You must manage the consultation with care, sensitivity and integrity (GMC 33).
- You must treat patients as individuals and be respectful of their dignity and privacy (GMC 25, 47).
- You must recognise and work within your limits of knowledge and competence (GMC 7, 14, 68).
- You must always be honest about your experience, qualifications, current role and responsibilities (GMC 66).
- You must understand and maintain confidentiality as appropriate (GMC 50, 69).
- You must not discriminate against patients whatever their life choices and belief system (GMC 48, 59).
- You must not express your personal beliefs to patients in ways that may exploit their vulnerability or are likely to cause them distress (GMC 52, 54).
- You must consider the needs of disabled patients and should make reasonable adjustments

to your practice so they can receive care to meet their needs (GMC 60).

- You must keep up to date with guidelines and developments relevant to the speciality of pain (GMC 8).
- You must seek help from colleagues of an appropriate discipline when a problem arises outside your area of competence (GMC 16d).
- If the patient or carer asks for your registered name and/or GMC reference number, you must give this information to them (GMC 64).
- You must regularly evaluate and seek to improve the quality of your pain practice (GMC 8, 9, 13).
- You must recognise that consultations in patients with pain can be highly challenging, often requiring considerable clinical and communication skills.

You must adequately assess the patient

- You must adequately assess the patient, taking into account the complexity of each clinical presentation (GMC 15a). The duration of the consultation should allow the medical, psychological and social influences on the experience of pain to be evaluated where appropriate.
- You must be aware of the pain management needs of special patient groups incorporated within your area of practice.
- You should start capturing the patient's narrative accurately early in the interview process.
- You should undertake a comprehensive clinical history. As well as the more traditional biomedical aspects, the patient's individualised needs and perspectives should be considered. This may include their ideas, concerns and expectations.
- You should undertake a comprehensive medical history considering the following:
 - Pain history
 - Pain treatment history
 - Current medications
 - Associated medical conditions
 - Mental health history
 - Alcohol and illicit drug use
 - Allergies

- Reason for attendance
- You should undertake a basic psychosocial assessment based on patient needs considering the following:
 - Home environment and support structure
 - Other social support including carers
 - Relevant educational and employment details
 - Finance and benefit support
 - Social and leisure interests or activities
 - Emotional and psychological distress factors including legal issues
 - Impact of pain on quality of life
 - Other pre-existing risk factors for the development of chronic pain
- You must assess for suicide risk when appropriate and recruit expert help urgently when clinically indicated. This may include liaising with the patients' GP, liaison psychiatrist or mental health crisis team.
- You should assess the patients' level of function such as capacity to undertake activities of daily living.
- You should consider forming hypotheses about key interactions between different elements of the history.
- You must examine the patient when it is clinically indicated. You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation (GMC 15a, 17).
- You should identify any possible under-investigated or untreated underlying medical conditions and, where necessary, make adequate provision either through appropriate referral or action (GMC 15b).
- You must be attentive to other health care needs and manage or signpost appropriately (GMC 15c).

You must communicate effectively

Tasks and objectives:

- You must introduce yourself and others present. If the patient brings a third party you should

establish who they are and confirm that the patient gives consent to them being present.

- You must be welcoming and strive to establish a good rapport (GMC 46).
- You must listen to patients, respect their views about their health and respond honestly to their questions (GMC 31).
- You must communicate with patients and when appropriate with their carers' in a way that they can understand (GMC32).
- You should liaise with your organisation to help meet the patients' language and communication needs; including use of interpreters (GMC 32).
- You should consider pain in the wider context of suffering where applicable.

Behaviours and skills:

- You should have an understanding of some relevant theoretical models of consultation and apply these flexibly to maximise the therapeutic benefit of a consultation.
- You should be aware of your own feelings during a consultation and how these can impact on the consultation process.
- You should adopt helpful (evidence-based) interview behaviours e.g. summarising, elaborating, hypothesis forming.
- You should strive to recognise and manage difficulties that arise within the consultation, these may include; anger, bad news, collusion, guilt and denial.
- You should be familiar with and recognise unhelpful patient beliefs. These may include; catastrophic thinking, dualistic thinking, unhelpful beliefs about cause or treatment, avoidance beliefs and kinesiophobia.
- You should use questioning styles appropriately (open, directive, leading and closed).
- You should identify and act on major cues that arise within the consultation.
- You should be aware that specific consultation techniques may work well in one context but may be unsuccessful or have unexpected consequences in another.

Professional Development

- You must recognise that communication skills can be improved through training and continuing professional development (GMC 13).
- You should monitor and maintain your interview skills. This may involve courses, video or recordings, peer observation and review and patient feedback (GMC 9).

You must strive to adopt a shared decision making approach

- You must develop the skills to give patients the information they want or need to know in a way they can understand (GMC 32). This will include but not be exclusive to;
 - An explanation of their condition and its likely progression.
 - The options for investigation and treatment including the associated risks.
 - Discussion of uncertainties in the progress of their care.
 - Clarification of who is responsible for each aspect of patient care, and how information is shared among those who will be providing their care.
- You must encourage questions and allow time to listen to the concerns of patients, guardians, parents or carers, during consultations and before interventional procedures (GMC 31, 32).
- You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support (GMC 33).
- You must acknowledge and be honest about the limitations of available therapies (GMC 68).
- You must respect patients' ethnic and cultural diversity and appreciate how this may interact with patients' decisions about pain management options (GMC 59).
- You must develop the skills to facilitate shared decision-making in the clinic but respect the patient's ultimate right of self-determination given their capacity to do so (GMC 49, 51).
- You should be aware that the impact of perceived power imbalance within the consultation may impede patients communicating what is important for them.
- You should encourage patients to take an interest in their health and take action to improve and maintain it (GMC 51).
- You should establish the expectations of the individual patient. You should be skilled in using narratives to help inform you about patient expectations, their journey and how these give insight into their pain in the context of culture, personality and experience.
- You should begin a process to manage expectations.
- You should be aware of the links between expectation and outcome.
- You should strive to make reassurance effective when offered, by identifying and elaborating on patient anxieties and concerns.
- You should be aware that a patient's decision making preference may not remain constant over time.

- You should have a good understanding of the communication of risk.
- You should be aware of the 'hand on the door' phenomenon: that what is really troubling the patient may come out just as they are in the process of leaving. It is important to be vigilant and respond appropriately to such disclosures.

You must formulate an individualised management plan based on the best available evidence

- You must formulate an individualised management plan based on the best available evidence. This may take into account local, national or international guidelines and recommendations e.g. from the Faculty of Pain Medicine (FPM), The British Pain Society (BPS), The International Association for the Study of Pain (IASP) or other sources of evidence (e.g. Cochrane, Bandolier, NICE) (GMC 11, 16a, 16b).
- You must offer appropriate evidence-based therapies to alleviate pain where possible and in the patient's best interest and support the patient to manage distress (GMC 16).
- You must ensure that the patient understands the nature and purpose of any proposed treatment or investigation and any significant side effects associated with it, thereby enabling them to make an informed decision (GMC 49a).
- You must obtain appropriate informed consent for procedures or interventions (GMC 17). This requires reasonable steps taken to ensure that patients are aware of any risks that are material to them and informed of all reasonable alternative treatments. Consent will need to be tailored to the individual patient.
- You must adhere to the laws and codes of practice relevant to pain medicine, including controlled drug and driving legislation (GMC 12).
- You must prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (GMC 16a, 16b).
- You should advise the prescription of strong opioids for chronic non-cancer pain only after careful consideration. Therapy should be focused on agreed dosing regimens and treatment outcomes with a clear plan for monitoring of therapy including the circumstances where opioids should be stopped. These discussions need to be clearly documented (GMC 16a).
- You must not refuse or delay treatment that is clinically indicated because you believe that a patient's actions or lifestyle have contributed to their condition (GMC 57).
- You must encourage self-care strategies that are helpful when living with chronic pain and advise how these might be learnt (GMC 51a).

- You must consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (GMC 16d). You must ensure that continuing care of the patient has been arranged when necessary and that other healthcare workers and the patient are aware of these arrangements.
- You must ensure that patient care is only delegated to colleagues who have appropriate qualifications and competence (GMC 45).
- You must respect the patient's right to a second opinion (GMC 16e).
- You should keep patients informed about the progress of their care (GMC 49b).
- When working as a member of a multidisciplinary team you should ensure that members are aware of the management plan for relevant patients.
- You should communicate the pain management plan and/or outcome of therapy, in writing, to the patient's general practitioner, other healthcare professionals as appropriate, and to the patient.
- You should consider making 'safety netting' provision within your management plan. This will include a clear outline of expectations from treatment and define under what circumstances patients should re-consult for further advice.

You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession

- You must promote trust with the patient through courteous behaviour, honest discussions and respect for their right to privacy and dignity (GMC 31).
- You must understand and apply your local institution's guidelines on chaperoning policy
- You must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate (GMC 14).
- You must understand and apply the duty of candour (GMC 55). If a patient under your care has suffered harm or distress, you should follow your local organisational and GMC policy. You must be open and honest with patients and carers if things go wrong. This may include:
 - Putting matters right (if that is possible) (GMC 55a).
 - Ensure that an independent witness is present for the meeting.
 - Offer an apology (if appropriate) (GMC 55b).
 - Explain fully and promptly what has happened and the likely short-term and

- long-term effects (GMC 55c).
- Answer questions openly and honestly.
- Ensure that the incident and patient visit are documented fully in the pain management records.
- You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange (GMC 61).
- You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient (GMC 62).
- You should meet with carers or advocates by appointment when asked to do so, and with the patient's consent (GMC 33).
- You must not allow any interests you have to affect the way you prescribe for, treat or refer patients (GMC 78).
- If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making (GMC 79).
- You must not ask for or accept – from patients, relatives or carers any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients (GMC 80).

You must keep your patients safe

- You must take appropriate action if a patient has suffered harm through misadventure or for any other reason (GMC 25).
- You must contribute to and comply with organisational systems designed to protect patients (GMC 23).
- You must contribute to adverse event recognition.
- You must report adverse drug reactions.
- You must ensure that critical incidents are entered in the organisation incident reporting system.
- You must safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with cognitive impairment (GMC 25).
- You should be familiar with local safeguarding policies including those for vulnerable children

and adults (GMC 27).

- You must make sure that all colleagues, for whose performance you are responsible, including locums and students, are supervised appropriately (GMC 40).

You must provide adequate documentation

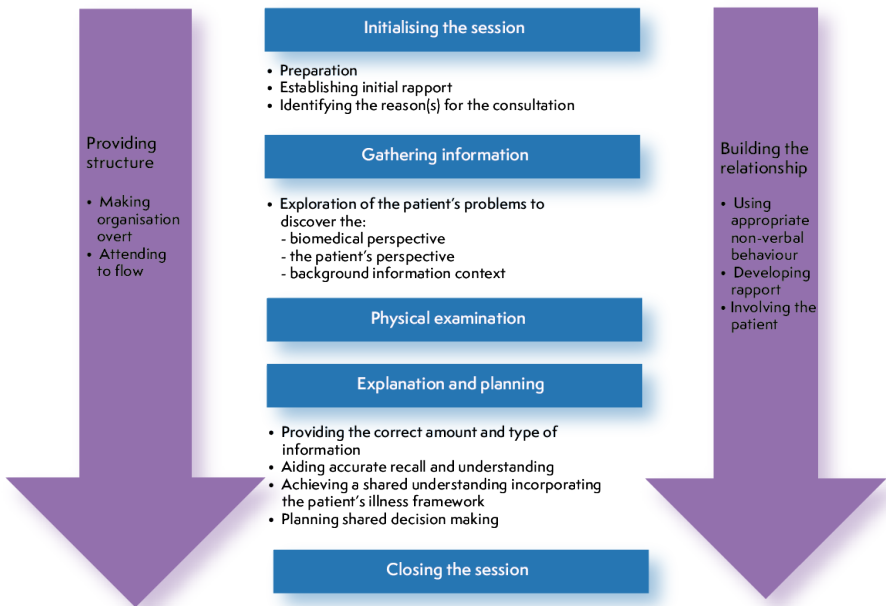
- Clinical record keeping must be clear, accurate, legible and up-to-date (GMC 19).
- You must make sure that any documents you write or sign are not false or misleading (GMC 71).
 - You must take reasonable steps to check the information is correct (GMC 71a).
 - You must not deliberately leave out relevant information (GMC 71b).
- When providing information for organisational systems designed to protect patients you should still respect patients' confidentiality (GMC 23, 50).
- Record keeping should be contemporaneous or undertaken as soon as possible after the consultation (GMC 19).
- Records must be kept securely, and in line with any data protection requirements (GMC 20).
- Clinical records should include (GMC 21);
 - Clinical history and any examination findings (when appropriate).
 - Diagnosis where relevant.
 - Information shared and discussed, decisions made and actions agreed with patient.
 - Investigation details and management plan including any onward referral.
 - Record signed and dated.
- You should ensure that the patient has appropriate written information about the agreed management plans including those relating to self-management.

Appendices

Conceptual models have been developed to facilitate health care consultations. Some of those most relevant to specialist pain consultations will be summarised and signposted here. This guidance is not designed to be prescriptive but rather to facilitate the development of a strategic model personalised to the clinician.

The Calgary Cambridge model ⁵

This is the most commonly taught consultation model within both undergraduate and postgraduate medical programmes. This allows a comprehensive integration of content, process and perceptual skills within the clinical interview. It addresses what the clinician communicates, how they develop the relationship as well as the internal decision making and attitudinal aspects. It promotes the communication needs between patient and clinician and aligns itself well with the biopsychosocial framework.



The Balint approach ⁶

Michael Balint was a psychoanalyst who nurtured the development of more psychologically aware physicians. His approach focused on the doctor-patient relationship where the therapeutic value of the doctor is recognised as well as the human interactions between patient and doctor. Useful concepts include the doctor's apostolic function: which describes consultation difficulties triggered by the clinician's tendency to have unrealistic expectations of the patient, based on their own personal values. The approach also explores the concepts of hidden agendas and the collusion of anonymity where patients will move from one specialist to another with no professional taking responsibility for the patient as a person.

Socratic questioning ⁷

Socratic questioning has been used effectively in both therapeutic and educational settings. Systematic, probing logic-driven questioning is used to explore the patient's knowledge or line of reasoning to help improve understanding and to enable their capacity to apply an analytical questioning approach to improve their own wellbeing. It can be utilised as a cognitive restructuring approach to explore the assumptions and evidence that underpin patients' beliefs about their pain problem.

Shared decision making model⁸

Shared decision making (SDM) has been gaining support within UK health care policy: including the document *Liberating the NHS: No decision about me, without me* (2012). SDM has been defined as: "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences". Elwyn et al have operationalised this approach into a 3 step model which includes introducing choice, describing options which can include integrating the use of patient decision support and thirdly helping patients explore preferences and make decisions.

Motivational Interviewing⁹

Motivational interviewing is well recognised amongst pain clinicians. Described by William R Miller, the focus is on motivational processes to bring about behavioural change. Motivational interviewing has recently been redefined as "a collaborative person-centred form of guiding to elicit and strengthen motivation for change." Ambivalence for change is managed by drawing out (described as evocation) the individual's own resources and commitment. Rollnick and Miller in their textbook of motivational interviewing also describe the "RULE":

Resist - "the righting reflex" i.e. directly challenging people not to do things will make them verbalise the reasons they do and thus become more entrenched as they listen to themselves speaking.

Understand - their motivations

Listen - good listening is a complex skill – it is not simply leaving gaps in your conversation

Empower - someone actively involved in discussion about the why and how of change is more likely to do something about it.

Patient Belief and Expectation¹⁰

These are key concepts within the consultation process. Their identification and management

will have an impact on the relationship as well as facilitating the effectiveness of the interaction. Chris Main and colleagues have explored these issues within the context of back pain consultations. They have suggested strategies for improving communication. These include an initial clarification of the patient's objectives for the consultation, establishing the therapeutic climate, enhancing non-verbal aspects, adopting patient-friendly terminology, facilitating self-disclosure and provision of simple explanation and realistic prognosis.

Self-management support¹¹

There is increasing focus on promoting self-management strategies; particularly with initiatives that nurture active participation and increased self-efficacy. These can impact positively on patient attitudes and behaviours, quality of life and efficient use of healthcare resources. The pain clinician should have a critical evidence-based understanding of general principles important in supporting self-management. These include shared decision making, proactive education, setting goals with review and helping people manage the social, emotional and physical impacts of their condition.

Useful consultation techniques¹²

The following are techniques that the clinician may consider in developing their individualised approach to each consultation. They have been contextualised for pain largely based on the work of Maguire.

- Understand the concept of different agendas: the patient and doctor.
- Develop detailed narrative.
- Ask evocative questions.
- Ask patient to outline the positives of a situation or thought.
- Use elaborative questions... "what else?.."
- Looking back or forward... "how were you then?..."; "how do you see your future?.."
- Explore values.
- Explore goals or mini-goals.
- Side-with the negative. "Perhaps, you are simply too busy to do a Pain Management Programme..."
- Affirmation: emphasising strengths... "your spine is strong.."
- Acknowledge: "I can see you feel very strongly about this. ..."

- Reflective listening. Consider the concept of reflexivity in the context of a consultation.
- Summarising back. “Let me summarise what you have said...”
- Distancing: “What would a friend/family say in answer to this question?”
- Actively solicit questions: invite patients to write down three questions in advance that they would like to ask you.

Consultation Analysis

There are a number of approaches that can be utilised to evaluate a clinician’s consultation skills since clinical experience alone is a suboptimal way of ensuring professional development. It is recommended that Pendleton’s rules are considered for consultation analysis feedback. Potential options for analysis include;

1. Observer in clinic.
2. Audio or video recording of the consultation and subsequent analysis.
3. Consultations described by physician after the consultation.
4. Role-play of consultations or scenario by professionals or with actors.

Consultation process measures¹³

Validated instruments have been constructed to evaluate aspects of the clinical encounter between patients and health care professionals. The Consultation and Relationship Empathy (CARE) questionnaire was developed to provide a patient-centred process measure of empathy in the therapeutic context of a one-to-one consultation. Originally this was developed for general practitioners but it has been successfully implemented by other health care professionals. A website has been constructed by the University of Stirling which allows practitioners to compare their own performance with their peers.

References

1. Pendleton D., Schofield T., Tate P., Havelock P. *The Consultation: An Approach to Learning and Teaching*. Oxford: OUP; 1984.
2. General Medical Council. *Good Medical Practice*; 2013.
3. Faculty of Pain Medicine. *The Good Pain Medicine Specialist*. 2022. Available from: <https://fpm.ac.uk/media/831>

4. Maguire P. Pitceathly C. Key communication skills and how to acquire them. *BMJ* 2002; 325: 697-700.
5. Silverman J. et al. *Skills for Communicating with Patients. 3rd edition.* Radcliffe Medical Press: Oxford; 2013.
6. Balint M. *The Doctor, his Patient and the Illness*, 2nd edition, Churchill Livingstone: Edinburgh; 2000.
7. Paul R. and Elder L. *The Art of Socratic Questioning.* Dillon Beach, CA: Foundation for Critical Thinking; 2006.
8. Elwyn G. Frosch D. Thomson R et al. Shared Decision Making: A Model for Clinical Practice. *J Gen Intern Med.* 2012; 27(10): 1361–1367.
9. Miller WR. Rollnick S. *Motivational Interviewing: Helping People Change.* 3rd ed. Guilford Press; 2012
10. Main CJ. Foster N. Buchbinder R. How important are back pain beliefs and expectations for satisfactory recovery from back pain? *Best Practice and Research Clinical Rheumatology.* 2010; 24; 219-225.
11. The Health Foundation. *Evidence: Helping people help themselves.* London; 2011.
12. Heaven C and Maguire P. *Assessing patients with cancer: The content, skills and process of assessment.* Cancer Research Campaign. Reprinted 1999. Website: www.caremeasure.org

Other useful resources

1. Petrie KJ. Frampton T. Large RG. Moss-Morris R et al. What Do Patients Expect From Their First Visit to a Pain Clinic? *Clinical Journal of Pain.* 2005; 21(4): 297-301.
2. Craig KD. The Social Communication Model of Pain. *Canadian Psychology.* 2009; 50(1): 22-32.
3. Charlton R. (Ed). *Learning to Consult.* Radcliffe Publishing: Oxford; 2007.



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