Images and the dynamics of pain consultations

In a London National Health Service pain clinic, a patient (whom we will call Sarah) gave the clinician a series of cards, one by one. Each of the cards carries an image that was cocreated by artist Deborah Padfield and patients with chronic pain to help represent individual patients‘ experiences of pain (figure 1). When she was waiting for her consultation, Sarah had looked through a large pack of these pain cards and selected a small number of cards to take into the consultation with her. As Sarah handed one of the pain cards (figure 2) to the clinician, the following interaction took place:

Sarah: “Um this has to do with my self-identity…”
Clinician: “Ah, okay.”
Sarah: “being worn away by always having to pain manage and knowing that I have an achy time.”
Clinician: “What about that one makes you think about your self-identity?”
Sarah: “Because that person’s face is burning off.”
Clinician: “Right, okay.”
Patient: “So for me that’s self-identity.”
Clinician: “That’s interesting, actually, because, um, I did some work with, I think it was her [points at the card], um, when doing this project, so it helps me identify with that as well.”

The image on the pain card could be interpreted in different ways. Sarah used it to disclose a sensitive and emotional aspect of the impact of the pain on her life: a sense of gradual loss of self-identity. The clinician gave responsive feedback throughout, asked for clarification, and then explained that her involvement with the previous phase of the project helps her “identify” with what Sarah is saying.

This kind of open, empathic interaction about pain and its consequences is not easy to achieve in a clinical consultation. There are many reasons for this. Time is short. The use of technology means that clinicians may spend more time looking at a screen than at the patient. Patients with chronic pain can find it difficult to express fully the character of their pain, and the effect of the pain on their own and others’ lives. Clinicians, meanwhile, spend less and less time gathering the patient’s history, and may not sufficiently value the personal stories that patients tell, or know how to respond to them. Yet, sensitive, successful interactions between patients and health-care professionals can contribute to diagnosis and to the identification of the most appropriate approach to care.

Sarah’s consultation seems to suggest that the pain cards opened up opportunities for expressing and acknowledging the emotional impact of chronic pain. Sarah was confident and articulate throughout the consultation, but she seemed to take more control and engage in greater emotional disclosure when she spelled out her reasons for choosing each of the cards. Does this happen with other patients too? As we reported at the Encountering Pain conference last year, we made a detailed analysis of the verbal and non-verbal behaviour of clinicians and patients in 38 pain consultations. Patients in 17 of the consultations made use of pain cards, and in 21 were not offered them. Patients came from the same referral base in consecutive years, and the two samples were similar in personal and medical details and in gender balance of the doctor-patient dyads. In the consultations involving the pain cards, we compared the parts of the interactions in which the cards were actively used with those in which they were not used. The pain cards seemed to encourage patients to speak more. Sarah and her clinician, for example, used roughly similar numbers of words when the cards were not being used. However, when the cards were brought into the interaction, Sarah spoke four times as much as the clinician.

This applies widely: all patients spoke proportionately more with the cards, and some patients spoke more than the clinicians when the image cards were used. When the cards were not used, we found that clinicians spoke more than the patients. Is there anything different about the language that is used around the pain cards? A computer-aided linguistic analysis suggested that there is. For example, patients used words such as “feel” and “feeling” more often when they were talking around the cards than without the cards. Those words were not only used to explain the quality of their pain (as in a “tight feeling just by my neck”) but also to reveal the emotional impact of the pain—for example, “I feel as if everything is coming apart”, “Sometimes I feel a gap between my family”, or “I feel lost, I don’t know what to do”. Clinicians also used words such as “feel” much more frequently with the cards, but, not surprisingly, they used them to validate or enquire about the patient’s experiences, including both physical sensations and emotions. For example, clinicians asked things like: “This is about how you feel frustrated and tense, yes?”; “So you feel a gap between, so you feel this, this generation gap yeah?”; or “You feel lost, or loss?”. Clinicians also used words that expressed positive evaluation more frequently around the cards, in response to patients’ reactions to the cards.

Non-verbal behaviour also seemed to be influenced by use of the pain cards. Clinicians showed more frequent affiliation behaviours—eye contact, nodding, smiling, leaning towards the patient, and a warm vocal tone—when the cards were available, particularly in interactions around the cards. For example, Sarah’s clinician moved her chair

towards her when the cards were introduced, and held each of the cards in turn. Unexpectedly, it was clinicians who showed more behavioural change than patients when the images were used in consultations, and they became more responsive to patients in their behaviour. We suggest that images could help patients to provide, and clinicians to hear, a fuller emotional account of the patient's unique pain experience, eliciting empathy in the clinician and building rapport between patient and doctor. The way the pain card influenced patients' and clinicians' use of language would seem to bear this out. But this is an area for further study: patients were neither selected into the image and no-image groups nor were they randomised, so we cannot say with certainty that there were no other differences between the two groups of patients that could have affected our results.
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Overall, the pain cards seemed to change the dynamics of the consultation in subtle but consistent ways. When using the cards, patients appeared to have more control of the interaction and disclosed more personal details, especially with respect to the emotional impact of pain on their lives. Meanwhile, clinicians provided more positive feedback, verbally and non-verbally, and behaved in ways that suggest a more equal relationship with patients.

All this work provides both opportunities and challenges for the future. Can the images truly lead to a more collaborative relationship in which patients become more active and involved in decision making? Could they increase patients' adherence to treatment plans by improving rapport and increasing trust with health-care professionals? Do clinicians have the resources, including time, to deal with greater disclosure about the impact of pain on patients' life and emotions? Would the use of images help bring more humanity to the clinical encounter—a need identified by Iona Heath, a former President of the UK Royal College of General Practitioners, when she called for "an injection of humanity" in medicine? We would encourage further study of any processes that enable patients to communicate better the emotional impact of their health problems, and that enable clinicians to hear—and feel—that impact, since this is so often identified as missing from medical consultations.

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Further reading

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Figure 1 The pain cards ©Deborah Padfield

Figure 2: Deborah Padfield with Nell Keddie from the series *perceptions of pain2001–2006*, silver gelatin print