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## Communication and Clinician Relationships to Improve Care for Patients With Chronic Pain

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### Introduction

In March 1927, Dr. Francis Peabody, Harvard Medical School educator and Boston surgeon, published a seminal article in the *Journal of the American Medical Association* with the oft-quoted maxim, “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”<sup>1</sup> Caring, by optimizing therapeutic relationships between clinicians and patients, has since been characterized as the practice of “patient-centered” medical care.<sup>2</sup> In 2001, patient-centered care was described by the National Academy of Medicine’s (formerly Institute of Medicine) *Crossing the Quality Chiasm: A New Health System for the 21st Century* as “respectful of and responsive to individual patient preferences, needs and values, and ensuring that patients’ values guide all clinical decisions.”<sup>3</sup> Patient-centered care consists of two essential components: 1) taking the patients’ perspective on their illness and their life and 2) activating the patient for self-care.<sup>4</sup> Both of these components are essential in the care of patients with chronic pain.

All clinically directed health care involves interpersonal interactions of patients with their treatment providing clinicians. So, why is this therapeutic relationship especially important in the context of caring for patients with chronic pain? Chronic pain, a biopsychosocial condition, by its very nature, includes more than just a straightforward communication of biomedical objective information. Unlike some other medical conditions, pain is not itself visible. Therefore individuals with chronic pain often struggle to have their condition recognized and legitimated. The comprehensive assessment and effective treatment of chronic pain also entails an understanding of its impact, so we must also understand our patients within the broader context of their pain experience and how they see themselves managing, or more likely struggling, with their persistent and intrusive painful sensations. This includes relationships with families and communities. It also includes managing home and work responsibilities and striving for life goals that offer meaning and purpose in their lives.

Hearing the patient identify personal goals of pain care and providing a space and an opportunity to comfortably disclose their beliefs and expectations and how it is that they *really feel* means that the management of patients with chronic pain requires a trusting relationship with a clinician. This type of relationship

requires communicating with patients in their own words and recognizing their behaviors from their unique perspectives, and also by acknowledging that their pain is “real.” Treatment relationships begin with therapeutically effective communication. This chapter will describe why empathic communication is especially important for chronic pain management, how a strong therapeutic alliance can improve chronic pain care outcomes, and what specific clinical competencies have been demonstrated to improve patient engagement in their treatment.

### Listening and Narrative Medicine

In 2010, Eloise Carr, RN PhD, a researcher studying patient experiences of chronic pain, recalled a patient’s statement: “Stop trying to cure me and start listening.”<sup>5</sup> Clearly, this individual’s prior experience of pain treatment did not include “being heard.” Being heard means being acknowledged. Being heard means being understood. Listening to the patient is fundamental to establishing the clinician-patient relationship.

However, *demonstrating* that you have listened and that you understand is another essential part. Check with your patient if you have understood their predicament with their pain. Restate what you have heard and ask the patient if you have it right. Acknowledge the pain and its impact on their life. When pain becomes chronic and therefore complex, objective physical exam findings, imaging, and laboratory studies are insufficient to capture the nature and effects of the illness for the patient. Patient self-reported pain intensity has long been a component of chronic pain evaluation.<sup>6</sup> But it is a gross oversimplification of a chronic illness and leaves many questions unanswered. In 2014, an undergraduate journalism major enrolled in an elective course titled “Pain” was asked, “What does 12/10 pain intensity mean?” He replied, “Maybe the patient is shouting.”<sup>7</sup> So, with a maximum score of “10” to rate an unimaginably severe pain experience, this “unheard” patient felt there was no other option than to increase the numeric volume to “12/10.” A patient who feels understood will be more likely to trust their provider, be more likely to follow suggested treatment recommendations, and be more satisfied with their care.

Communication begins with an *action*, such as a patient sending a message of distress, followed by an *interaction* whereby the

physician responds with a message of understanding, and a *trans-action*, such as commitments to a future course of action.<sup>8</sup> The style and techniques for effective listening will vary based on the differences of personality, temperament, and cultural and racial experiences of clinicians and their patients. Communication is also much like a dance since each partner strives to follow the other's cues. Although conversations with patients struggling with chronic pain do follow a classical choreography, it often requires a jazz-like improvisation.

Published recommendations now call for a wider range of questions beyond quantification of pain intensity, including interference with function, enjoyment of life, sleep, mood, treatment expectations, and goals.<sup>9</sup> Above all, patients want to tell the story of their pain, and they want to know that their clinicians have understood it. Chronic pain is experienced within an individual's unique life events, preformed and yet changeable social context, and subjective cognitive and emotional states.<sup>10</sup> Pain neuroscience researchers describe a so-called "dynamic pain connectome" based on fMRI evidence of "brain-wide network communication on multiple timescales," and that "attentional states are in constant fluctuation."<sup>11</sup> According to pain neuroimaging researcher Irene Tracey, "Pain is not a unitary thing, and no two pains are the same, even in the same individual."<sup>12</sup> Scientific medicine relies upon measurement to both diagnose and track treatment outcomes. Without specific biomarkers that can describe, record, measure, and track the variable and dynamic human experience of pain, validated patient reported outcome questionnaires are necessary.<sup>13</sup> So too is listening.

The biopsychosocial evaluation and treatment of chronic pain also depend upon an in-depth exploration of the patient's own beliefs and attributions, what *it is* they understand to be causing their pain and why it persists even after extensive biomedical evaluations and many treatments have been tried and failed. What does the patient believe to be the cause for their persistent pain? It may be that the cause for their pain has so far simply been missed. Why do they believe prior treatments have failed? It may be a conviction that their prior doctors just do not know, or worse, do not care. What are their worries? Often it is being told "*there is nothing left to be done*" or thinking, "*it's all in my head*." What might other family members and friends be thinking? Maybe "*I'm just making it up*," "*I'm a burden on everyone*," or "*I'm not someone they want to be with anymore*." What expectations will define a successful outcome? Maybe the doctor "*could do the correct surgery*," the "*right procedure*," or prescribe the "*best medication*" and everything would be how it was before their pain began. What else is going on in the patient's life? Might it be: "*All my time is spent finding a way to get better*," or "*Since nothing else matters but my pain, there's no point in planning ahead*"? What are the patient's own goals? It is important to know whether it is to become pain-free or if it is to be able to return to improved function and begin to recover their life. Since many pain treatments will require an effortful and patient-directed commitment to a range of behavior changes and self-management approaches, treatment will need to be tailored to the patient's perceived needs and hopes. Interpreting pain, function, and mood numeric ratings are, of course, important. For many complex chronic pain presentations, such as those more complex patients referred to pain specialists, much depends upon the patient's own story. Pain, a biopsychosocial condition, requires more than just the "medical story." Knowing how patients experience their pain requires effective patient-centered communication. The mystery is in the history.

## Clinician-Patient Relationships: Empathy and Therapeutic Alliance

Empathic listening to the patient's story using the techniques of "narrative medicine" is a long established approach to advance care and improve chronic illness treatment outcomes.<sup>14</sup> "Not only is diagnosis encoded in the narratives patients tell of symptoms but deep and therapeutically consequential understandings of the persons who bear symptoms are made possible in the course of hearing the narratives told of illness."<sup>15</sup> Intentional and directed attention to what our patients say, *active listening* is not merely kind and courteous but will increase the likelihood of a more effective treatment outcome. Effective communication explicitly acknowledges patients as persons: "The clinician must know the patient well enough to be able to answer the patient's question 'What would you do, if you were me?'"<sup>16</sup> Empathy is commonly described as the ability to understand the inner experiences of patients, to communicate this understanding, and to respond therapeutically.<sup>17</sup> Empathy is distinct from sympathy. Sympathy names the ability to feel someone else's emotions, especially by feeling sad about their misfortune. Empathy names the ability to understand other people's feelings as if we were having them ourselves.

Empathic listening and compassionate clinical care date to antiquity, long before medicine had developed as a scientific profession (e.g. Hippocrates, 5th century BCE: "Cure sometimes, treat often, comfort always"; Ovid, 1st century: "When the mind is ill at ease, the body is affected.") More recently, Abraham Verghese, physician and author of the widely acclaimed 2009 novel *Cutting for Stone*, wrote, "Tell us please, what treatment in an emergency is administered by ear? ... I met his gaze and I did not blink. 'Words of comfort' ..."<sup>18</sup> The same unblinking response applies to clinicians caring for patients with chronic pain, which for many patients represents an unrelenting emergency.

Modern scientific medicine has since elevated the role of clinical objectivity and technical competency. However, technical access to objective disease can displace empathic concern for what our patients tell us about their individual illness experience. This competing tension has reportedly led to an overall decline in empathy as trainees progress through medical school and residency training.<sup>19</sup> Efforts are underway in medical school curricula to improve medical student empathy and narrative competency,<sup>20,21</sup> but these efforts encounter competition for space in the crowded time to cover other crucial biomedical topics, technical competencies,<sup>22</sup> and other recommended pain topics.<sup>23</sup>

Empathy, in its most basic form, is described as "emotional contagion," characterized by unconscious state-matching (the contagious yawn!). Neuroimaging studies in humans,<sup>24</sup> and even electrophysiologic<sup>25</sup> and behavioral findings in rodents,<sup>26</sup> suggest that empathy for pain is evolutionarily conserved. Therefore we are hard-wired for empathic behavior; we need only harness this natural capacity to show that we understand our patients' feelings as if we were having them ourselves. The significance of empathy is even more striking in pain medicine since chronic pain is a complex social phenomenon that often leaves individuals with chronic pain socially isolated from family and friends and feeling misconceived and misunderstood by their doctors.<sup>27</sup> Neuroscience research has shown that social exclusion and physical pain also share neuroanatomic structures and functions.<sup>28</sup> The clinician has a unique opportunity to provide a "social buffer" that, even in the absence of any other intervention, may positively impact the patient's pain experience.

In a busy clinic setting, it is challenging to take adequate time to listen, sit down, look directly at our patients rather than their electronic health record, and not interrupt patients who may be attempting to understand our questions. However, it is possible to allow more time by scheduling longer or more frequent visits or by dedicating periodic visits to pain exclusively so as not to be distracted by the many other general health and preventative medicine concerns also needing attention. If such measures are not feasible, we can introduce even very brief breaks from our intensive data-gathering agenda to practice active listening. Look our patients in the eye; patients notice these actions, particularly those who have had a long history of feeling ignored. Listen without judgment and pay attention to nonverbal cues. Take a few moments to paraphrase what we have heard and demonstrate to our patient that they have been heard. If we fail to listen, patients may register negative feelings of clinicians' disinterest and disdain rather than empathic concern, in other words, "They don't want anything to do with you."<sup>29</sup> Hurried and tightly scheduled primary care and pain specialty practices are challenged by system-related (e.g. too little time<sup>30,31</sup>), patient-related (e.g. difficult communication,<sup>32</sup> particularly when opioid management is involved<sup>33</sup>), and physician-related barriers (e.g. compassion fatigue<sup>27</sup>) that may lead to reduced empathic behaviors. Empathic failure can reduce patient satisfaction and compliance with treatment guidelines, worsen clinical outcomes, reduce ratings of clinical competence, and increase burnout, medical-legal risk, and overall healthcare costs from excess diagnostic test expenditures.<sup>34</sup> Demonstrating empathy may also improve the accuracy of clinical decisions since pain related medical decision making is so often based on personal features and values of the patient that extend beyond objective medical evidence.<sup>35</sup>

## Expectations Influence Pain

The patient expectation of pain relief is among the leading causes of placebo analgesia and associated with many of the described psychological and neurophysiologic mechanisms of placebo response. Placebo analgesia response has been proposed to be a form of "top-down" conditioned modulation, an "evolutionary imperative to optimize the selection of future actions" in response to "bottom-up" peripheral pain sensations that may or may not represent potential bodily injury.<sup>36</sup> There is extensive literature on neurophysiologic and behavioral mechanisms of placebo analgesia studies, including several recent excellent reviews.<sup>37,38</sup> Nocebo response, the experience of a *negative* response to an otherwise inactive treatment, is also conditioned by expectations. Nocebo response can be predicted by prior lack of response, adverse events, or even negative outcomes following prior ineffective medication, behavioral health, physical therapy, or surgical treatments. Any time spent is well invested when patients better understand their condition, share expectations of their treatment, are provided clear instructions, and shared goals are communicated in advance of treatment delivery, whether it be medication, behavioral health interventions, physical therapy, or procedural management.<sup>39,40</sup>

Taking a step further, setting realistic expectations in advance of initiation of pain treatment "*-any treatment-*" would then be likely to predict more favorable treatment outcomes. Cheerfulness and unfounded optimism can lead to patient and clinician frustration and further disappointment when new or different treatment approaches are not met with immediate positive results. How can we determine what our patients expect? Since patient and physician expectations of pain treatments are frequently not aligned

(e.g. just temporary relief from local anesthetics, only modest response to a gabapentinoid or serotonin-norepinephrine reuptake inhibitor, or delayed benefit from cognitive behavior or physical therapies), it is important to understand what the patient expects treatment to accomplish and how long it may take to perceive benefits.<sup>41,42</sup> Favorable treatment outcomes can result as much from the pharmacologic activity of a drug, the technical precision of an interventional procedure, or the specific physical therapy modalities as from the clinicians' method of communication delivery. The nocebo response is also relevant. An otherwise potentially effective treatment that had been previously tried and "failed" because of minor initial side effects may have become unacceptable and indefinitely rejected by the patient. By establishing trust using empathic communication and acknowledging prior side effects, resetting expectations with a very gradual upward titration may find a prior unsuccessful treatment to be well tolerated and effective. Similarly, reframing "failed" behavioral health or physical therapy by explaining a clear rationale and establishing patient-centered goals may overcome prior objections. Being heard and being understood matters across all domains of chronic pain management. So, pain treatment outcomes—positively or negatively—will be significantly affected by what we say to our patients, how we say it, how it is understood, the confidence we have earned, and the overall quality of a shared therapeutic alliance.

## Patient-Centered, Shared Decision Making

Patient-centered, shared decision making is a widely advocated clinical practice intended to improve patient adherence, satisfaction, and clinical outcomes across many disciplines.<sup>43-45</sup> Based on the assumption that patients are experts in their own experience of disease, patient-centered care is especially relevant for the uniquely personal experience of chronic pain that is often biomedically invisible. Patient-centered means that the care has solicited and included the patient's personal goals of treatment. However, shared decision making in chronic pain treatment presents unique challenges since pain science remains poorly understood by both patients and many care providers and much depends upon self-motivated patient self-management activities (e.g. behavioral and physical therapies). This is, in contrast, to passively delivered drug administration and surgical treatments effective for many other common chronic medical conditions. In addition, non-opioid treatments and procedural interventions often provide less than hoped for pain relief and remain highly dependent on concurrent long-term patient commitment to behavioral, fitness, and lifestyle modifications. Furthermore, while opioids unquestionably provide significant relief for acute and perioperative pain, their effectiveness in chronic non-cancer pain is not proven for many commonly occurring pain conditions, and their side effects and management risks are significant.<sup>46</sup> Opioid prescribing for chronic pain does represent a challenge to patient-centered, shared decision making since it is the clinician, NOT the patient, who ultimately controls prescribing. Notably, published United States opioid guidelines for chronic pain recommend clinicians should "collaborate" and "*empathically* review benefits and risks..." and should *offer to work with the patient*.<sup>47</sup> Regardless, patient-centered shared decision in chronic pain remains important and possible.

An individual who understands why chronic pain persists despite normal tissue healing and who is knowledgeable about treatment risks and benefits is more capable of active participation in informed patient decision making. This will require time and

effort dedicated to straightforward patient-level education about basic neurobiology and neurophysiology of pain processing by the nervous system that is both accessible and understandable to be truly patient-centered. There have been increasing numbers of popular self-help books and online resources that can be recommended and may be helpful to support in-clinic pain education for patients and families.<sup>48–52</sup> Neuroscience education for patients with chronic musculoskeletal pain disorders has been demonstrated by physical therapists with a positive effect on pain, disability, catastrophizing, and physical performance.<sup>53</sup> Evidence also supports the benefits of neuroscience education in chronic low back<sup>54</sup> and spinal pain.<sup>55</sup> Even very brief in-clinic physician and/or nurse or social worker directed education followed by recommended online, in-print reading or audiobooks improves adherence to drug and non-drug treatments, engagement in self-motivated pain-relieving behaviors (e.g. exercise initiation, pacing, relaxation techniques), and compliance with referrals for behavioral counseling can be beneficial.

## Motivational Interviewing

Motivational interviewing (MI) is a well-established interview technique, initially developed as a systematic approach to engage patients in substance abuse treatment.<sup>56</sup> MI explores the gap between the patient's own aspirations for health behavior change and their current health behaviors. MI is intended to identify and develop patients' own motivations to change self-defeating behaviors. By exploring internal conflicts about the patient's values and behaviors, MI aims to uncover ambivalence about behavior change (e.g. physical exercise, sleep hygiene, medication, and healthcare seeking) and discover the patient's own motivations for change.<sup>57</sup> MI depends upon an active listening technique and a systematic and responsive approach to questioning intended to promote patient recognition of self-identified specific obstacles to achieving their own stated goals using their own words. MI is more applicable in difficult opioid prescribing situations than shared medical decision making since solicitation of the patient perspective is crucial, specifically the life goals and health aspirations that are part of an MI conversation. Although MI techniques have been most widely used in substance abuse care, they can be readily deployed in other aspects of pain medicine because engagement in self-management is essential if patients are to improve sleep, fitness, and diet. MI is directly linked to narrative pain management:

*Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued. People often get stuck, not because they fail to appreciate the downside of their situation, but because they feel at least two ways about it. The way out of that forest has to do with exploring and following what the person is experiencing and what, from his or her perspective, truly matters.<sup>58</sup>*

DiClemente and Velasquez frame the link between MI and the *stages of change* “through which people pass as they change a behavior.”<sup>59</sup> They also provide a very useful verbal script for pain clinicians: “How has your pain changed you as a person, or stopped you from growing, from moving forward?” Since chronic pain cannot be separated from the person who has it, the clinician's task is to engage the patient to become the agent of their own change.

MI may be particularly useful when introducing the option of tapering and discontinuing opioids and other controlled substances because many patients are ambivalent about continuing

on long-term opioid therapy and may benefit from MI techniques for patients to self-identify opioid related problems.<sup>60</sup> At times, MI can be effective in de-escalating difficult conversations, a well-recognized challenge in clinician-patient communication,<sup>32</sup> since the mere mention of de-prescribing medications can generate negative and confrontational interactions.

The use of a multidimensional tool at initial clinical assessment and then tracking change at every visit provides consistent opportunities to identify patient-reported outcomes (PRO) that are well suited to introduce specific domains for motivational change are especially valuable.<sup>13</sup> Though there are many ways to introduce MI into chronic pain conversations, eight PRO items measured by zero to ten numeric rating scales that are easily understood and have been very well accepted by patients can be used to facilitate the process. These include the three item PEG tool (i.e. pain intensity, pain interference with the enjoyment of life, pain interference with general activity),<sup>61</sup> two items about pain interference with sleep initiation and sleep maintenance, and the four item Patient Health Questionnaire (PHQ-4),<sup>62</sup> which assesses symptoms of anxiety and depression. At the initial visit, the clinician can review these items with patients asking them to identify which of these eight areas of their life they could possibly change. When pain intensity exceeds seven out of ten, a shared agreement can be developed when the status quo is not working. Other items can be viewed, and the clinician can seek shared agreement on which area they prefer to tackle first (e.g. poor quality of life, poor function, poor sleep, poor mood). Sleep disturbance is exceptionally common in chronic pain; nonpharmacologic options can be offered (e.g. sleep hygiene), and consider other potentially effective non-sedative hypnotic sleep medications (e.g. melatonin, low-dose tricyclic when appropriate). If patients choose to tackle general activity, possible ways to accomplish that (e.g. short walk, aquatic therapy, slow-paced targeted physical therapy) can be shared. Asking patients for their own interpretation of their outcomes by acknowledging that their time and effort are valued and that the information they shared will guide your shared treatment decisions. [Table 12.1](#) delineates a four step approach, modified from Lussier and Richard's step-wise “communication tips” for nonpain-related topics applicable for motivating patients with chronic pain to behavior change.<sup>57</sup> Reducing pain intensity is the least likely to change, a trailing indicator of success, and so clinicians should do their best to steer patients away from expecting a reduction in pain intensity as their first step goal.

**TABLE 12.1** Sample “Tips” for Motivating Patients to Change Behaviors to Improve Management of Chronic Pain

1. Is the status quo working?

Examples: “How does poor sleep/fitness /anxiety/depression/sedating or opioids medications affect your life?”

2. Is change possible?

“How do you think you might be able to get better sleep/become fitter/feel less depressed/take fewer pills?”

3. Can change happen?

“I see that you are now sleeping better/exercising more/seeing your therapist/taking fewer pills.”

4. Coach to sustain change

“How can you keep going with your sleep/fitness/therapy/medication taper plan?”

## Enhancing Clinician-Patient Relationships With a Collaborative Pain Care Model

Both pain experts and primary care providers often find it difficult to “be with” patients demonstrably suffering from chronic pain. Making this a satisfying line of work and avoiding burnout by working as a pain management *team* is very helpful. Incorporating a collaborative care model within multi-disciplinary pain management practice promotes improved communication by

### Summary: Putting It Into Practice

The long history of the healing arts is founded on communication, caring, and compassionate listening. Acknowledging patients by empathically listening to their stories, narratives, and medical history is key to effective communication. Being with and sitting alongside patients as conversation partners and lead with open-ended questions since a therapeutic alliance arises from two-way conversations. Affirmation of patient progress toward their goals is key to motivating patients to continue to engage in changes necessary to improve their lives in the face of pain. At times fear, anger, and tears may be unavoidable, yet consolation may require just your silent presence and behaviorally communicated empathy. A few words of comfort may be all that is necessary, an acknowledgment that they are not alone and that their pain and suffering are not misunderstood. Remember that empathy is the ability to *understand* other people’s feelings *as if* we were having them ourselves. However, they are not our feelings; they are theirs. A senior colleague from decades ago, recovering from protracted cancer treatment, once said, “It’s always better to be the doctor than the patient.” We are reminded of this when encountering a quagmire of anger and tears and then redirect this flood of emotions to deliberative clinically proven approaches that can offer some hope of relief and promote healing.

Ideally, a clinician’s practice setting is already set up as a collaborative care model and includes a team of interprofessional pain care providers so that a nurse care coordinator, clinical psychologist, or clinical social worker can step in to help, so you would have no need to run away from an upset patient, and instead to redirect care

### Key Points

- Management of chronic pain, a biopsychosocial condition, by its very nature, includes more than just a straightforward communication of biomedical objective information.
- Patient-centered chronic pain care consists of taking the patients’ perspective on their pain and activating the patient for self-care.
- Shared medical decision making aims to align therapeutic goals, improve patient treatment engagement, and support an agreed upon self-management plan.
- Narrative medicine communication skills such as empathic, reflective listening, and use of nonjudgmental language endeavor to strengthen clinician-patient therapeutic alliance, improve treatment acceptability and compliance, and increase patient and clinician satisfaction with pain care.
- Motivational interviewing (MI) challenges patient behaviors by contrasting these with patient aspirations. It can be used to change interfering behaviors such as poor sleep hygiene, insufficient exercise, inconsistent treatment adherence; and is particularly useful when tapering and discontinuing opioids and other controlled substances.
- A collaborative care model can improve communication by deploying an inter-disciplinary team who share the same understanding of the interacting biopsychosocial dimensions of chronic pain. This can reduce requirements for a medically trained pain expert to singlehandedly communicate and deliver all aspects of complex chronic pain care.

### Suggested Readings

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deploying a team of interprofessionals, who can then share the challenges and reduce the requirements for a medically trained pain expert to singlehandedly deliver emotional and social communication. A coordinated team of experts from multiple disciplines (e.g. medicine, psychology, physical therapy, social work, nursing, pharmacy), who share the same understanding of the interacting biopsychosocial dimensions of chronic pain, communicate effectively across their interprofessional competencies and keep *caring* for the patient as a common goal, will indeed have a positive impact on pain treatment outcomes.

temporarily to another qualified member of your pain care team. Although it is ideal to have an interprofessional pain care team embedded within one’s practice setting, when such a team is not available, an effective alternative is to maintain a readily available, vetted, updated, and shared list of other appropriate community-based clinicians knowledgeable, skilled, and interested in the collaborative chronic pain care of your patients. A physical therapist focused on sports medicine and postoperative orthopedic rehabilitation may be unhelpful or may even frighten patients away from exercise of any kind.<sup>53</sup> Similarly, a psychologist focused on insight alone or supportive counseling approaches may omit important cognitive and behavioral skills addressing negative thoughts about pain, goal-setting strategies for structured behavioral activation routines, and communication strategies around pain related difficulties, which have been shown to be particularly important.<sup>50</sup>

To successfully care for those who present after months to years of chronic pain, exhaustively evaluated, seen by many other clinicians over many years without alleviation of symptoms, with the stigma of “a chronic pain patient,” and without hope is no small challenge. To help to make a change in the lives of patients with chronic pain and to hear “thank you for giving me back my life” is a remarkably satisfying experience for patients, their families, and, of course, for clinicians. Improved communication skills that emphasize the patient perspective and leverage our natural empathic abilities can and do improve the care and outcomes for patients with chronic pain. Moreover, for successful pain clinicians, nothing is better than that.

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