Effective reassurance in primary care pain patients

Tamar Pincus
Royal Holloway University of London
What I’ll cover

• Reassurance- why does it matter?
• How to reassure patients
• The evidence
• A tentative model
Reassurance

• **reassurance removes the fears or doubts about pain/illness** - the effect is to comfort.

• **Reassurance always takes place within the dynamics of the interaction between the caregiver who has the intention to reduce worry, and the patient who is concerned.**

• **Ultimately, reassurance is achieved if the patient changes his/her behaviour, understanding or thoughts.**

• **The method of “reassurance”, on the other hand, is in the behaviour of the healthcare provider.**

  Linton et al., Pain, 2008
Reassurance as cornerstone in treatment

• “Provide the worker with **reassurance** about their individual concerns... Reassure the worker that low back pain usually resolves within a few weeks...”  *GL, Gov SA 2012*

• “The UK, US, Swiss, Finnish and Dutch guidelines recommend providing **reassurance** by explaining that there is nothing dangerous and that a rapid recovery can be expected”  *Eur guidelines, 2006*

• “It is important to **reassure** patients through adequate information instead of making them insecure by stating that ‘nothing was found’...”  *Swiss GL, 1998*
Other conditions

- Reassurance within the context of good practitioner-patient interaction has also been recommended for:
  - neck pain (Moffett & McClean 2006, Childs et al 2008)
  - irritable bowel syndrome (Khan & Chang, 2010)
  - Plantar fasciitis (Roxas, 2005)
  - tension-type headaches (Bendsten et al., 2010).
How to reassure patients:

- Acknowledging the pain of the patient
- Being supportive and avoiding negative messages.
- Give a full explanation in terms that the patient understands, for example, back pain is very common; although back pain is often recurrent, usually the outlook is very good; hurting does not mean harm; it could arise from various structures, such as muscles, discs, joints or ligaments.
- Core items of adequate information should be: good prognosis, no need for x-rays, no underlying serious pathology, and stay active. Consistency across professions is very important.

_Eur Guidelines for the management of non-specific acute LBP, 2006_
And always

• Be positive and optimistic about outcomes

• Sound confident

• Give the impression that you really know what you’re talking about and have seen it all before

Kessel, The Lancet, 1979
Does it work?

• Simple reassurance is perceived by patients as a dismissal of legitimate concerns and results in increased health-related anxiety.

• Providing a physical explanation can be perceived by patients as lack of understanding and undermining the legitimacy of their problem, which results in them asserting their complaints more forcefully.

• Informing patients that the problem is minor and they are likely to recover has also been shown to increase, rather than decrease worry.

Reassurance in the context of uncertainty

- Acknowledge the pain
- Being supportive and avoiding negative messages.
- Give a full explanation in terms that the patient understands,
- Core items of adequate information should be: good prognosis, no need for x-rays, no underlying serious pathology, and stay active.

- ‘Poor you! This is awful’ reinforces catastrophic thinking.
- In fact, there is evidence to suggest that practitioners are particularly bad at communicating with patients with non-specific pain (Gulbrandsen 2010).
- How to avoid accurate and correct negative messages?
- Mostly pain does come back.
- The consequences of false reassurance?
- How to give a full explanation about unknown causes, mechanisms and prognosis?
Despite the emphasis on providing reassurance to patients, what constitutes effective reassurance and how to deliver it remains one of the most neglected areas of research.
In the context of uncertainty about cause, prognosis and treatment, consultation-related factors are important for educating and reassuring patients, and improving self-management.

But not much is known on HOW to reassure patients.

We decided to focus on prospective cohorts to examine WHAT (which component) improved outcomes.
Method

• A literature search, systematic appraisal of study methodology, and narrative synthesis.

• Extracted information on the characteristics of patients and practitioners, pre-consultation baselines, follow up and components of consultations, outcomes and analysis methods.

• Carried out methodological assessment identified studies which measured and adjusted for baseline factors and measured outcome at follow up, rather than post consultation.
Inclusion criteria

• Populations: Adult groups attending primary care consultations with painful medical conditions, where:
  – Investigations are not indicated or have been negative
  – Self management rather than medical monitoring
  – E.g. LBP, IBS, fibromyalgia, unexplained chest pain...
• Or mixed clusters defined in the study as MUS.
• Or mixed clusters with large proportion of the above (> 50%)
• Explicitly measured consultation factors
Exclusion criteria

- Populations with disorders for which reassurance and subsequent health-related behaviour required regular testing, monitoring or interventions from health care providers, such as, diabetes, cancer, dental, rheumatoid arthritis, and psychiatric disorders.

- Studies where a majority of patient participants were aged under 18.

- Studies focusing exclusively on information leaflets, ordering tests and giving test results, prescriptions, duration rather than content of the consultation, continuity of care and practitioner demographic characteristics such as gender, age and ethnicity.
Scoping on PubMed and PsychInfo: 464 titles and abstracts read by two independent researchers

9 studies

Backward citation search of 464 hits in scoping: 4436 titles and abstracts read by two independent researchers, applying inclusion and exclusion criteria.

15 new articles

Forward citation search of 464 scoping hits: 3293 abstracts read by two independent researchers, applying inclusion and exclusion criteria.

7 new articles

Total studies for synthesis and model development: 8193 abstracts read, 35 publications, 31 studies identified
Methodological coding

- **Study participation:**
  Adequate description of sampling frame and recruitment, recruitment setting geographic location, description of inclusion and exclusion criteria, reported participation in the study by eligible individuals, individuals entering the study adequately described for key characteristics (e.g. presenting problems, gender, age, socio-economic status, education).

- **Study attrition:**
  Frequency of loss to follow-up from sample to study response <40%, or adequate comparison of baseline between participants who completed the study and those who did not.

- **Prognostic factor measurement (consultation factors)**
  Clear description of practitioners taking part (e.g. numbers, expertise, years of experience, gender); A clear definition or description of the consultation factors measured (e.g., duration of consultations, and clear specification of the method of measurement); adequate validity and reliability; Coders- independent double coding of transcriptions, audio-tapes etc.

- **Outcome measurement**
  A clear definition of the outcome of interest was provided, including duration of follow-up; measure and method report or refer to adequately validity and reliability.

- **Confounding measurement**
  Baseline measures of potential confounding variables which may impact both on consultation-factors and on patient outcomes (e.g. pain, disability, health status, expectations, duration of problem), measured with adequately validity and reliability, and accounted for in the analysis (i.e., appropriate adjustment).

- **Analysis**
  Used multivariate analysis, with adequate sample size for statistical analysis.

Adapted from Hayden, 2006
Results (no pooling)

• Satisfaction (n=25)
  ↑ information, explanation; ↓ unmet expectations.

• Clinical outcomes (n=16)
  ↑ positive approach from practitioner, met expectations. NS patients centred approaches (n=5).

• Health care utilization and adherence (n=8)
  ↑ expectations met, NS quality of communication, pt centred approaches.

• Psychological outcomes (n=10)
  ↑ patients active, patient centred, positive approach, expectations met, seeking and receiving information.
  ↓ simple reassurance
Summary of Findings

• We identified 31 prospective observational studies (10 with strong methodology) that examined the impact of consultation-related factors on outcomes in patients presenting in primary care with a variety of non-specific pain conditions.

• The majority of studies were in heterogeneous groups, and there is insufficient findings for non-specific pain conditions.

• The evidence is limited, but it suggests that eliciting and addressing patients’ expectations, having a positive attitude and involving patients in the consultation improves outcomes.

• There was contradictory or insufficient evidence for other factors, such as practitioner style, and empathic communication.

• There was insufficient or contradictory evidence for request fulfilment for tests, referrals and medication prescription (which fits with recent reviews of excluded studies).

• Most common and predictive expectations were for a diagnosis, explanation and prognosis.

• But clinicians expressing uncertainly reduced patients’ reassurance- a positive approach improved outcomes.
Some tentative thoughts about reassurance

Affective reassurance

• I can see that you’ve been suffering
• I am really listening
• I really understand
• I really care
• You can rely on me to help
• I know what I’m talking about
• It’s going to be alright

Cognitive reassurance

• Here is an explanation which I think fits what you’ve described
• Here is what I propose we do
• Here is what I think might happen in the future
• Here is what you can do about it
Effective Reassurance in LBP

Pre-Consultation

Practitioner Characteristics
- Self, characteristics
- Orientation
- Perceived role
- Patients-related beliefs
- Work related factors

History & Examination

Emotional Reassurance (Caring)
- Explore Symptoms
- Establish empathy / rapport
- Elicit concerns / feelings
- Elicit illness perceptions / causal attributions
- Explore expectations, diagnosis / treatment
- Recognise / respond to distress cues
- Psychological support

Trust

Treatment & Advice

Cognitive Reassurance (Educating)
- Back pain info (target pts perception)
- Agree goals
- Negotiate treatment options
- Discuss prognosis and future care
- Advise intervention
- Check understanding
- Discuss obstacles
- Summarise final plan
- Give take-away info

Post Consultation

Immediate Outcomes

Satisfaction
- Perceived Knowledge
- Perceived Support
- Trust in practitioner
- Reduced anxiety
- Change in illness perceptions
- Enhanced self-efficacy

Medium Term Outcomes

- Compliance
- Better management of symptoms / impact
- Acceptance
- Coping with relapse
- Appropriate further consultation

Long Term outcomes

- Improved health
- Reduced impact of health problems on life
- Reduced health care utilisation

Patient Factors

Psychosocial Factors
- Previous experience
- Education & Knowledge
- General health & fitness
- Pain & Function
Where next?

- There is a need for a large inception prospective cohort
- Of patients with acute non-specific pain conditions (or single conditions)
- Explicitly measures components of patient-practitioner interactions
- Measures short and long term outcome
- While accounting for known predictors measured at baseline (pre consultation)
Sure, that’s sounds easy, lets go!
Thank you!

• My collaborators-

• To you!