When Pain Can be Managed by Managing the Communication: An Analysis of Patient Feedback on Clinicians' Pain Management Strategies

Justin Velten
The University of Texas at Tyler
jvelten@uttyler.edu

Rauf Arif
Texas Tech University
raufarif@yahoo.com

Wyley McCoy
Christus Trinity Mother Frances Hospital
wyley.mccoy@tmfhc.org

Abstract

With advancements in the healthcare sector, human beings not only tend to live longer lives as compared to their ancestors, but also value quality of life in every stage. In the healthcare business, one important aspect leading to a high quality of life is the need to manage pain among patients either with chronic or short-term conditions and there is a wealth of literature addressing this prolongation of life and the quality thereof. There is a gap in the literature, however, in that these studies typically place the role of healthcare practitioner interpersonal communication competence as of peripheral importance in the process of pain management. This study utilizes a HCAHPS mixed-methods approach within the hospital setting to assess the importance of interpersonal communication in generating positive patient perceptions regarding healthcare providers' management of pain. Results of this 12 month mixed-methods study indicate that healthcare setting interpersonal communication effectiveness is a leading factor in patient perceptions of pain management, even greater than the administration of pain medication.

Key Words: HCAHPS, pain management, interpersonal communication competence.

Introduction

A wealth of literature regarding healthcare deals with the prolongation of life and has led to an increase in the average American life span. Recent research has transitioned to a focus on patient quality, rather than quantity, of life. Within these studies lay a common theme regarding the role of medication in the provision of healthcare. However, there is less focus on the important role interpersonal communication plays in the patient satisfaction in healthcare providers' efforts to improve patient quality of life. This is not to say that competencies in interpersonal communication can or should replace the use of medications, but communication between healthcare provider and patient plays a significant role in the perception of patient care and pain management.

Aim of the Study

Past studies have expressed a minimal interest in the role of communication in healthcare pain management, viewing communication between the practitioner and patient as merely peripheral. We posit that interpersonal communication plays a more central role in creating positive patient perception of practitioner pain management. Thus, the purpose of this study is to shift the focus of pain management from medication-only to more readily recognize the role of interpersonal communication in the process of patient pain management. Within the field of communication, ventures aimed at a better understanding of the role of communication in the healthcare sector are ever relevant. This study offers a robust and in-depth mixed methods approach to garner knowledge as the

partnership between healthcare and communication continues to flourish.

Review of the Literature

With the advancements in healthcare sector, human beings not only tend to live longer lives as compared to their ancestors, but also value quality life in every stage of their life spans. In the healthcare business, one important aspect to lead a quality life is the need to manage pain among patients either with chronic or short-term conditions. There have been several studies conducted in the recent years with an aim to improve and device new strategies in the field of pain management. This section of our investigation spotlights some of the influential studies in the field, which will help us better understand issues and challenges related to pain management, besides providing us an opportunity to move forward with devising new strategies and avenues to look into this important area of research.

During a review of the literature on pain management, we observed that some of the researchers urge for more attention to the perception of pain in everyday healthcare systems (Carolyn, 2010). Others simply place blame on the lack of healthcare provider empathy as a root cause of the problem in managing pain. Banja (2008) argues that the power relationship between a doctor and a patient may lead to certain hurdles in pain management. If a patient is complaining a lot, or is rude, or questions a doctor's treatment, a doctor may lose the empathy toward the patient.

Other researchers believe that asking the right question about pain based on a patient's physiological and psychological needs and history may improve overall pain management results (Barkin, 2010). Going one step further, Barkinsuggests that listening to patients is not only the answer, but clinicians should pay equal amount of attention to those who accompany the patient (i.e. family):

> Clinicians must know the right questions to ask when reviewing the patient's medical, surgical, and psychiatric history, but they must also be able to listen carefully to the patient's responses and to those who accompany the patient. Clinicians must know the right questions to ask when reviewing the patient's medical, surgical, and psychiatric history, but they must also be able to listen carefully to the patient's responses and to those who accompany the patient.

Challenging the typical 10-point rating scale, Barkin adds that the assessment of pain should go far beyond the scale by necessitating "ongoing bilateral communication between the pharmacist and the prescriber(s) to ensure adequate pain control while reducing the risk of adverse effects and medication misuse, abuse, or diversion" (p.11).

Canaday (2009) blames miscommunication as one of the factors that hinders effective pain management treatments, stating, "Communication between the patient, pharmacist, and prescribing physician is essential to avoid misunderstandings and prevent inappropriate medication use" (p. 44). Some researchers, however, shift the focus of pain management debate from clinicians and pharmacist perspective to patients' perspective (McHugh, 2001). According to Clarke and Iphofen (2008), there is plenty of evidence that patients with chronic pain complain that they feel their caregivers do not believe them. The researchers argue that healthcare professionals can show they believe patients by adopting simple means such as active listening and being non-judgmental.

Gender consideration is another important factor that gets ignored in the debate of pain management. For example Frantsve and Kerns (2007) point to the fact that female patients may face additional challenges when communicating their pain concerns with providers. They suggest that collaborative treatment decision-making might help improve overall pain management. Not only gender, but racial and ethnic factors may contribute significantly in the overall pain care experience. A study by Green et al. (2003) argues that pain has significant socioeconomic, health, and quality-of-life implications, and the evidence suggests that racial and ethnic minorities tend to be undertreated for pain when compared with non-minorities. The study emphasizes the need for improved training for healthcare providers in order to mitigate these challenges.

Even though none of these studies specifically reviewed the role of communication in pain management, they do imply that communication remains an important factor to be considered while devising strategies in pain management. For example, some researchers call communication issues a misperception of pain, while others describe it as a lack of empathy, urging for considering race, gender and ethnicity in order to ask the right questions. Looking carefully, one can observe that all these considerations involve communication as a central, not peripheral issue to consider. That is why this investigation aims at studying the role of communication in pain management as the most important aspect of pain management. It is imperative that healthcare providers develop strong interpersonal communication competence in order to positively affect patient perceptions of pain management.

Interpersonal Communication Competence

Interpersonal communication competence refers to one's knowledge of and ability to enact a variety of communication tactics dependent on the situation or context. The more one is able to interpret the situation accurately and utilize the appropriate corresponding interpersonal communication skills, the more competent he or she may be perceived (Hample, 2005). There is an array of interpersonal communication competencies, including cognitive complexity (Burleson & Caplan, 1998), level of skill in behavior performance (Burleson, 2007), empathy (Wiemann & Backlund, 1980; Lakey & Canary, 2002), ability to self-monitor (Spitzberg & Cupach, 1981; Vangelisti & Daughton, 1994), and commitment or level of care regarding the relationship (Hart, Carlson, & Eadie, 1980) to name a few.

Spitzberg and Cupach's (1984) foundational model of interpersonal communication competence involves the three major components of motivation, knowledge, and skills. For purposes of this study we hope to focus on interpersonal communication skills and the effectiveness of skills training, which Kealey (2015) and Spitzberg (2015) claim incorporates the subset of intercultural communication competence. Healthcare providers can increase patient and family perceptions of his or her interpersonal communication competency through efforts to increase empathy, improve self-monitoring, and implementing the appropriate communication style in each situation (Litchfield & Johsdottir, 2008; Donaldson & Crowley, 1978).

The past decades have seen a thrust within healthcare to provide a more structured approach that encompasses and strengthens interpersonal interaction between the healthcare provider, patient, and family members (Alligood, 2010; Ritter-Teitel, 2002). There remains a continual challenge for healthcare providers to view patients as people first and patients second. It is within this paradigm that providers are able to make sense of their role of caregiver through the lense of interpersonal communication competence skills (Greene et al., 2012; Zolnierek, 2013) in what Kim (2010) refers to as the healthcare metaparadigm. In such, providers must focus on empathy and the development of interpesonal relationships with patients as a foremost responsibility (Clark, 2010; Crowe, 2000; Wager & Whaite, 2010). When interpersonal communication skills are practiced proficiently, provider and patient enter into an interpersonal relationship through what Ruesch (1961) deemed "therapeutic communication" (Doheny et al., 2007).

Interpersonal Perception

When a healthcare provider enters a hospital room to care for a patient, both the patient and his or her present family and friends immediately begin to judge based on perceptions. The process of building perceptions involves selection, organization, and interpretation. We develop judgments regarding social roles after selecting on what to focus (caregiver's behavior), deciding if this behavior fits social norms by building expectations about the caregiver based on stereotypes, and organizing and making sense of the person's interaction with the patient in the given context (Swann, 1984)

In such, we use attribution to help us understand the behavior of the healthcare provider, which in turns helps us rationalize what we have observed (Kelley, 1967). This process of buildling and understanding perceptions through attribution does not always provide an accurate picture. Ross (1977) noted that in some cases we tend to attribute a person's less than attractive behaviors as due to their internal characteristics rather than external factors. Therefore, perception-building of healthcare providers must take into consideration their respective external stimuli, including their responsibilities.

For example, when a nurse enters the room of a patient, he or she will immediately view the patient, but may not physically stop to speak with the patient prior to checking monitors and adjusting IV tubing. Onlookers, typically family and friends, can falsely attribute this behavior to a lack of concern for the patient when in reality the nurse is carefully listening to the patient speak and monitoring vital signs at the same time. In this scenario, the nurse is practicing his or her professional healthcare skills so far as they relate to keeping a person alive, yet is failing the fulfillment of his or her role by not managing patient-perceptions through the mastering of effective intepersonal communication skills.

Relativity

Pain rating scales have provided health care providers with a somewhat accurate depiction of patient pain, however there is still room for improvement as the many intricacies of healthcare require differing scales (Breivik, et al., 2008). The overarching challenge of describing pain is the assumption that if we visit a hospital, we typically assume our pain must be at a peak of severity. This is not always the case as individuals enter healthcare establishments with less painful injuries or a prolonged injury that, though still very serious, has become commonplace in one's daily routine. In order to counter this phenomenon, healthcare providers utilize

pain scales when attempting to better understand a patient's level of pain.

Moreover, pain scales work with patient tendencies to overexaggerate pain by providing a form of relativity. Relative language allows communicators to explain a situation as it compares to another (Adler & Proctor III, 2014). Through the use of relative language, we are able to more accurately explain our perceived level of pain (Prentice, 2005). It is imperative that the healthcare provider assist the patient in understanding the pain scale so that not every patient with a sore hand claims 10/10 on the scale. Instead, patients learn that their pain is greater than that of a sprained ankle (4/10) and less than that of a lacerated finger (7/10), which assists healthcare providers with establishing more accurate diagnoses and care. Therefore, our following research questions are primarily focused on investigating the need for the role of communication at multiple levels of the pain management process.

Research Questions

RQ1: What is the role of communication in managing pain?

RQ 2: In what ways does patient perception of quality in interpersonal interaction affect perceptions of pain management?

Hypothesis: Communication within the healthcare context influences post – experience patient HCAHPS scores regarding perceptions of pain management.

Methods

This study utilizes a mixed-methods approach by way of a standardized assessment methodology that incorporates both empirical and qualitative data collection. For purposes of this study, patient feedback was solicited via Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores regarding pain management. The HCAHPS initiative uses a standardized survey instrument and data collection methodology for measuring patient perspectives on hospital care (Hospital Consumer Assessment of Healthcare Providers and Systems, 2015). This study utilizes already collected quantitative and qualitative data regarding pain management from discharged patients. This study focused on two specific questions regarding how the pain was managed and how much the hospital staff appeared to provide for a patient's pain over the course of a calendar year. As many as 1,773 participants (approx. 147/month) completed the survey for question number one and 1,778 (approx. 147/month) completed for the second question.

Procedures

This study was conducted in partnership with a Southwestern United States hospital. Operating six hospitals and 36 health clinics in North, Central, and Northeast Texas, this hospital conglomerate is a significant provider of healthcare to a large population. As the largest multi-specialty healthcare group in its area of Texas, this hospital has over 300 healthcare providers in 38 specialities throughout its network.

With 474 beds, this hospital is placed it within the HCAHPS category of *large hospital*, which includes all hospitals over 450 beds. The hospital currently holds a 73 percenton pain management scores, while the national average is only 71 percent and an overall hospital rating of 79 percent, while the national average is at 71 percent. These scores become especially important for hospitals for two reasons. First of all, the federal government provides medicare funding to hospitals based largely on these externally appropriated scores that influence the hospital's percentile ranking as they relate to similar hospitals. Secondly, these scores are important because consumers can easily access hospital scores via medicare.org, allowing the consumer to compare hospitals in his or her area and choose which one they would like to visit.

Due to the importance of HCAHPS scores on hospital federal funding, hospital administrators launch a work group to initiate pain management tactics that might increase patient perceptions of pain management, thus increasing HCAHPS scores regarding pain management. This work group first met in the Fall of 2014, one year prior to the collection of data, allowing the work group time to create and integrate pain management strategies across their healthcare system.

HCAHPS scores are calculated by way of patient perception surveys collected from a randomized portion of post-hospital stay patients. These surveys are sent and collected via mail and include a list of questions followed by a section where patients can write in additional comments. It is important to note here that in some cases, patient family and/or friends complete these surveys on behalf of the patient. During these continual meetings of the hospital work group, nurses, doctors, and administrators continually monitored HCAHPS scores to garner knowledge of any change in patient perceptions regarding pain management.

One of the first steps this work group took involved educational sessions with healthcare practitioners (nurses and doctors) to create a better understanding of the analgesic guide and the pain menu. More specifically, admnistrators ensured doctors were aware of alternative methods of pain management and how to assist patients in better understanding how to

describe their pain through the pain menu. In turn, healthcare providers spent more time with each patient, making sure he or she understood that there was more than one method available regarding the implementation of their pain management strategy.

Healthcare providers were also encouraged to and implemented strategies to increase their transparency with patients through open communication and to increase the amount of time they spent with each patient. For example, once patient pain levels were discussed, the practioner would clearly state that it is going to take some time for him or her to get the medication order in and for the hospital pharmacy to get the medication to the nurse's station and then for the nurse to bring the meds to the patient. The practioner would then, instead of just walking out, ask if he or she could provide anything during this wait that could create a more comfortable atmosphere for the patient (i.e. warm compress or an extra pillow).

Data Collection and Analysis

Instrument

Quantitative and qualitative data was collected via Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, a nationally standardized method of healthcare assessment used by the federal government in the process of funding allocation. This 32 questions survey provides hospitals and patients with information regarding overall hospital quality of care. Of the 32 survey questions, this study focused on the two dealing with pain management. The first question asked if patient pain was managed while at the hospital and the second question asks if hospital staff did everything they could to minimize pain. These questions are administered via a randomly assigned post-discharge mail survey and data is collected to ensure confidentiality via the Press Ganeycorporation. When compiled, results from these two questions provide hospital administrators information regarding the hospital's overall pain management proficiency.

Questions are asked on a likert scale and patients must rank the hospital as *always* caring for specific needs in order for the hospital to receive credit. Customer service surveys provide hospital administrators quantitative and qualitative data, known as HCAHPS scores. This data that both help administrators understand their patient scorings on a scale of zero to 100 in specific area and ranking percentiles to comparative hospitals. Quantitative scores are then made available via medicare.org for public information and hospital rankings.

Results

Results of this study indicate that when appropriate communication skills are utilized in the healthcare setting, patient perception of pain management changes. Moreover, from figures one and two, it is evident that there was a significant increase in patient perceptions of pain management provided by the hospital.

Figure 1 *Depiction of Pain Management Scores across One Year: Regarding Question One*

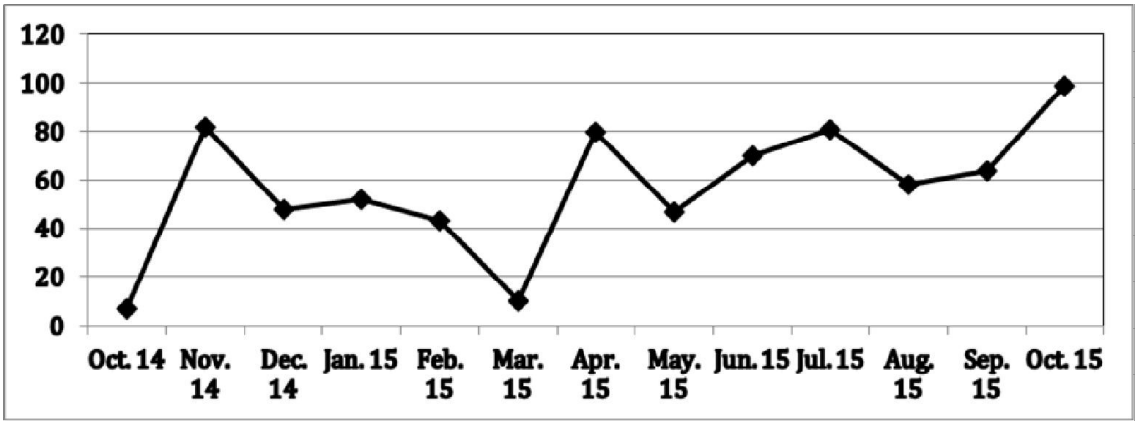
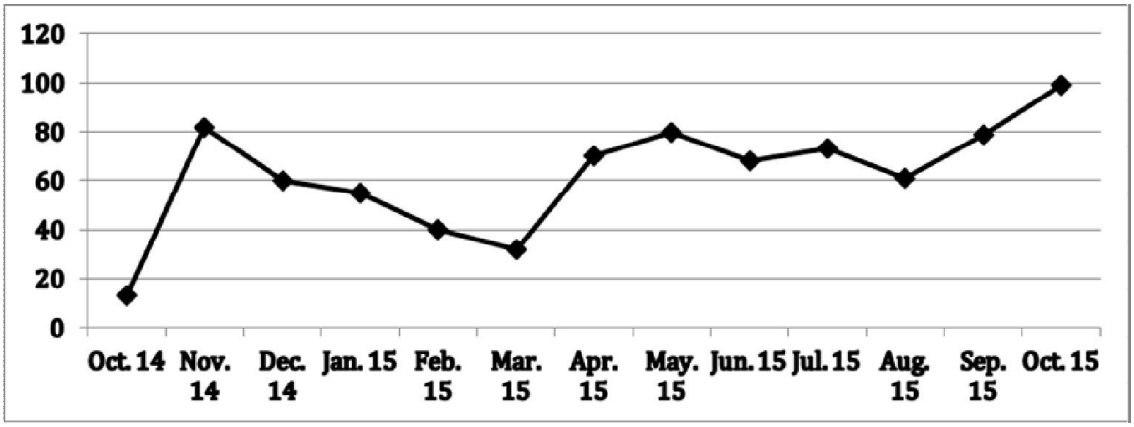


Figure 2 *Depiction of Pain Management Scores across One Year: Regarding Question Two*



Results depict a gradual increase in overall hospital pain management scores over the course of one year. Within the period of just over a year, scores for question one went from seven to 99 and 13 to 99 for question two. It is also apparent from the quantitative results that pain management scores did not consistently climb across this period. During a *post hoc* interview with a hospital administrator, it was revealed that during early spring, when the dip in scores occurred, there was a hospital-wide issue with a shortage of nursing staff. It is assumed that pain management scores may have reflected the fact that the hospital maintained the same number of patients during a period of less nursing staff. A second potential reason for dip in the scores at this time is that the hospital was closing a portion that is only used temporarily during a peak in hospital occupancy. Once this season has ended, the hospital's protocol is to move patients from the overflow area back to traditional rooms, which can create patient dissatisfaction.

Discussion and Conclusion

Health communication research typically focuses on communication between the practitioner and patient. However, patient rooms are typically filled with family and friends who can, at times, better relay information to the healthcare providers. This study considers the practitioner's interpersonal communication competence and its role in creating an atmosphere of trust and confidence where both patient and his or her family/friends share a sense of satisfaction in pain management.

Communication plays a significant role not only in our everyday lives, but also is vital to our healthy life styles. In fact, in everyday patient-doctor relationship, the level of communication that takes place between the two parties determines the overall hegemony of this partnership. Thus, any chances of lack of communication or even miscommunication may adversely affect the overall perception of cure, but also such scenarios can result in distrust and skepticism of the treatments being suggested by the healthcare providers.

During the analysis of the data, particularly the qualitative responses of discharged patients, it was observed that some of the important communication-related themes kept emerging. Participant responses centered on terms such as care, attention, respect, and caregiver disposition to name a few. Excluding only two comments regarding specific cases of tangible pain medication issues, all comments focused instead on care from the interpersonal communication perspective. In other words, positive communication earned positive feedback and negative interpersonal interactions garnered the opposite perceptions of pain management. A positive trend was discovered dictating that positive interpersonal interactions between healthcare provider and patient led to positive patient perceptions of pain management and vice versa, thus supporting our hypothesis that communication within the healthcare context influences post–experience patient HCAHPS scores regarding perceptions of pain management. The implications of this study place high importance on interpersonal communication skills development in healthcare if hospitals wish to raise HCAHPS scores. For the purpose of simplicity, thematic content is fleshed out below.

Listening as an Interpersonal Communication Competence

The findings of this study suggest that patients who responded to their pain management question as *always* were of the view that healthcare practitioners including nursing staff paid special attention and listened for their problem carefully before recommending a pain

medication. This aspect of listening carefully significantly improved patients' confidence in the treatment that was provided to them while in the hospital. As we have already discussed in the literature review that in an interpersonal communication, listening remains the most important competence because it implies that the listener cares about you. We suggest that the whole idea of caring and curing goes hand in hand. Thus, hospitals that are interested in improving their pain management scores should also improve the overall quality of interpersonal communication skills of their healthcare providers. More attention should be paid and more resources should be allocated in organizing such training programs that cater to the ability of healthcare professionals not only to be better listeners, but also to pretend that they are paying special attention to patient needs while trying to minimize pain.

According to Velten (2011), anxiety regarding stimuli is lessened when those in positions of authority emanate immediacy behaviors, such as calling someone by their name, listening, and showing genuine concern. The current study echoes these findings, reinforcing the importance of listening in interpersonal relationship comfort. When patients do not feel heard, they automatically assume the caregiver does not in fact care. Such patients noted, "no one listen to my health concern", "I was invisible patient … Left emotionally frustrated".

Conversely, patients who perceived attention from healthcare providers judged their hospital stay positively, noting "everyone in that hospital was very nice helping you, listen to you". This was especially true when healthcare providers went the extra step of listening to, remembering, and using patient names, as one patient noted, "They didn't treat me like a number. They used my name every time". Herein, an automatic bond was created between patient and caregiver simply through the use of the patient's name. This unconscious process of likability increases when someone uses our name (Carnegie, 1936; Allport, 1937; Howard, Gengler, & Jain, 1995).

Health Practitioner Verbal and Non-Verbal Response

The second theme also relates to some extent to our previous discussion. The communication between a patient and a healthcare professional takes place both at verbal and non-verbal levels. In fact, sometimes the non-verbal communication (including but not limited to body language, facial expressions of irritation and/or smile, etc.) carries a stronger and long lasting impression on other people's minds just because such non-verbal queues are self-explanatory and need no further interpretation even if the patient is a non-native speaker of a particular language. For example, one patient said, "I have been in hospitals for many different reasons, but at this hospital I feel more like a guest that the entire personnel went out of their way to make it as pleasant as possible for my entire stay, with prompt service and pleasant courteous attitudes". Thus, we suggest that hospitals need to incorporate and acknowledge the non-verbal responses on the part of their staff and patients as equally important while managing pain.

There were both positive and negative cases where patients perceived healthcare providers to be providing high or low levels of pain management based largely on respective verbal and non-verbal communication skills. For example, one patient wrote regarding pain management, "I know she thought she was helping but all she ended up doing was scaring me". Even though the patient acknowledges the nurse was making an attempt to help, which was evident, the non-verbal communication gestures led to a negative patient experience regarding pain management.

Oppositely, positive sentiment regarding healthcare provider verbal and non-verbal communication included, "I was treated with a lot of dignity". Patients were "very impressed with the promptness and respect that all caregivers showed" and stated that "the nurses were very good and paid good attention to everything". This level of personal attention via both verbal and non-verbal communication led one participant to claim, "They almost felt like family ... [they] were always cheerful and helpful". Herein, it becomes evident that healthcare provider disposition plays an important role in how patients perceive their pain is managed during a hospital stay.

Quality versus Quantity of Communication Interactions

The third theme uncovers the importance of both the quality and quantity of time caregivers interact with patients. This study revealed two significant practices that can increase positive patient perceptions regarding pain management: the amount of patient rounding and an initial patient plan for discharge. First, this study discovered that patients are more likely to perceive their healthcare in a positive manner when a nurse or physician checks on them regularly. In this way, healthcare practitioners are able to preempt patient calls or requests for additional care or to simply gain assistance to use the restroom. For purposes of this study, nurses and doctors were asked to round on patients once per hour.

The second revelation regarding quality and quantity of patient interaction came in the form of patient discharge folders. Typically, a nurse will provide a patient with a large folder of documents to take home

that are intended to help the patient care for him or herself over the coming days. For purposes of this study, nurses were encouraged to provide patients with a discharge folder as soon as they entered the hospital room. In this manner, nurses were then able to explain the contents of the folder time and time again, referring back to the documents if and when a patient had a question regarding his or her care post hospital stay. When patients were officially discharged, they were already familiar with the documents and perceived that the nursing staff cared about their post hospital care prior to the discharge.

This continual reinforcement of information throughout the patient's stay provided a clear communication from the nursing staff that they cared about the long-term care of the patient. In addition, the hospital created a large two-page poster-like analgesic reference guide that was placed in each hospital room. These guides were visible by nursing staff and provided them a method by which they could listen to the patient, refer to the standardized guide, and provide immediate feedback that was both fast and accurate. In this manner, patients perceived that the nurses were providing immediate care, rather than having to contact a doctor or walk back to the nurse's station for care confirmation. Notice that the nurse's role did not change, but with proper tools the nurse was able to greatly influence the patient's perception of pain management. This increase in quality and quantity of interactions between the healthcare provider and patient echoes Velten and Arif (2016) findings that when people communicate more often the perception is that a long-term relationship is desired.

The quantity and quality of communication between patients and their healthcare providers seems to in-part dictate patient perceptions of pain management. For example, regarding pain management, one patient noted that the nurse did nothing for pain except talk patient to him/her when pain erupted, stating, "My night nurse … was great informing me down when the pain sent me into a panic attack". Another patient's spouse noted, "My wife phoned Dr….with some questions and he actually returned the call in person". These moments of personal contact with a doctor seem to effect patient perceptions of pain management even when no medication is mentioned. Other examples include, "They explained things happening and calmed my fears" and "I was afraid", yet medical staff "assured me I would be OK". It is again evident that communication is a key component to perceptions of pain management.

Conversely, rude behavior expounds perception of pain, as one patient noted how a nurse "who was very rude to me when I was in horrible pain, and another stated, "the doctor & nurse I had left me in SO MUCH PAIN … when the next staff found me they were A LOT better". One disgusted patient recognized that too many doctors with differing medical opinions rotated through and stated, "I didn't know what was going on". In such cases, patients are receiving much information from numerous people, many of whom were simply talking at them rather than to them, leading to high quantity of information, but low quality and clarity. In one case, a patient proclaimed, "The ER doctor I had should be fired".

Results of this mixed-methods study indicate a clear connection between interpersonal communication and patient perceptions of pain management within the healthcare system. More research in this area is needed, but at this time there is sufficient evidence to substantiate the importance of strong interpersonal communication skills for each healthcare provider toward the end-goal of providing strong health care and increasing HCAHPS scores regarding pain management. In other words, positive communication earned positive feedback and negative interpersonal interactions garnered the opposite regarding perceptions of pain management.

Even though findings of this study create a clear path for healthcare providers, they are not generalizable. The findings are based on one hospital's HCAHPS data, and thus do not represent the larger healthcare community. However, participants numbered nearly two thousand, a relatively large number. Based on the results, administrators should encourage healthcare provider education in the area of interpersonal communication that teaches skills such as how to explain upcoming procedures and medications to patients, how to non-verbally express listening and care to a patient while checking monitors, etc.

Therefore, a positive trend was discovered dictating that positive interpersonal interactions between healthcare provider and patient led to positive patient perceptions of pain management. The implications of this study place high importance on interpersonal communication skills development in healthcare if hospitals wish to raise HCAHPS scores. In the end, patient perceptions regarding pain management are not so much about malpractice as they are about maltreatment.

References

Adler, R. B., & Proctor III, R. F. (2014). *Looking out looking in.* Boston: Wadsworth.

Alligood, M. (2010). *Nursing theory: Utilization and application.* Maryland Heights: Mosby Elsevier.

Allport, G. (1937). *Personality: A psychological interpretation.* New York: Holt.

Banja, J. (2008). Toward a more empathic relationship in pain medicine. *Pain Medicine*, 9(8): 1125-1129.

Barkin, RL. (2010). Treatment challenges of acute and chronic pain: Current concepts. *Advanced Studies of Pharmacy*, 7(1): 11-17.

Breivik, H., Borchgrevink, P. C., Allen, S. M., Rosseland, L. A., Romundstad, L., Breivik Hals, E. K.,Kvarstein, G., Stubhaug, A. (2008). Assessment of pain. *British Journal of Anaesthesia*, 17-24.

Burleson, B. (2007). Constructivism: A general theory of communication skills. In B. B. Whaley, & W. Samter, *Explaining communication: Contemporary theories and exemplars* (pp. 105-128). Mahwah: Erlbaum.

Burleson, B. R., & Caplan, S. E. (1998). Cognitive complexity. In J. C. McCroskey, J. A. Daly, M. M. Martin, & M. J. Beatty, *Communication and personality: Trait perspectives* (pp. 233-286). Creskill: Hampton Press.

Canaday, BR. (2009). A day in the life: Pain management strategies for frontline pharmacists. *Advanced Studies of Pharmacy*, 6(2): 37-44.

Carnegie, D. (1936). *How to win friends and influence people.* New York : Simon & Schuster.

Carolyn, A. Land (2010).*Nurses' Knowledge on Pain Management Practices and Organizational Pain Management Policy*.Unpublished Thesis.Ball State University, Muncie, Indiana.

Clark, A. (2010). Empathy: An integral model in the counseling program. *Journal of Counseling Development*, 348-356.

Clarke, K.A., Iphofen, R. (2008). The effects of failing to believe patients' experience of chronic pain. *Nursing Times*; 104: 8, 30-31.

Crowe, M. (2000). The nurse-client relationship: A consideration of its discursive content. *Journal of Advancements in Nursing*, 962-967.

Doheny, M., Cook, C., & Stopper, M. (2007). *The discipline of nursing.* Stamford: Appleton & Lange.

Donaldson, S. K., & Crowley, D. M. (1978). The discipline of nursing. *Nursing Outlook*, 113-120.

Frantsve L., Kerns, RD. (2007). Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision- making. *Pain Medicine*, 8, 25-35.

Green, CR., Anderson, KO., Baker, TA., Campbell, LC., Decker, S., Fillingim, RB., Kaloukalani, DA., Lasch, KE., Myers, C., Tait, RC., Todd, KH., & Vallerand, AH. (2003). The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain. *American Academy of Pain Medicine*, 4(3): 277-294.

Greene, S., Tuzzio, I., & Cherkin, D. (2012). A framework for making patient-centered care front and center. *Permanente Journal*, 49-53.

Hample, D. (2005). Invitational capacity. In F. van Emeren, & P. Houtlosser, *The practice of argumentation* (pp. 337-348). Amsterdam: John Benjamins.

Hart, R. P., Carlson, R. E., & Eadie, W. F. (1980). Attitudes toward communication and the assessment of rhetorical sensitivity. *Communication Monographs*, 1-22.

Howard, D. J., Gengler, C., & Jain, A. (1995). What's in a name? A complimentary means of persuasion. *Journal of Consumer Research*, 200-211.

Kealey, D. (2015). Some strengths and weaknesses of 25 years of research on intercultural communication competence: Personal reflections. *International Journal of Intercultural Relations*, 14-16.

Kelley, H. (1967). *Attribution theory in social psychology.* Nebraska Symposium on Motivation.

Kim, I. (2010). *The nature of theoretical thinking in nursing* . New York: Springer .

Lakey, S. G., & Canary, D. J. (2002). Actor goal achievement and sensitivity to partner as critical factors in understanding interpersonal communication competence and conflict strategies. *Communication Monographs*, 217-235.

Litchfield, M., & Jonsdottir, H. (2008). A practice discipline that is here and now. *Advanced Nursing Science*, 79-81.

McHugh, G. (2001). Living with chronic pain: the patient's perspective. *Nurse Stand.*18;15(52):33-7.

Prentice, W. (2005). *Therapeutic Modalities in Rehabilitation.* New York: McGraw Hill.

Ritter-Teitel, J. (2002). The impact of restructuring on professional nursing practice. *Journal of Nursing Administration*, 31-41.

Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. *Advances in Experimental Psychology*, 174-214.

Ruesch, J. (1961). *Therapeutic Communication.* New York: Norton.

Spitzberg, B. H. (2015). Is past prologue, or just passed and lacking presence? *International Journal of Intercultural Relations*, 24-26.

Spitzberg, B. H., & Cupach, W. R. (1981). *Self-monitoring and relational competence.* Anaheim: Paper presented at the Speech Communication Association.

Spitzberg, B. H., & Cupach, W. R. (1984). *Interpersonal communication competence.* Beverly Hills: Sage.

Swann, W. (1984). Quest for accuracy in person perception: A matter of pragmatics. *Psychological Review*, 457-477.

Vangelisti, A. L., & Daughton, S. M. (1994). The nature and correlates of conversational sensitivity. In M. V. Redmond, *Interpersonal communication: Readings in theoryand research.* Forth Worth: Harcourt Brace.

Velten, J. (2011). Student speech anxiety: The effects of teacher immediacy. *Journal of Faith in the Academy*, 39-52.

Velten, J. & Arif, R. (2016). The influence of snapchat on interpersonal relationship development and human communication. *Journal of Social Media in Society*.

Wagner, D. J., & Whaite, B. (2010). An exploration of the nature of caring relationships in the writings of florence nightingale. *Journal of Holistic Nursing* , 225-234.

Wiemann, J. M., & Backlund, P. M. (1980). Current theory and research in communication competence. *Review of Educational Research*, 185-199.

Zolnierek, C. (2014). An integrative review of knowing the patient. *Journal of Nursing Scholarship*, 3-10

.