THE TIMES

The importance of describing pain to your GP

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Choose your words carefully when describing pain to your doctor — it can make all the difference

The first question your doctor will ask is where does it hurt. That's an easy one. It's the next question that usually creates the difficulties and often leaves patients tongue-tied: now can you describe the pain?

Describe what? Although we can usually figure out where it's coming from, pain is very much inside of us, even when there is a visible injury on the body's surface. We can't see pain, touch it, hear it. So how can we possibly paint a picture of what is inaccessible to our senses, for pain — as Emily Dickinson, the American poet, once said — "has an element of blank".

What compounds the blankness is the fact that doctors never seem to have enough time, patience or training to help patients find the right words, or any words for that matter. And yet a good description of pain can be as important as a physical exam or an MRI scan in making the right diagnosis of an illness.

One young man we'll call Peter might have understood that better than anyone. He developed pain in

his back soon after he started working out in a gym. When the pain didn't go away, he consulted his doctor. He prescribed the 33-year-old, otherwise healthy patient ibuprofen for muscle strain. Six weeks later Peter called to tell the doctor that the pain was getting worse. This kind of thing could take a while to resolve, the doctor said. Only after new pain developed in the patient's chest a month later did the doctor investigate further. Peter was found to have testicular cancer that had spread to the spine and ribs. He died less than a year later.

In this golden era of advanced, hi-tech medicine, there is little premium placed on communication. Why listen to patients when doctors can map genomes or observe neurons firing in the brains? Yet diagnostic tests still have to be ordered and the basis for deciding on a plan of action is still an old-fashioned "history" – a patient's report of what he or she is feeling. If Peter had been given the chance to elaborate on his generic symptom "pain", if his doctor had coaxed him into painting a better picture, a bone scan might have been carried out much sooner.

Ephrem Fernandez, a psychologist, and his colleagues at the University of Texas who study the language of pain, are finding that metaphorical descriptors often provide invaluable clues that point to one cause of pain over another. Bone cancer pain such as Peter's tends to feel "sharp" and "stabbing" in nature. Musculoskeletal back pain, on the other hand — the kind that might be triggered by an injury at the gym — tends to be more "aching" and "gnawing". Similarly, a headache that is "throbbing" is more likely to be because of migraine while a "dull, constant pain" is more typical of a tension headache.

In Peter's case you could argue that an earlier diagnosis might not have changed the outcome. The cancer had already spread too far. But the statistics don't always hold for a particular patient and I'm sure that Peter would have preferred to know what was happening sooner.

In dealing with pain, medicine has a poor track record, shockingly poor when you consider that pain is the most common reason people visit doctors in the first place. Nor is it just a matter of failing to diagnose the cause of pain, as in Peter's case, but failing to alleviate pain as well. Numerous studies from the 1970s to the present show that cancer patients are routinely not prescribed enough painkillers and that significant numbers die in severe, unremitting pain.

Medicine has also not been very successful at dealing with chronic pain, defined as pain that lasts longer than six months. Nearly eight million people in the UK suffer chronic conditions such as lower back pain and fibromyalgia and the number keeps growing. Many of these patients trudge from doctor to doctor without ever finding relief. Some will lose their jobs and become clinically depressed. Clearly this is tragic for the sufferers, but it also affects the country as a whole, through increasing health care costs and the growth in the numbers of disabled people. Pain experts consistently point to three major reasons for medicine's failing: primary care doctors being poorly educated in pain management, disproportionately low funding for pain research (compared with cancer or Aids research), and a lack of access to pain medications and specialists.

But the most obvious and easily correctible problem is almost always overlooked: a breakdown in basic communication. If doctors were more patient and ready to listen, if patients were encouraged to speak, critical information could be ascertained inexpensively and relatively quickly. That

information would help doctors to appreciate the severity and quality of their patients' pain. And surely that, in turn, would make it more likely that Peter and so many like him would receive better care.

My advice to patients, however, is not to wait for doctors to learn more about pain or to become better listeners. Instead, patients should take a more active role in their care. And by this I don't mean doing extensive research on the internet and determining what they need before consulting a doctor. Even more important and practical, patients should really think about their symptoms and be prepared to paint a vivid picture of what they are feeling before their visit.

They should think about the severity of their pain, only not in terms of those primitive numerical scales such as the Faces Pain Scale. Saying your pain is a seven out of ten doesn't convey very much. Rather, tell the doctor how pain affects your life — it's so bad that it wakes me up at night — and what makes it better or worse — it helps to prop my leg on a pillow. A good story always registers more effectively than an abstract number.

Patients should also be prepared to describe their pain. Even if there is nothing to see or touch or smell, imagine something that you can see and touch and smell. Patients need to be a little less literal and a little more metaphorical when it comes to pain. They need to think more like poets, who are especially adept at mixing categories, talking about one thing in terms of other things. Peter might have seen his pain in the form of a knife with a sharp, stainless steel blade plunging into his spine. A person with shingles might imagine a pot of boiling, hot water spilling on to her leg. A migraine patient, a volcano beneath the skull, simmering and rumbling until it finally blows.

The point is to make the pain as visible as possible so that your doctors can see it. Because if they don't see the pain, they may not believe it. Or they may not appreciate how bad it is. Or appreciate the particular qualities of the pain that can distinguish it from other pains and thereby point to a specific diagnosis and treatment.

Communicating pain is a necessary first step in the process of alleviating pain.

Dr David Biro teaches at SUNY Downstate, an academic medical centre in New York. *The Language of Pain: Finding Words, Compassion, and Relief* by David Biro is published by W. W.Norton, 18.99