Henry SG and Eggly S, "The Effect of Discussing Pain on Patient-Physician Communication in a Low Income, Black, Primary Care Patient Population," *The Journal of Pain*, 2013.

eAppendix 1: Protocol for selecting thin slices

Tape No. _____White (1-75) Green (101-181) Coders_____ Date _____

Tape #	Slice #	Start time	Stop time	Pain Slice?	Notes
				Y N	
				Y N	
				Y N	
				Y N	
				Y N	

Goal: Identify 30-second "thin slices" from videos that coders will rate for affect. Prior research shows that ratings of short segments are good approximations of ratings for an entire visit. The main research question is whether affect is more or less negative when discussing pain compared to discussions of non-pain topics. We want to be able to compare affect for pain-related discussions and non pain-related discussions within the same video, and also to compare patients who discuss pain compared to patients who do not.

All slices MUST 1) be 30 seconds long; 2) involve a discussion in which both doctor and patient interact (ie not just one person talking for 30 seconds; 3) have both patient and doctor visible on video tape for the majority of the slice 4) be in sequential order (eg slice 1 comes first in the visit, then slice 2, then slice 3).

If possible, 30-sec slices should not include physical examinations. Use the sheet with MD in/out times & the master coding sheets to help identify thin slices. Use the following rules for picking thin slices:

Non-pain videos (2 slices per video):
SLICE#1: Choose a 30-second slice after introductions are finished, (ie once patient and doctor have started to discuss medical problems). It is more important for slices to contain a good discussion than to match with start/stop times of discussions. If for some reason the first 30-second segment would not be good for coding, then pick a 30-second slice any time within the first 2 minutes after introductions are finished.

SLICE#2: Choose 30 seconds at the end of the visit before the MD leaves to discuss with the attending physician, excluding goodbyes & non-medical subjects. Try to get a slice sometime in the last 2 minutes before the MD leaves.

Pain videos (3 slices per video; with at least 1 pain and at least 1 non-pain slice each):
SLICE#1: Same rule as Slice#1 for non-pain videos, but it's important that slices be either pain-related or not-pain related. For example, if a pain discussion starts 15 seconds into the visit, pick a slice after the 15 seconds so the segment will all be about pain.

SLICE#2: Choose a 30-second slice involving a pain discussion from the middle of the visit if possible. Some tapes may only have one 30s segment involving pain or discuss pain in only one part of the visit, so you have to pick that segment. If possible pick a slice involving pain discussion from the middle of the visit. If Slice#1 was about pain, try to make Slice#2 separated in time from Slice#1 and towards the middle of the visit.

SLICE#3: Choose 30 seconds from the end of the visit in the same way as you do for the non-pain videos. Again the segment should be either all pain or no pain, and try to get a segment within the last 2 minutes.

Some tapes will have 2 pain slices and 1 non-pain slice; others will be 1 pain slice and 2 non-pain slices. Try to get at least 1 pain and 1 non-pain slice for each pain video. If pain dominates the start and end, the non-pain segment may have to be in the middle. Some pain videos have brief discussions of pain without an unbroken 30-second pain segment. If the video has a pain sequence at least 25 seconds long, watch it and if it involves a suitable discussion about pain, pick 30 seconds that include that discussion (okay if it has a little physical exam). If there is nothing close to a 30-second pain segment, treat the video as a non-pain video (ie get only 2 slices, one for beginning and one for the end). If there is no discernable non-pain sequence, code three slices for pain.

Henry SG and Eggly S, "The Effect of Discussing Pain on Patient-Physician Communication in a Low Income, Black, Primary Care Patient Population," *The Journal of Pain*, 2013.

eAppendix 2: Factor analysis results

Factor loadings for patient-physician rapport variables*

Variable	Factor 1	Uniqueness
Rapport	0.9678	0.0633
Liking	0.9459	0.1053
Attention	0.9242	0.1459
Coordination	0.9332	0.1291
Trust	0.9331	0.1292

* iterated principal factor method with varimax rotation

Factor loadings for patient affect variables*

Variable	Factor 1	Factor 2	Uniqueness
Warm/ Friendly	-0.1815	0.9099	0.0973
Tense/ Anxious	0.8365	-0.0906	0.2410
Engaged/ Attentive	0.1302	0.8579	0.2103
Disagreeable/ Antagonistic**	0.2943	-0.1026	0.6569
Upset/ Distressed	0.9685	-0.0288	0.0433
Sad/ Depressed §	0.5224	-0.581	0.2488

***** iterated principal factor method with varimax rotation
** excluded from further analyses due to minimal variation across our sample
§ excluded from further analyses because it did not add independent information to the two-factor solution.

Factor loadings for physician affect variables*

Variable	Factor 1	Factor 2	Uniqueness
Warm/ Friendly	-0.1253	0.7729	0.3690
Tense/ Anxious	0.6926	-0.0341	0.2726
Engage/ Attentive	0.0966	0.7689	0.3799
Disagreeable/ Antagonistic**	0.5695	0.0254	0.6223
Hesitant/ Uncomfortable	0.8778	-0.0141	0.2285
Rushed/ Hurried**	0.1224	0.0158	0.6511

***** iterated principal factor method with varimax rotation
** excluded from further analyses due to minimal variation across our sample