

## Paired Narratives of Shared Experiences around Chronic LBP:

### Classic Mismatch between Patients and their Doctors



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## Background



- Despite our best efforts, chronic low back pain (LBP) continues to carry a high burden of suffering for patients and significant costs for society
- Current treatments are inadequate
- *New approaches, new frameworks needed*



## New Approach: Narrative Inquiry



### Narratives

- Long tradition of storytelling in medicine- revitalized through the Narrative Medicine movement
- Help patients and physicians make sense of experiences, absorb meanings, and interpret illness

### Narrative inquiry

- Narrative approach: Gathering information for research through storytelling

### Paired Narratives

- New methodology to gather and compare stories from multiple parties
- Potential to further understanding, enhance interactions and outcomes



Connelly, Claudia "Stories of Experience and Narrative Inquiry" *Ethn Researcher* 1999.  
Charon R. *Narrative medicine: honoring the stories of illness*. Oxford University Press, 2006.  
Dionysius M. Stories for life: introduction to narrative medicine. *Care From Physicians* 2007.



## New Method applied to an Old Problem

- Research shows that shared views & negotiated plans (agreement/concordance) of doctors and their patients related to better outcomes
  - *But how to elicit views & apply them in a clinical context?*
- Study Aim: Explore the **paired narratives of shared experiences** among chronic LBP patients and their physicians

Stapp, et al. *BIFF REPORT: Patient-physician agreement as a predictor of outcomes in patients with back pain*. *J Gen Intern Med* 2005.  
Bain, et al. *The physician's actions and the outcome of illness in family practice*. *J Fam Pract* 1986.  
Starfield, et al. *The influence of patient-practitioner agreement on outcome of care*. *Am J Pub Health* 1981.  
Herman, et al. *Doctor-patient concordance and patient initiative during episodes of LBP*. *Br J Gen Pract* 2000.



## Methods

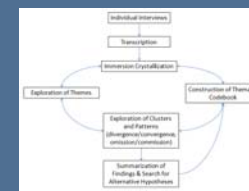


- **Participants:** Purposeful sample
- **Site:** urban family medicine center
- **Data collection:** In-depth interviews of patient-physician dyads



## Data Analysis

- Iterative cycles of **immersion crystallization** and template analysis/codebook
- Focus on important themes, major areas of **convergence** and **mismatch**, **omissions** and **commissions**



## Results:

### Patient Themes: disability, trust, treatments

- Nearly all describe severe/disabling LBP
- High level of trust in and reliance on their family physicians
- Effectiveness of treatment options varied greatly

*"It's like taking a sledgehammer and basically just hitting you in the back with it."*

*"If it wasn't for [my doctor], I'd probably be in the ground right now."*



## Physicians Themes: Frustrations & Identity

Many frustrations and challenges caring for LBP patients

- Lack of clinical or functional progress
- Significant social barriers to improvement

Patient identity often linked to the LBP disability

*"I'm struggling...I'm feeling like I'm not helping [the patient] very much other than that I'm here."*

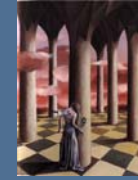
*"We've worked together for a long time without a lot of success."*

*"The back pain is front and center. Everything else sort of revolves around that...It's almost like without the back pain, I'm not sure what else would fill the void."*



## Convergence of Paired Narratives between Patients and their Doctors

### Where the stories meet



- Seriousness/severity of illness
- Lack of effective treatments
- Existence of barriers to care



## Where the Stories Diverge: Mismatch of Models



- Model of illness: Biomedical vs. biopsychosocial
- Treatment goal of reducing pain vs. improving function
- Importance of a definitive diagnosis



## Model Mismatch: Biomedical vs. Biopsychosocial

	Biomedical/ Biomechanical	Biopsychosocial
Patient	21	2
Doctor	1	22

$p < 0.001$

**Patient:** "... I took a fall and that injured me..."

**Physician:** "He has more than just mechanical lower back problems...I think he knows that he's depressed, but he feels like he's depressed for other reasons. I don't think he realizes they are connected - he doesn't have insight."



## Omission/Commission

Patients:

- Ignored role of psychological factors
- Avoided admitting to abusing illicit drugs or diverting their narcotics (high prevalence in area - \$1 per mg of oxycodone)

Physicians:

- Ignored or downplayed the search for pathoanatomical dx
- Did not acknowledge patients' feelings of victimization
- Were more critical, dismissive, and judgmental of LBP patients in private interviews



## Summary

- Themes and patterns apparent:
  - **Convergence** around LBP's severity, doggedness and difficulty to treat
  - **Divergence/Mismatch** prevalent regarding explanatory models, treatments, and need for a definitive diagnosis
  - Omission and Commission abound – each group "sees what they want to see & disregards the rest"
- Limitations

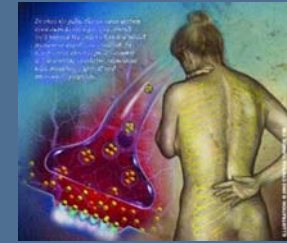


## Future Directions

- Potential for Clinical Intervention
  - bridge communication gaps
  - reduce mismatch between physicians and LBP patients
  - Introduce the potential for negotiated shared models, narratives, treatment plans, and expectations
- Potential for Research:
  - New method to gain insights into shared experiences
  - Clinical Intervention Trial of Paired narratives



## Thank You!



## Results: Patient Demographics

Participants (M/F)	23 (12/11)
Age (average/range)	45 (28-72)
Employment Status	
Employed	7
Unemployed	6
Disability Insurance	10
Narcotics Rx (%)	16 (70%)
Psych Co-morbidities (%)	16 (70%)
Depression	6 (26%)
Anxiety	3 (13%)
PTSD	2 (9%)
Substance Abuse	



## Limitations

- Small sample size
- Single site
- Purposeful sampling
- Cognitively filtered experience vs. direct observation



## Artwork



Remedios Varo, *Dolor* series, 1948

