

Chronic low back pain in general practice: the challenge of the consultation

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Background. Chronic low back pain (CLBP) is a symptom commonly presented to GPs, accounting for a significant proportion of their workload. It is also a common reason for sickness absence, and thus of national economic importance.

Objectives. This qualitative study aimed to provide an understanding of how GPs understood CLBP, how they approached the consultation with CLBP patients and how they conceptualized the management of this problem.

Method. Qualitative research techniques were employed. Twenty GPs working in North-West England were interviewed. Interviews were semi-structured and recorded on audio-tape. Transcripts of these interviews were then subjected to constant comparative qualitative analysis.

Results. Subjects described their difficulties in responding to and managing CLBP. They acknowledged the link between CLBP and psychological distress, and that it legitimizes long-standing illness behaviour. They were pessimistic about the chances for successful cure or palliation of CLBP.

Conclusion. Subjects seemed to be cognisant of collusion between doctor and patient, in cases where the patient's explanatory model of back pain is not challenged. We argue that this can be accounted for by the patient operating within a physical model of pain causation, while doctors operate using a model that stresses psychosocial factors. The incommensurability of these models lies at the root of the CLBP consultation as a problem.

Keywords. Chronic low back pain, doctor–patient relationship, illness behaviour, sickness absence.

Introduction

Chronic low back pain (CLBP)—in which pain is localized to the lumbar spine or referred to the leg—is commonly presented in general practice.¹ Much CLBP is resistant to diagnosis, and it has been estimated that up to 80% of such cases may present no identifiable pathology.² Elsewhere,³ we have explored the way in which patients presenting with non-specific CLBP in an inner-city general practice were aware of the diagnostic and treatment dilemmas that their doctors faced, and uniformly pessimistic about the outcome of medical interventions. In the present paper, we will explore GPs' constructs of the CLBP consultation. We will argue that such consultations involve an interaction that maintains

the doctor–patient relationship but which reinforces illness behaviour.

Background

CLBP is the most common of the musculo-skeletal disorders presented in general practice,¹ but its clinical management presents a significant problem.² In part, this is due to the high degree of diagnostic accuracy that attends serious spinal pathologies and neurological problems, (for example, disc prolapse, spinal tumours and stenosis). Such disorders 'fit' a disease model in back pain directly. However, that contemporary medicine has little to offer the patient (and the doctor) presenting with non-specific CLBP is because it is not a disease defined through the medical model of organic pathology but rather a symptom located within a biopsychosocial model of illness behaviour. In part, this has been recognized in the Clinical Standards Advisory Group (CSAG) guidelines for British physicians.⁴ These attempted to put the biopsychosocial model to practical use for clinicians, by

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firmly defining symptomatology that is presented by people with no identifiable pathology. Thus the term ‘chronic low back pain’ refers to a symptom complex in which pain is localized to the lumbar spine or referred to the leg, where other specific causes have been excluded.

How to achieve pain relief and restoration of function in CLBP has been widely debated for 30 years.⁵ The biopsychosocial model provides a powerful rationale for an active exercise approach to CLBP, emphasizing a progressive increase in mobilization and rehabilitation rather than specific clinical treatment. There is now good evidence showing reduction in both reported pain and physical impairment as a result of the maintaining of physical activity, and evidence-based guidelines have been published by both CSAG⁴ and the Royal College of General Practitioners.⁶

Even so, the patient’s psychological distress and illness behaviours can confuse both assessment and diagnosis, while simultaneously exerting pressure on the doctor to ‘do something’.⁷ In turn, this can lead to increasing demands to find a ‘cause’ and thus a ‘cure’, and thus to a risk of over-diagnosis based on over-sensitive investigations (with high false-positive rates). In such cases both doctor and patient will latch on to a nominal diagnosis, initially as a convenient label, but then treat it as a substantive diagnosis. Since CLBP is a complex array of symptoms that do not easily sit within a medical model, its management has to be seen in the context of interaction between patient and doctor, where negotiation about the meaning of specific symptoms exerts an important influence on patient outcome.

Method

This paper reports data collected in a wider study of the management of back pain in inner-city general practice. Initially, 20 patients participated in semi-structured interviews focusing on their experience of CLBP and interaction with doctors.³ A natural progression of this work was to repeat this process with a study group of GPs. Sampling was purposive. Anticipating a response rate of less than 50%, we sampled 50 GPs from the four Health Authority lists in the North-West NHS Region. The sample was constructed to give a range of practice sizes, but since our study of patients had drawn its sample from an area of high social and economic disadvantage, we selected our sample on the basis of wards in receipt of the Deprivation Allowance. Twenty-four doctors agreed to take part, and 20 GPs were interviewed, all from inner-city general practices in a major North-Western conurbation. All subjects were unknown to the interviewer (CC-G). A qualitative approach to data collection and analysis was taken:⁸ interviews were semi-structured, tape-recorded with the subject’s consent and subsequently transcribed. The interview schedule explored: responders’ views on the causes of CLBP; perceptions of

patients’ expectations of treatment; and their responses to consultations for CLBP and views on sickness certification. The interviewer also presented some of the findings from the earlier study of patients with CLBP³ and asked responders to interpret these. Transcripts were subsequently thematically coded according to the general precepts of a ‘grounded theory’ approach,⁸ and three specific themes arising from this data are discussed in the present paper: (i) making a diagnosis; (ii) negotiating diagnoses; and (iii) negotiating the doctor–patient relationship.

Making and negotiating a diagnosis

Earlier we noted that there is a potential conflict between ‘medical’ and ‘biopsychosocial’ models of back pain. Inevitably, this was reflected in subjects’ accounts of their diagnostic work. Most subjects accounted for this along a continuum of causes, which ranged from specific organic dysfunction to patients who presented with no identifiable pathology. In terms of diagnostic categories, these were relatively simple:

“Er, I’ve long since decided to divide low back pain into backache or sciatica and leave it at that.” (GP 6)

As might be expected, most subjects distinguished between organic and psychological problems.

“Well, we get quite a few muscular sprains, and that, from industry and gardening etcetera, er I’m sure a lot of it is psychogenic (...). Well, a lot of people presenting with back pain, particularly of a chronic nature, I’m sure, are depressives or some other psychiatric disturbance going on, or, er, problems at home, or social problems.” (GP 16)

“I would think, er, mostly, it’s er, how do you put it? Mechanical, due to bad posture, bad working practices, bad sitting, just to bad back care. Most are chronic, there are *some* that are due to genuine physical problems, but an awful lot of them are, I think, what people do with their backs.” (GP 10)

Finally, not all subjects saw pathology of any kind as the primary cause of consultations about CLBP:

“(the) need for sick notes, any excuse to get money off the tax payer, avoidance of work, and—occasionally—genuine discomfort.” (GP 9)

Uncertainty about why the patient is ‘really’ consulting leads to frustration. After all, medical training emphasizes the importance of diagnosis as the first step in the management of a ‘real’ pathology. Where this step cannot be confidently taken, the diagnosis itself needs to be negotiated with the patient.

The first point that needs to be made here is that negotiation over the diagnosis is fundamentally about negotiating the reality of the patient’s experience of

pain. In our study of patients' experiences of back pain,³ subjects were quite prepared to recognize that there was a psychological component to their apprehension of pain. However, they were also eager to emphasize that their experience was of real organic pain, and that GPs were confused about its cause. Subjects in the present study were not so much uncertain about its cause in a mechanical sense, but about its underlying reason. Therefore we might regard the activity that they undertake at this stage as negotiating the boundaries of their own explanatory models.

“It is something very difficult to prove or disprove. Without calling someone a liar you can't say they haven't got back pain. It's a ... I mean, there are all sorts of reasons why people use illnesses. Sometimes it's 'cos they don't want to work; sometimes it's because they are looking for sympathy from partners', sometimes because they want to get out of something they don't want to do.” (GP 10)

Practical uncertainty in the consultation was thus a source of considerable frustration.

“I absolutely despair ... it's a psychiatric illness. I'm not saying that backache isn't painful, but it's a psychiatric illness isn't it?” (GP 6)

“And do you take a psychiatric approach?” (C C-G)

“If you call telling them to 'get a life' a psychiatric approach, then yes.” (GP 6)

This subject took a particularly negative view of CLBP patients, and was the only one in the study group who suspected that some such patients were consciously manipulating the system of sick certification or were otherwise 'malingering'. Others, however, were more expansive:

“I'm convinced that there are some very depressed people, whose back pain entitles them to have a physical reason to be off ill, not coping. I prescribe antidepressants, and have more review consultations on depression, try to make it less stigmatising.” (GP 13)

Similarly,

“I think if we didn't have back pain as an excuse, we'd find something else, so we'd put depression.” (GP 7)

In responding to the patient with non-specific CLBP, subjects in this study saw themselves dealing with a fundamentally intractable problem. It was intractable because it crossed explanatory models. Patients presented with a symptom belonging, in their view, to a disease model. They were absolutely committed to their pain having an organic cause. But doctors, having discounted sinister and other organic causes, switched models and

set CLBP in a psychosocial context. Once they did so, it was impossible for them to press the diagnostic case that they had built up without profoundly disturbing their broader relationship with the patient.

The doctor–patient relationship in CLBP—negotiation or collusion?

All doctors are schooled to employ a body of knowledge that is not possessed by their patients and to exercise power through the medium of diagnosis, treatment and ultimately to cure or palliate. This kind of power is productive—indeed it has a fundamentally moral intent.⁹ Where it cannot be exercised, the resulting frustration is quite powerful.

“Well, you get the chronic ones, coming for years ... the persistent 'nothing makes it better'. The persistent offender, I get really fed up with it.” (GP 16)

“I find it frustrating in a way ... we go into medicine, perhaps, because we feel we want to help, to do something, then maybe feel we haven't got our pay-off, so what do we do? We get mad with the patient, or impatient with the illness.” (GP 7)

The doctor is, all the time, aware that patients have low expectations of medical knowledge and practice in such cases.

“You're on a hiding to nothing in the majority of cases. So, someone with back pain, who's had it for many years, they've been through it all, they know we can't do very much.” (GP 3)

Once in this position, the doctor reaches a full-stop, and is forced to respond by acceding to those requests that they can match: agreement that the patient is ill and the provision of a sick note. Once this is done, the doctor has effectively admitted that the patient's self-diagnosis is the correct one. To do otherwise is to threaten the doctor–patient relationship.

“How do you approach that consultation?” (C C-G)

“Give them what they want, otherwise it only causes bad relations with people, and you don't seem to get anywhere. Anyway, they go somewhere else, get a sick note off another doctor.” (GP 9)

“So you wouldn't confront or challenge a patient?” (C C-G)

“I might be a bit sarcastic or make it obvious from the expression on my face. But I would never actually say, I don't believe you, because I always feel that there's always a risk that they might not come back with something genuine in the end, and they've got to be able to come back.” (GP 9)

Most subjects agreed that they were to some extent colluding with the patient. GP 3 for example, was quite open about this, saying “Yes, I’m colluding with the patient, I gave up challenging patients two or three years after entering general practice”. But, as with GP 9, this was usually conceptualized in moral terms.

“You can’t get them to accept this [lack of organic pathology] ... I wouldn’t dare to suggest this ... If you really upset them, they’re not going to trust you again.” (GP 10)

The relationship between doctor and patient is attributed a very great degree of significance in General Practice, and the consultation is the cornerstone on which this is founded. However, the authority of the doctor in the consultation depends upon the capacity to act positively to alleviate symptoms in some way, in collaboration with the patient. The problem for the doctor here is that it is the patient who is powerful; the doctor is able to act only if the patient accedes to a psychosocial model of illness, rather than a disease model centred on organic pain. In the case of non-specific CLBP, the doctors in this study were rendered powerless because they were reluctant to challenge the medical model of pain causation deployed by the patient. And once in that position, they were caught in a ‘Catch 22’: a conservative disease-oriented approach (involving referral to specialist services) was just as likely to end in failure as an approach that emphasized psychogenic causes. In fact, patients do appear to recognize that there is an intimate connection between their psychological state but are keen to be seen as ‘genuine’ sufferers, and not as psychological ‘cases’.³

Discussion

From the accounts given by our responders it seems that non-specific CLBP is a problem due to a mismatch of explanatory models. Patients experience ‘real’ pain, which they conceptualize in terms of organic causes, inevitable mechanical degeneration and loss of function.³ This is predicated on the diffusion of medical models into lay understanding.¹⁰ Doctors conceptualize this pain in psychological terms, and yet become the instrument of somatization. Both parties then become trapped by the doctor’s accession to the patient’s explanatory model—which is necessary to avoid disturbing further the doctor–patient relationship. In turn this fuels pessimism and resentment on both sides.

The doctor–patient relationship is given considerable weight in medical rhetoric about general practice¹¹ and GPs have good reasons not to disturb this. Even so, the understandable anxieties and frustrations of subjects in this study raise some important questions. It is now

well established that there is no health gain associated from withdrawal from normal activities in cases of non-specific CLBP. In fact, the opposite is true.⁴ Colluding with the patient who presents with CLBP and expects their medical model of pain to be legitimized by the doctor reinforces illness behaviour, but far from maintaining the doctor–patient relationship, undermines it. It results in neither doctor nor patient having confidence in the other.

One of the features of this study is the uniformly low expectations that both patients and professionals had of one another, and the great sense of pessimism that pervaded their accounts of medical encounters. In the case of GPs, perhaps the key message—as one of the subjects in this study put it—is that “*if it wasn’t back pain it would be something else*”. In other words, the basis of such presentations lay precisely outside the realm of physiological problems, and that rather this *type* of patient mediated psychological and social problems.

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References

- McCormick A, Fleming D, Charlton J. *Morbidity Statistics from General Practice. Fourth National Study 1991–1992*. OPCS (Series MB5, No. 3). London: HMSO, 1995.
- Waddell G. A new clinical model for the treatment of low back pain. *Spine* 1987; **12**: 632–644.
- Chew CA, May C. The benefits of back pain. *Fam Pract* 1997; **14**: 461–465.
- Clinical Standards Advisory Group. *Back Pain: Report of a Clinical Standards Advisory Group*. London: HMSO, 1994.
- Waddell G. Biopsychosocial Analysis of Low Back Pain. *Clinical Rheumatology* 1992; **6**: 523–527.
- Royal College of General Practitioners. *Clinical Guidelines for the Management of Acute Back Pain*. London: RCGP, 1996.
- Waddell G. How patients react to low back pain. *Acta Orthop Scand* 1993; **Suppl 251**: 64.
- Strauss A. *Qualitative Analysis for Social Scientists*. London: Cambridge University Press, 1987.
- Masiede P. Possibly abusive, often benign, and always necessary. On power and domination in medical practice. *Sociol Health Illness* 1991; **13**: 545–561.
- Salmon P, May C. Patient’s influence on doctors’ behaviour: a case study of patient strategies in somatization. *Int J Psychiatr Med* 1995; **25**: 319–329.
- May C, Dowrick C, Richardson M. The confidential patient: the social construction of therapeutic relationships in general practice. *Sociolog Rev* 1996; **44**: 187–203.