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"We Need to Get You Focused": General Practitioners' Representations of Chronic Low Back Pain Patients

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Abstract

Although subject to considerable research from perspectives including general practitioners, patients, and perspective guidelines, chronic low back pain (CLBP) continues to be a common but contentious condition in primary care. We used medical consultation records, critical incident interviews, and a think-aloud problem-solving task to examine how general practitioners applied professional knowledge of the condition, especially in relation to psychosocial care. Using qualitative content analysis and thematic analysis, we identified a pragmatic, goal-focused approach to patients, a schema based on biomedical knowledge and tacit theories of motivation. The doctors' expectations for CLBP included uncertainty over symptoms and doubts over patient credibility, which helped to explain an autonomous rather than collaborative approach to managing back pain patients. The findings are discussed in light of social representations theory, self-determination, and research on the therapeutic relationship.

Keywords

chronic illness; communication, doctor-patient; decision making, clinical; pain, chronic; relationships, health care

Chronic low back pain (CLBP), a condition in which pain persists for more than 3 months, is the most common musculoskeletal disorder (e.g., Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006). It is associated with uncertainty and suffering, presenting a severely challenging personal experience (Smith & Osborn, 2007), but chronic back pain is a descriptive rather than diagnostic label. Most CLBP is classified as "nonspecific," and the absence of a definitive cause is itself a distressing experience for patients (Kent & Keating, 2004).

Regardless of cause, CLBP affects sufferers' quality of life, well-being, and capacity for daily activities. It is associated with distress, anxiety, stigma and disbelief, and fear of future decline (Borkan, Reis, Hermoni, & Biderman, 1995; Dean, Smith, Payne, & Weinman, 2005; Smith & Osborn, 2007). CLBP is characterized by recurrent acute flare-ups in a pattern often persisting for years. The period following the onset of an acute flare-up is a critical period for addressing the risk factors for long-term disability (Schultz, Crook, Milner, Meloche, & Lewis, 2008).

The biopsychosocial model is by consensus the standard preferable approach to treatment, in which CLBP is regarded as a recurrent but usually manageable problem. Many risk factors for long-term disability are modifiable, including beliefs about the link between pain and physical harm, negative expectations for recovery, and cognitive catastrophizing (Schultz et al., 2008). The psychological nature of risk factors calls for patient-centered care, an approach neglected in medical training and practice (Yeheskel, Biderman, Borkan, & Herman, 2000).

Over the past decade, research on CLBP as a psychosocial condition has represented three main perspectives: the patient's experience of pain, including interactions with the medical system; general practitioners' views on CLBP patients and treatment; and policy guidelines derived from research evidence. Each provides a different perspective on motivations and beliefs among CLBP sufferers.

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Patient Perspectives on CLBP

The past decade has seen considerable interest in patients' subjective experience of CLBP (e.g., Borkan et al., 1995; Smith & Osborn, 2007). This has revealed a mismatch between patient and general practitioner constructions of CLBP. Patients tend to understand mood problems in terms of strain and loss of control arising from adverse events, compared with doctors' reliance on psychiatric labels such as depression (Cornford, Hill, & Reilly, 2007). Qualitative studies of the patient experience have explored CLBP in phenomenological terms and in respect of perceptions of primary care (Campbell & Guy, 2007; Dean et al., 2005). The costs of CLBP shown in this work range across functional disability, financial problems, stigma, personal vulnerability, and despair. In phenomenological terms, this experience represents an "assault on the self" (Smith & Osborn, 2007).

Back pain patients commonly report negative experiences of medical care (Corbett, Foster, & Ong, 2007), prompting the search to find a medical opinion they can trust and accept. Borkan et al. (1995) differentiated between patients who seek solutions through medical treatment, referrals, and tests, and those who veer from medical care and seek autonomy in living with pain. Both doctors and patients value clear communication and respect (Parsons et al., 2007), but their beliefs about the pain experience appear to be discordant. General practitioners have been described as losing interest once pathology is ruled out, and health professionals describe patients' expectations as unrealistically high (Chew-Graham & May, 1999; Dean et al., 2005).

General Practitioners' Experiences

For doctors, CLBP resonates with the phenomenon of medically unexplained symptoms (MUS; Ringsberg & Krantz, 2006), a condition associated with patient deficits, distress, and depression (Chew-Graham & May, 1999). It is also associated with uncertainty. Some of the clinical uncertainty about CLBP is objective, as it is frequently not possible to resolve the diagnosis. Doctors also experience uncertainty because of doubts about patient claims of pain and disability when legal compensation cases or work-related claims are involved. This introduces complexity and a challenge to balance the professional responsibility for supporting patients with doubts about patient credibility (Krohne & Brage, 2007). For reasons such as these, CLBP patients can be perceived as difficult and demanding by general practitioners.

Best Practice Guidelines

Based on the biopsychosocial model, contemporary guidelines present CLBP as a manageable, chronic condition with multiple contributing variables (Borkan et al., 2002). More than 20 CLBP guidelines have been developed internationally for primary care (van Tulder, Tuut, Pennick, Bombardier, & Assendelft, 2004), emphasizing self-management, activity maintenance, and short-term pain relief. Success in guideline implementation has been limited, reflecting the difficulty of integrating prescriptive guidelines with an existing professional model that prizes autonomy (van Tulder et al., 2004). Efforts to address these difficulties have included linking disability risk assessment to specific, focused measurement scales and the adoption of the "flags" approach to discriminate red flags (indicator of severe physical danger) from yellow flags (severe psychological or psychiatric risk; Kendall, Linton, & Main, 1997; Linton, 2005).

Although considerable work has been carried out, CLBP remains an elusive phenomenon subject to different interpretations. In this study we used documentary records, retrospective critical incidents, and concurrent think-aloud problem solving to examine how general practitioners represent CLBP in an applied context, especially in relation to psychosocial care, critically comparing findings with CLBP research themes and other relevant literature.

Methodology

Design

We used a mixed method qualitative research design, with three sources of qualitative data collected on general practitioners' applied knowledge of CLBP. These data were originally collected to develop an ecological model of general practitioner care in a judgment analysis study of medical decision making. Using qualitative content analysis and thematic analysis, the present study used the dataset to carry out a separate enquiry to assess how CLBP patients are represented by doctors, especially in terms of psychosocial care.

Sample

Medical records. Records were collected on 75 patients across six primary care practices. All consultation records for back pain with the patients over a 15-month period were transcribed. Each patient had a diagnosis of CLBP, was aged 25 to 65 years, and had at least one CLBP consultation within the previous 15 months. The average age of patients was 50.76 years (*SD* = 11.64, range = 27 to

65 years) and average duration of back pain was 10 years (*M* = 10.06 years, *SD* = 6.96, range = 1 to 28). Patients attended general practitioners nearly four times, on average, over a period of 15 months (*M* = 3.77, *SD* = 3.38, range = 1 to 16). The demographic profile was typical of CLBP (van Tulder et al., 2004).

Interviews and think-aloud task. We recruited 12 general practitioners to the interview phase of the study, from seven practices where medical records had been collected or identified through our local professional contacts. Doctors worked in rural, urban, or mixed areas dispersed across the province. Participants' ages ranged from 31 to 45 years (*M* = 36.7, *SD*: 4.94), and they possessed an average of 10.45 years of professional experience (*SD* = 6.46, range = 2 to 30 years). Nine were men and 3 were women. Doctors reported an average of 13.4 low back pain presentations each month (*SD* = 8.5; range 3 to 30).

Interview Materials

Two forms of data were collected to identify verbal and conceptual knowledge. A critical incident interview schedule was designed to explore retrospective accounts of a particular case nominated by the respondent (Flanagan, 1954). Doctors described a recent challenging incident involving a CLBP patient, one that had a psychosocial element (e.g., litigation, psychological difficulties). Following review of a thumbnail sketch, the case was explored more fully (Klein, Calderwood, & MacGregor, 1989).

A think-aloud problem-solving task was designed to explore in vivo problem solving (e.g., Jaspers, Steen, van den Bos, & Geenen, 2004). Doctors responded to a paper patient case ("Jonathan") constructed from an anonymized patient record and pilot tested with three doctors. Approaching the case as if it related to a primary care consultation, the task was to (a) identify current significant problems, and (b) recommend a response to Jonathan's requests for more medication and a work sickness certificate. Jonathan was single, aged 49, with CLBP for 3 years. He had an ongoing compensation case, current severe back pain, and reduced mobility. Previous assessment had yielded few conclusive findings; he experienced job insecurity and had a history of depression with possible alcohol misuse.

Procedure

The study received ethics approval from the university research committee and the Irish College of General Practitioners. Practices were selected to represent rural, urban, and mixed areas in one province of Ireland. We used local knowledge to identify three practices and the remaining four were identified from a professional register. Under Irish regulations, individual patient consent is not required for medical records that are anonymized. The sample of 75 patients reflected studies employing documentary records (e.g., Ziegert, Fridlund, & Lidell, 2007). Medical records data were transcribed from electronic patient records by the second author and imported to NVivo 7, a computer software application (QSR International, 2008).

The general practitioners gave informed consent to take part in interviews. The critical incident interview and think-aloud task were designed to assess psychosocial issues, and took place in the respective doctor's consultation room or a university office. The think-aloud task was presented following completion of the critical incident interview. All sessions were audio-recorded and transcribed verbatim into a word processing computer program before being added to the NVivo 7 database (QSR International, 2008). Twelve interviews were carried out, reflecting typical sample size in think-aloud and critical incident studies (Hoffman, Shadbolt, Burton, & Klein, 1995). A consistent pattern of responses was established across the interviews, indicating saturation had been achieved (Guest, Bunce, & Johnson, 2006).

Analysis

The combined dataset of coded medical records and interviews were used in a two-stage process comprising qualitative content analysis and thematic analysis (Braun & Clarke, 2006; Hsieh & Shannon, 2005). Qualitative content analysis was used to identify patterns in biomedical and psychosocial data at a detailed level, which in the case of medical records would have been especially difficult to do otherwise. The specificity of content analysis also allowed for double coding of thematic and cognitive aspects of interview data. The meaning and context-driven approach of thematic analysis added further to this approach, allowing underlying issues of attitudes and relationships to be assessed.

Analysis began with qualitative content analysis of medical records. We devised inductive content analysis category labels following open coding of 10 records and an overview of the records as a whole. This resulted in a codebook of eight major codes and 33 subcodes applied to all 75 records (Boyatzis, 1998). The codes described the entire range of the data using thematic labels (e.g., "pain consultation: flare up," "patient request," "psychosocial factors"). The interview and think-aloud data were then coded. A smaller set of categories was required because interviews were more focused, comprising an adaptation of 12 medical record codes and three new codes. Reliability of coding was assessed through daily review meetings and verification checks on a sample of the medical records and all interview and think-aloud data.

The interview data were then double coded using a second set of codes developed to describe the cognitive context in which thematic codes were used. In contrast to thematic codes, this set of category labels referred to the judgment and decision-making process in the form of strategies and patterns of information use such as "hypothesis" and "information cue." Double coding was carried out with the objective of exploring intersections of thematic content with cognitive strategies. Most of the analysis presented here refers to thematic codes, with illustrative reference to cognitive strategies.

Qualitative content analyses were carried out following coding. Each of the three types of data were analyzed to assess patterns in the prevalence and frequency of each category label. This gave an initial depiction of how general practitioners represented CLBP, showing reliance on biomedical content analysis codes in documentary records and use of psychosocial codes primarily in interviews and think-aloud problem solving.

The latent meaning and subjective attitudes underlying these patterns were assessed using thematic analysis. The original source documents were reviewed to assess the context and purpose of code use, and to note how categories related to one another. The resulting image of how the doctors represented CLBP is described by a superordinate theme of professional knowledge: a schema for back pain. This overarching theme is introduced with particular emphasis on the two subthemes particularly relevant to the study's psychosocial focus. They relate to the therapeutic relationship and representing the person's experience. The final interpretation takes place in the discussion, where the findings are critically analyzed in relation to prior research trends and theoretical work not previously applied to CLBP.

Findings

The superordinate theme represents beliefs about CLBP as an extensive network of biomedical and psychosocial knowledge featuring largely implicit expectations and assessment strategies. Two subthemes within this schema of professional and experiential knowledge highlight psychosocial aspects of CLBP:

- The therapeutic role: Managing the therapeutic relationship as a guide, moral guardian, and gate keeper
- Representing the person's experience: Beliefs based on depression and social knowledge, legal and work issues, and uncertainty about patient motivations

Consultation records were predominantly concerned with medication and physical findings. For instance, an equivalent number of references were recorded for one of several common medication codes ("nonopiate analgesics") as for all aspects of psychological care. Thus, psychosocial care was largely invisible in documentary records, but was embedded in more personalized accounts of CLBP patients given in interviews.

Professional Knowledge: A Schema for Back Pain

Doctors' extensive knowledge of CLBP was organized as a network of professional and personal beliefs rather than formalized, guideline-based evidence. The analogy of a schema to describe back pain knowledge and treatment options captures the integrated nature of this resource. The tacit and pragmatic nature of back pain knowledge was reflected in the intangibility of clinical and personal assessment ("on examination, ascertain how much spasm is in his back"; "nonverbal cues . . . what his appearance is like, how he seems") and the use of pattern recognition to make judgments ("you can just generally see in his appearance that he looks . . . like a man who is under a bit of pressure, you know stressed; furrowed eyebrows, looks like he's not sleeping"). Descriptions of patients in the medical records were focused on mobility, functional ability and the characterization of pain ("sudden, severe," "extreme tenderness," "paralumbar; right side of cerv spine"). Brief global judgments were used (e.g., nerve pressure, seized up), and rather than being oriented to subjective experience were oriented to a medical representation ("muscle tenderness++").

Interview and think-aloud data yielded more personalized accounts of the pain experience, revealing the more subtle sense making possible through the back pain schema:

> Jonathan doesn't see his behavior, I'm sure he doesn't see his depression and suspected alcohol misuse and legal case as having any relevance to his back pain whatsoever. He just knows he's in pain, and I've no doubt that he is.

In this instance the doctor said the pain was genuine, and reflected an acknowledgement in interviews that pain seriously undermines basic comfort and equilibrium. Expectations for back pain equally supported disbelief of patient claims. Explicit disbelief was seldom conveyed in medical records but was subtly communicated through distancing strategies, using phrases such as "allegedly" or "apparently," and recording patient self-reports as statements rather than facts. A more open attitude was displayed in interviews, evident in discussion of legal compensation and demands for pain medication (e.g., "[The patient says], 'You know what is brilliant for my pain is valium,' and my answer to that is, 'Of course it is. If I took valium for a short while I'd feel great and then I'd want some more'").

Access to the professional schema served pragmatic functions, including goal setting to avoid long-term disability, the least preferred outcome. Chronic disability meant severe social consequences such as repeated work absence, early retirement, or losing a job, and was associated with high consultation rates, complexity (e.g., multiple diagnoses), pain clinic referrals, surgery, and opiate prescription. Another function of the CLBP schema was to manage uncertainty, for instance in suggesting an informal theory of "wear and tear" after assessment had not produced a plausible account for pain causation ("We've out ruled . . . an underlying pathology and [there's], let's say only chronic mechanical back pain now").

The use of red and yellow "flags" was a semiformalized approach to clinical judgment, a heuristic for risk assessment. Red flags related to physical risk (e.g., "She had no neurological signs, no red flags"). To a lesser extent their psychosocial equivalent, yellow flags, had been assimilated:

> Then I'd have in my head from previous guidelines what they call yellow flags. . . . Things that are in the background that are probably making him not get better as quickly so, things like his work situation, his family situation.

Exploring the clinical schema using content analysis. As noted above, think-aloud responses were coded twice, using thematic (content) codes and cognitive (process) codes. A matrix query carried out through NVivo 7 (QSR International, 2008) examined patterns in the cooccurrence of thematic and cognitive codes. This allowed psychosocially oriented themes to be mapped onto the elements of the judgment process. Psychosocial themes were coded to the cognitive code for "hypothesis," whereas medication themes were typically coded to the "decision choice" and "goal" cognitive elements.

Applied to a particular transcript, data coded to "hypothesis" were coded thematically for "family," "legal issues," "alcohol," and "work." This illustrates the use of the back pain schema in making sense of the case, where Jonathan is represented as a long-term disability risk. As a single man he was compromised ("He may not have anybody to guide him and keep him on the right side"), potentially with a hidden agenda ("The fact that there's a legal case pending makes me think, 'Uh-oh'"). Psychologically he was not taking personal responsibility ("Suspected alcohol misuse makes me a bit disappointed because it may show some degree of demotivation").

Text units coded to "decision choice" in the same transcript were coded thematically for both physical and psychosocial themes. The decision to grant a work absence certificate was based on pragmatic relationship management, otherwise Jonathan was "going to then change practices until he keeps getting what he wants." The response coded to "goal" was coded thematically to "therapeutic relationship," highlighting the role of the relationship in achieving the priority to keep Jonathan "onside" and engaged ("trying to keep the door open for him, and managing his expectations").

The Therapeutic Relationship

This subtheme of the CLBP schema encompasses content analysis codes such as "therapeutic relationship," "general practitioner role," and "encouragement." Psychosocial work was conveyed in minimalist terms in the medical records ("counseled," "reassured"), elaborated in interviews into multiple roles as patient guide, gatekeeper for access to care, and moral guardian.

As a professionally frustrating condition, CLBP had a distinctive identity that framed the therapeutic relationship. Ongoing legal cases dragged out rehabilitation ("Oh, frustrating for me as well. I know that this guy's not going to, he's going to have low back pain every time I see him until that case is settled"), and CLBP could be demanding of the time resource to which doctors were continually attuned ("The consultation ran on and on and on because she gave me a huge big fill-in on all her history, which was very helpful but it was also very time consuming").

Patient guide. The doctors gave a lead to patients by advancing a strategy of active encouragement and motivation to shape beliefs and expectations ("It all depends on whether he is able to give anything to the whole situation, if it's entirely one sided and he's expecting me to fix him"). Good patient motivation meant the patient's attitude and approach were concordant with a plan for regaining activity and functioning ("He was well motivated, he wanted to get back to work so he did adhere to the treatment and that tells us a lot"). Doctors were assertive in seeking compliance ("That's part of my bargaining with him, if you like, to say, 'I need to see you in a week and if you don't attend that appointment I'm afraid that that will strain the doctor–patient relationship we have'"). This was partly because patients might not have been self-regulated ("My main job with this lady is to give her back the locus of control and at the moment she doesn't really want it"). Forceful expression of preferences might be seen as manipulative, and might have been resisted:

> A certain type of patient that is, “I know so much more about my illness than you do and I’m going to tell you what to do.” . . . You want to have a team effort with the patient but you also don’t want to be bullied. . . . On days when you are feeling a bit under par they can be the toughest patients to deal with.

Gatekeeper. Doctors tried to ensure that pain medication, disability pensions, and specialist services were not abused. This example shows gatekeeping by shaping beliefs about specialist referral:

> I usually say to people if I’m going to send them for an MRI scan it’s on the basis that if I find something we’ll operate on it. . . . MRI scans are expensive. . . . There is a long waiting list . . . so I try to focus the mind of the patient on whether they really, really want to have it done.

Explicit patient requests were infrequent in medical records, and could be framed in a tone of doubt (“Says some of his friends suggested second opinion”). Medication requests had particular credibility problems because of concerns about addiction and management problems, evident in interviews (“She was quite demanding and I don’t think anyone had said ‘No’ to her”) and medical records (“Demands home visit and an injection,” “complaining ++++”).

Moral guardian. This role is seen in strategies to encourage patient compliance and return to work. In this example the doctor’s approach can be interpreted as benevolent, driven by confident professional knowledge, but presenting the patient with a stark choice:

> I’d say, “Look, I expect the pain to be on you for a few weeks. I’m going to give you this cert [certificate] but we’re going to stop them from then. We need to get you focused on the substantive issues that this pain might be with you for life and how are you going to cope with it . . . and be able to work.”

Representing the Person’s Experience

This subtheme shows how depression, social knowledge, and lifestyle factors were used to represent the subjective experience of the person with CLBP. These domains accommodate material from content analysis codes such as “mood” and “work.” Doctors had no difficulty giving a personalized account of the patient’s struggle for normality. Trust and personalized understanding had a pragmatic function in progressing treatment goals (“Hopefully he would feel that his problems are taken seriously . . . once the rapport has developed, move to his depression, ongoing problems of maybe unhappiness of life”). Yet CLBP was colored by associations with patients working at variance with the doctor; for instance:

> Very difficult patient now that I recall him and very little ability to self-motivate and do stuff for himself. He was always trying to get you to do everything for him and a bit of a time waster as well.

Thus, although the struggle of CLBP was acknowledged, the personal experience was represented in largely pragmatic terms, oriented toward treatment goals and drawing on knowledge about depression, social categories, work, and legal issues.

Depression. Depression was an important concept for doctors. Conceptualizing the person in terms of depression provided an extra perspective on the person’s pain (“His physical perception of pain might be a sign that his mood and his coping mechanisms and strategies are reduced”), but also supported medicalized treatment involving antidepressants. Psychiatric diagnoses such as depression and anxiety were identified for 27% of the medical record, with little elaboration beyond the diagnostic label. Alongside psychiatric depression, everyday and common-sense understandings of mood were used. Terms such as “miserable” and “in good form” were used in medical records, with interviews illustrating easy access to lay beliefs about mood:

> He’s frustrated with the, the back pain, he’s frustrated with the medico-legal situation that it’s still ongoing, and he’s just frustrated in general. . . . He’s just really, you know, browned off that he’s left almost in limbo.

Doctors carried a large responsibility for psychosocial support in these circumstances, but were not altogether comfortable in the role of therapeutic communication and counseling (“I certainly found it difficult when I was running into blind alleys when I mentioned it”).

Social categories. Informal expectations based on social categories such as gender were used to contextualize judgments about patient mental health:

> Men or males tend to be less able to discuss their feelings and tend to manifest it in other ways, so if he’s describing that he’s feeling unhappy at work, maybe that’s just an opener for him to want it out in the open that he’s depressed.

These informal expectations were not dispassionate, and could convey a frame of reference as a problem patient of moral disrepute (“It’s easy to look at it and say, ‘Oh, this guy is just a malingerer' . . . because of the history of depression and alcohol misuse"). Nevertheless, access to informal judgments was seen as separable or bracketed from serving the patient ("You can't let that judge how to manage the case, you know. So, I mean you have to manage based on the clinical findings and . . . what he says").

Work and legal issues. Even "genuine" patients could have a legitimate concern with favorable case presentation ("There's Catch 22 as in if he gets better he probably feels that he won't get as much compensation"). Return to work was synonymous with recovery and successful adjustment, but work avoidance and ulterior motives were part of the script for CLBP ("It's a small cohort, in fairness, that want to I suppose the longer they stay out of work the better it looks"). An ongoing legal compensation case was seen as erecting a barrier to communication ("I'd find it difficult to discuss that with him. . . . It's very hard to bring something like that up without sounding like you're accusing them of using it").

Taken together, these influences resulted in a reading of Jonathan's subjective experience that highlighted doubt and risk more than phenomenological identification with his plight as a person, and as potentially difficult to motivate and focus, illustrated here by application of a malingering script:

> Spinal movement is reduced by 50%. I mean that could be genuine, or it could be, keep in mind the fact he has a court case and he's all kind of things going on. You'd have to be on guard this man isn't laying it on.

Discussion

The aim of this study was to analyze written and verbal accounts of CLBP given by general practitioners alongside clinical guidelines and existing research with doctors and patients. Medical attitudes recalled the depiction of CLBP in prior research as a low-status, frustrating condition, its management based on implicit professional knowledge rather than evidence-based, patient-centered guidelines (Chew-Graham & May, 1999; Goffman, 1963; Mead & Bower, 2000). Nevertheless, the doctors' goal-oriented approach, concerned with intrinsic motivation and personal responsibility, evoked formal patient activation interventions that have been devised (Michie, Smith, Senior, & Marteau, 2003).

Goal directedness did not imply adoption of a partnership-oriented, collaborative relationship. The therapeutic relationship was in the mold of medical sovereignty, a regulatory, biomedical orientation (Parsons, 1951; Starr, 1982) rather than corporatist, provider–client care based on shared decision making (Charles, Gafni, & Whelen, 1999; Heritage & Maynard, 2006; May, 2007). A similar approach to shaping attitudes has been noted in studies of other chronic conditions in primary care (Lutfey, 2005). Among these, CLBP is distinguished by unfavorable conditions where uncertainty might prevail in diagnosis, treatment, patient agenda, or motivation. Concurrently, patient expectations of a cure exist in the face of sometimes intractable medical and social problems (Chew-Graham & May, 1999).

Doctors did express interest in patients as individuals, but their representation of the person differed from the subjective experience described in phenomenological studies (Barry, 2002; Smith & Osborn, 2007). Their beliefs did not feature frustration and anger to the same degree as the patient literature. The doctors had a clinical interest in understanding personal motivations, as it allowed them to make sense of the patient presentation. Images of the patient agenda were split between motivated patients—adherent to treatment goals, and patients counter-motivated toward a hidden agenda or not motivated at all.

CLBP and Patient Motivation

CLBP has particular scope for incongruence between doctor and patient beliefs (Mishler, 1984). Doubts about patient motivation were a central motif, with doctors adopting the role of keeping patients focused on acceptable treatment goals. They were alert to transgression of normative rules for good motivation, steering the patient back because of benevolent intentions, not from a desire to control the patient for the sake of control. Doctors' approach to recruiting patient motivation was pragmatic in focusing on functional goals and strategies. Thus, the therapeutic relationship was an aid to assessment and a vehicle for goal acceptance and encouraging motivation (Lutfey, 2005). For example, the decision to grant a medical certificate in the think-aloud task could be justified as a means to build trust and promote acceptance of treatment goals. It was not necessarily based on a clinical reading of the patient's request. This illustrates the allowance of generous constraints to patients as a motivational strategy (Gomart, 2002).

Self-determination theory (SDT; Deci & Ryan, 2000) offers a reference point for further explorations of the beliefs doctors and patients hold about motivation. This theory has been utilized to understand motivation across a range of applied domains, but not in the case of implicit motivational theories held by health care providers. References to motivational strategies can be mapped on to the extrinsic–intrinsic motivation continuum in SDT, in the use of tangible motivators (the medical certificate), normative warnings ("We don't want you sliding into disability"), and promoting treatment goal acceptance (“good motivation”). SDT can aid critical reflection carried out by practitioners, framing their relationship to patients as one based on promoting self-regulation and internalization, to be achieved within a humanistic framework.

CLBP as a Social Representation

CLBP is a professional challenge, one doctors acknowledge to be difficult to manage, and evoking dissonance with a self-image of confidence and expertise (Shye, Freeborn, Romeo, & Eraker, 1998; Wileman, May, & Chew-Graham, 2002). The doctor is faced with uncertain and ambiguous information, and must display psychosocial awareness and engagement skills. In describing their responses, doctors relied on an applied understanding of patients in the form of the back pain schema described in the findings. The schema was shared among doctors, a resource of beliefs, expectations, and scripts for taking action. This knowledge form allowed doctors to assimilate a new patient to functional, implicit categories such as malinger or male-pattern depression (Burgess, van Ryn, Crowley-Matoka, & Malat, 2006; Hadfield, Brown, Pembroke, & Hayward, 2009; Lutfey, 2005; Werner & Malterud, 2003). In this sense, characterized by integrated clinical and social knowledge commonly understood within a professional community, the schema constitutes a social representation of back pain (Howarth, 2006).

Thus, doctors’ mingling of colloquial common sense with technical, privileged language does not imply confusion or disorganization (Howarth, 2006; MacNeela, Scott, Treacy, & Hyde, 2007). Instead, access to these discourses offers coherence in the face of uncertainty, serving the preferred professional role of setting clear goals. Although this socially situated schema was a complex representation of CLBP, its pragmatic, professional focus meant that the patient voice was largely silent. Consequently, what the phenomenological literature describes as an “assault on the self” might be interpreted as clinical depression by the doctor (Smith & Osborn, 2007).

Implications

The general practitioners had considerable autonomy in managing CLBP. They could choose to fit a patient to a script for risk and malingering or, alternatively, one of sympathy and support. The routinization of treatment guidelines was seen in just one respect: the use of red and yellow flags to identify risk (Main & Burton, 2000). Freedom in the art of caring for CLBP has problematic aspects. For example, deficits in doctors’ skill in shared decision making and patient education have been noted (Saba et al., 2006), along with limitations in professional preparation for psychosocial engagement (Shye et al., 1998; Yeheskel et al., 2000). Content analysis of thematic codes alongside cognitive codes showed psychosocial labels used in the sense-making phase, in making an assessment and case formulation more than in decision making about treatment. The social representation underlying knowledge about CLBP was a resource for doctors, but its verbal, tacit basis presents a challenge to the goal of promoting evidence-based psychosocial care interventions.

Limitations

The findings are not generalizable to other general practitioners and other places. The majority of the doctors interviewed were men, although medical records were written by both male and female doctors. Despite these factors, the picture of CLBP care described in the study is consistent with other findings that show limited penetration of guidelines and corporatist health care relationships (Lutfey, 2005). The biomedical focus of the medical records in particular contrast with the self-management strategies reported by patients who suffer chronic pain (Shariff et al., 2009).

Each form of data about CLBP gave a particular, contextual image of medical care. Written patient records were an uncontested account of biomedical and implicit professional knowledge interpretable by other members of the profession (Shaw, Clegg-Smith, Middleton, & Woodward, 2005). Think-aloud and critical incident interviews showed psychosocial care embedded in oral, professional knowledge, a consensual social representation for sense making, expectation setting, and decision making. What the research methodology did not capture was how beliefs and expectations are negotiated in consultations. The medical consultation provides scripted opportunities for doctor–patient collaboration (Heritage & Maynard, 2006). Despite this, previous research has not supported the idea that consultations routinely meet criteria for collaborative and shared decision making (Skuladottir & Halldorsdottir, 2008).

Conclusion

Chronic low back pain was depicted in medical records through biomedical terms that doctors could easily defend. Although one fourth of patient records included a psychiatric diagnosis, the written account of care was largely silent on psychological and social aspects of CLBP. This is despite the responsibility doctors have for this domain of care, in the front line of patient engagement. References to psychosocial care in verbal data were focused by a schema for back pain that prioritized goal setting and featured doubts over patient credibility. Doctors exercised a largely sovereign role by using a social representation of CLBP to understand and respond to clinical, psychosocial, and lifestyle issues. Future work should explore methods that work with the back pain schema and existing approach to collaboration, to accommodate evidence-based guidelines and patient-centered interview research.

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