

A meta-ethnography of healthcare professionals' experience of treating adults with chronic non-malignant pain to improve the experience and quality of healthcare

Fran Toye*, ^{1,2} Kate Seers, ³ Karen Barker, ^{1,2}

¹ Nuffield Orthopaedic Centre, Oxford University Hospitals NHS Foundation Trust, Windmill Road, Oxford, OX3 7HE, UK; frantoye@hotmail.com; +44 1865 737526

² Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences (NDORMS), University of Oxford, Oxford, UK.

³ Kate Seers, Royal College of Nursing Research Institute, Warwick Medical School, University of Warwick, Coventry, UK, CV4 7AL

*corresponding author

Conflict of interest declaration

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FT, KB and KS authored 2 studies included in this qualitative evidence synthesis.

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Scientific summary

Background

Each year over five million people develop chronic non-malignant pain. They do not always feel valued or believed by healthcare professionals (HCPs) and can experience an adversarial struggle in healthcare. In order to improve this, we need to understand what it is like for HCPs to provide healthcare for people with chronic non-malignant pain and why this can develop into an adversarial relationship. There is a large body of qualitative research exploring HCPs' experience of providing healthcare to people with chronic pain, but no attempt to systematically search for and integrate this knowledge in order to improve healthcare. Existing research highlights mismatches in patient-clinician experience. We aimed to use this existing knowledge to help us to improve our understanding of this complex process of healthcare. Our findings allow us to understand some of the challenges of providing healthcare for people with chronic non-malignant pain, and inform us how to improve the experience for both HCPs and for people with chronic pain.

Aim

- To undertake a Qualitative Evidence Synthesis (QES) of qualitative research using meta-ethnography to increase our understanding of what it is like for HCPs to provide healthcare to people with chronic non-malignant pain and thus inform improvements in the experience and quality of healthcare.
- To make our findings easily available and accessible through a short film.
- Contribute to the development of methods for QES that aim to bring together qualitative research findings so that healthcare can be improved.

Data collection

We searched five electronic bibliographic databases from inception to November 2016. We included studies that explore HCPs' experience of providing healthcare to people with chronic non-malignant pain. We included a combination of MESH and free text terms adapted from the InterTASC Information Specialists' Sub-Group (ISSG) Search Filter Resources. We screened the titles, abstracts and full text of potential studies for relevance and used methods of quality appraisal to frame our discussions. We utilised the GRADE-CERQual framework to rate confidence in review findings.

Analysis

We used the methods of meta-ethnography developed by Noblit and Hare and recently refined for larger studies by Toye and colleagues. Meta-ethnography involves identifying concepts from the studies included and progressively abstracting these concepts into a line of argument, or conceptual model. We used qualitative analysis software to assist in the organisation of the analysis.

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The study design, analysis and dissemination plan was developed in collaboration with an advisory group that included patients and HCPs.

Research findings

We screened 954 abstracts and 184 full texts and included 77 published studies reporting the experiences of over 1551 national and international HCPs including doctors, nurses and allied health professionals. We abstracted six themes that help us to understand HCPs experience of providing healthcare to people with chronic non-malignant pain : (1) a sceptical cultural lens and the siren song of diagnosis; (2) navigating juxtaposed models of medicine; (3) navigating the patient-clinician borderland; (4) the challenge of dual advocacy; (5) personal costs; (6) the craft of pain management. We produced a short film, 'Struggling to support people to live a valued life with chronic pain', which presents these themes on YouTube (<https://www.youtube.com/watch?v=477yTJPg10o>) (last accessed 24/07/17). We also developed a conceptual model which helps us to understand the complexity of providing healthcare to people with chronic non-malignant pain. The innovation of this conceptual model is to propose a series of tensions that are integral to the experience of providing healthcare to people with chronic non-malignant pain, between: a dualistic biomedical model and an embodied psychosocial model; professional distance and proximity; professional expertise and patient empowerment; the need to make concessions to maintain therapeutic relationships and the need for evidence based utility; patient and healthcare system advocacy. The figure below illustrates the tensions that underpin our conceptual model. This model may be transferable to other chronic conditions and potentially be useful for HCPs treating other conditions that do not comfortably fit the biomedical model, for example fatigue and unexplained symptoms. Our findings demonstrate that these tensions underpin HCPs experience of providing healthcare to people with chronic non-malignant pain and can

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contribute to an adversarial relationship. Importantly, HCPs navigate towards the biomedical model and siren song of diagnosis. HCPs can find it challenging to provide healthcare to people with chronic non-malignant pain because they feel that they have failed in their professional duty to find and fix a medical problem.

The bio-psychosocial model is an alternative model used in chronic pain management. This recognises that the experience of pain is result of a complex relationship between biological and psychosocial factors. Our findings indicate that even where HCPs advocate a bio-psychosocial model, for some, the model remains *dualistic* at its core. This can mean that HCPs make an abrupt shift towards psychosocial explanations when they cannot find a biomedical explanation. Our findings also indicate that some HCPs utilise a more *embodied* bio-psychosocial approach and focus on understanding the lived experience of pain alongside efforts to define pain in biomedical terms, from the outset at the first consultation. Embodiment focuses on unique personal meaning which can only be understood in the context of the individual's social, cultural and historical context. At times, HCPs who focus on gaining an embodied understanding can feel 'bombarded by despair'. However, there was a sense that, although it can impose a personal burden, this embodied approach can also be rewarding for both patient and professional. This embodied approach might also help to reduce the sense of professional failure that comes from the desire to medically *fix* things. Findings also indicate the complexity of navigating the interface between professional and patient. HCPs can find it difficult to balance the dual role of representing the healthcare system and at the same time maintain an effective therapeutic relationship with individual patients. The ability to successfully manage patients with chronic pain is described as a craft that is learnt through experience. At times HCPs can feel under skilled in chronic pain management. We also identify themes to help us understand the experience of prescribing opioids. These themes are underpinned by the ambiguity surrounding opioid prescription for chronic non-malignant pain and these highlight the complexity for HCPs of managing chronic non-malignant pain.

We rated confidence in review findings as moderate to high and comment on the utility of GRADE-CERQual for determining confidence in qualitative syntheses. We also outline criteria that might help reviewers to consider which studies to include in future qualitative syntheses.

Conceptual model – complexity of providing healthcare to people with chronic non-malignant pain



Conclusions

This innovative meta-ethnography reveals for the first time that there are many complex tensions that HCPs have to navigate when working with people who have chronic non-malignant pain, and this experience can be adversarial. Our findings can help us to consider the experience of healthcare from the perspective of HCP and to understand potential tensions that may contribute to this adversarial experience. HCPs can use our conceptual model to help them to think about their encounters with patients with chronic pain, for example;

- Am I making a sudden shift to psychosocial explanations?
- Am I considering psychosocial factors at the outset?
- Do I understand this patient's experience or am I too distant;
- Am I trying to enforce my decisions?

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- Am I making a concession and for whose benefit?
- What is the effect of dual advocacy on me and my patient?
- What personal impact is this having on me?
- Am I feeling like I have failed?

We invite HCPs to use our 'mixing console' to help them to think about their encounters with patient. The poles are neither inherently *good* nor *bad*; just as bass and treble are neither inherently good nor bad. It is the correct mix within a context that contributes to the quality of music. Our console also incorporates the *pitch* or level of loss, both professional and personal, that can contribute to the harmony or dissonance of a therapeutic encounter. This console may be transferable to other chronic conditions.

Implications for healthcare

- Findings indicate an underlying scepticism that might contribute to an adversarial relationship between a patient and their HCP. Believing patients' experiences may provide a more secure foundation for an effective therapeutic relationship.
- Findings indicate a dualistic approach where HCPs make a sudden shift from biomedical to bio-psychosocial explanations for the pain after exhausting attempts to decipher a diagnosis. This abrupt shift may exacerbate a sense of loss of credibility for patients.
- Findings indicate that some HCPs engage in judgements about what is real or not real, that are underpinned by a cultural duality of *real* (biomedical) and *not real* (psychosocial).
- Findings suggest that an embodied, rather than a dualistic, bio-psychosocial model which focuses on the personal meaning of pain from the outset might help to lessen the adversarial experience and also reduce the HCPs sense of failure.
- Findings have clinical and educational implications. How can we enable HCPs to manage the tensions that underpin the experience of providing healthcare to people with chronic non-malignant pain? How do we recognise and support the complexity of skills and emotional cost of providing healthcare to people with chronic non-malignant pain?
- Findings highlight the benefits of reciprocity, mutuality and collaboration between HCPs and the benefits of being able to break down or cross professional boundaries and hierarchies.

- Findings highlight a need to consider the emotional costs to HCPs of providing healthcare to people with chronic non-malignant pain.