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

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Scientific summary

HCPs' experience of treating adults with chronic non-malignant pain

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Scientific summary

Background

A recent systematic review of population studies indicates that as many as 28 million adults in the UK are affected by chronic pain (Fayaz A, Croft P, Langford RM, Donaldson LJ, Jones GT. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. *BMJ Open* 2016;**6**:e010364). They do not always feel valued or believed by health-care professionals (HCPs) and can experience an adversarial struggle in health care. To improve this, we need to understand what it is like for HCPs to provide health care 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 health care to people with chronic pain, but there has been no attempt to systematically search for and integrate this knowledge in order to improve health care. Existing research highlights mismatches in patients' and clinicians' experiences. We aimed to use this existing knowledge to help us to improve our understanding of this complex process of health care. Our findings allow us to understand some of the challenges of providing health care for people with chronic non-malignant pain and inform us of how to improve the experience for both HCPs and for people with chronic pain.

Objectives

- 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 health care to people with chronic non-malignant pain and thus inform improvements in the experience and quality of health care.
- To make our findings easily available and accessible through a short film.
- To contribute to the development of methods for QES that aim to bring together qualitative research findings so that health care can be improved.

Data collection

We searched five electronic bibliographic databases (MEDLINE, EMBASE, Cumulative Index to Nursing and Allied Health Literature, PsycINFO and Allied and Complementary Medicine Database) from inception to November 2016. We included studies that explore HCPs' experiences of providing health care to people with chronic non-malignant pain. We included a combination of medical subject heading and free-text terms adapted from the InterTASC Information Specialists' Sub-Group search filter resource. We screened the titles, abstracts and full texts of potential studies for relevance and used methods of quality appraisal to frame our discussions. We utilised the Grading of Recommendations Assessment, Development and Evaluation Confidence in the Evidence from Reviews of Qualitative research (GRADE-CERQual) framework to rate our confidence in the review findings.

Analysis

We used the methods of meta-ethnography developed by Noblit and Hare (Noblit G, Hare R. *Meta-Ethnography: Synthesising Qualitative Studies*. California, CA: Sage Publications; 1988) and recently refined for larger studies by Toye and colleagues (Toye F, Seers K, Allcock N, Briggs M, Carr E, Barker K. Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative studies. *BMC Med Res Methodol* 2014;**14**:80). 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.

Patient and public involvement

The study design, analysis and dissemination plan were 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 > 1551 national and international HCPs, including doctors, nurses and allied health professionals. We abstracted six themes that help us to understand HCPs' experiences of providing health care 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; and (6) the craft of pain management. We produced a short film that presents these themes, 'Struggling to support people to live a valued life with chronic pain', which is available on YouTube (YouTube, LLC, San Bruno, CA, USA) (see *Report Supplementary Material 1*; URL: www.journalslibrary.nihr.ac.uk/programmes/hsdr/1419807/#/documentation; accessed 24 July 2017). We also developed a conceptual model that helps us to understand the complexity of providing health care 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 health care 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; and patient advocacy and health-care system advocacy. *Figure a* 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 (e.g. fatigue and unexplained symptoms). Our findings demonstrate that these tensions underpin HCPs' experience of providing health care to people with chronic non-malignant pain and can contribute to an adversarial relationship. Importantly, HCPs navigate towards the biomedical model and siren song of diagnosis. HCPs can find it challenging to provide health care 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 biopsychosocial model is a model used in chronic pain management that recognises that the experience of pain is the result of a complex relationship between biological and psychosocial factors. Our findings indicate that even when HCPs advocate a biopsychosocial 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, from the outset, during the first consultation, some HCPs utilise a more embodied biopsychosocial approach and focus on understanding the lived experience of pain alongside efforts to define pain in biomedical terms. Embodiment focuses on unique personal meaning that can be understood only in 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 is a sense that, although it can impose a personal burden, this embodied approach can also be rewarding for both the patient and the professional. This embodied approach might also help to reduce the sense of professional failure that comes from the desire to find a medical solution. The findings also indicate the complexity of navigating the interface between the professional and the patient. HCPs can find it difficult to balance the dual role of representing the health-care 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 underskilled 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 they highlight the complexity for HCPs of managing chronic non-malignant pain.

We rate our confidence in the 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.

FIGURE a Conceptual model: complexity of providing health care to people with chronic non-malignant pain. Reproduced from Toye F, Seers K, Barker KL. Meta-ethnography to understand healthcare professionals' experience of treating adults with chronic non-malignant pain. *BMJ Open* 2017;**7**:e018411. This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: http://creativecommons.org/licenses/by/4.0/).

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 that this experience can be adversarial. Our findings can help us to consider the experience of health care from the perspective of HCPs and to understand the 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?
- 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 patients. The poles are neither inherently good nor inherently bad, just as bass and treble are neither inherently good nor inherently 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 health care

- The 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.
- The findings indicate a dualistic approach whereby HCPs make a sudden shift from biomedical to biopsychosocial explanations for the pain after exhausting attempts to decipher a diagnosis. This abrupt shift may exacerbate a sense of loss of credibility for patients.
- The 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).
- The findings suggest that an embodied, rather than a dualistic, biopsychosocial model that focuses on the personal meaning of pain from the outset might help to lessen the adversarial experience and also reduce the HCP's sense of failure.
- The findings have clinical and educational implications. How can we enable HCPs to manage the tensions that underpin the experience of providing health care to people with chronic non-malignant pain? How do we recognise and support the complexity of skills and emotional cost of providing health care to people with chronic non-malignant pain?
- The 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.
- The findings highlight a need to consider the emotional costs to HCPs of providing health care to people with chronic non-malignant pain.

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