

WHAT IS “THE GOOD BACK-CONSULTATION”? A COMBINED QUALITATIVE AND QUANTITATIVE STUDY OF CHRONIC LOW BACK PAIN PATIENTS’ INTERACTION WITH AND PERCEPTIONS OF CONSULTATIONS WITH SPECIALISTS

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Objective: To identify core elements of what patients with chronic low back pain perceive as good clinical communication and interaction with a specialist (“The Good Back-Consultation”).

Design: Qualitative study including observation of consultations and a subsequent patient interview. Quantitative data were also recorded.

Subjects: Thirty-five patients with chronic low back pain referred to a specialist.

Methods: Thirty-five consultations were observed with respect to history-taking, clinical examination and interaction between patient and doctor. Patients were subsequently interviewed about how they perceived the consultation. Fourteen specialists with various specialty branches and 35 patients (18 males) participated. For 3 of the specialists a positive effect (return to work) on patients with chronic low back pain had been documented in previous randomized controlled trials. Qualitative data analysis was performed using a template method.

Results: Most patients thought that the history-taking and clinical examination had been thorough and satisfactory. Patients emphasized the importance of being given an explanation during the examination of what was being done and found, of receiving understandable information on the causes of the pain, of receiving reassurance, discussing psychosocial issues and discussing what can be done. The most important characteristic of “The Good Back-Consultation” was that the specialist took the patient seriously.

Conclusion: The findings may represent an important potential for enhancing clinical communication with patients.

Key words: clinical communication, chronic low back pain, combined qualitative and quantitative study.

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INTRODUCTION

A substantial body of evidence has shown that the content and quality of clinical communication may have significant influence

on patient satisfaction (1), health status measures (2, 3), compliance (1), placebo and nocebo effects (4), as well as on malpractice litigation (5). Communication skills are thus an essential part of clinical competence (6).

Over the last 2–3 decades, many models have been developed to improve the quality of consultations, not least in primary care settings (7–9). One commonly applied model for improving the consultation is the patient-centred clinical model (8, 9), which is a bio-psycho-social model emphasizing the importance of mutual understanding and alliance between physician and patient. This model underlines that the physician should try to achieve a common ground for shared decisions and responsibility after having explored the disease through clinical history and somatic findings. Another main principle is to search actively for the patients’ perspective including illness aspects, thoughts on what is wrong, fear and other feelings about the problem, perceived functioning, and expectations about what should be done (8–10).

Within the domain of healthcare for patients with low back pain (LBP) the last decade has seen a growing awareness of the importance of the patient–healthcare provider interaction including communication and shared decision-making (1, 11–13). According to Richard Deyo (14), for instance: “We often apply frightening diagnostic labels”. Gordon Waddell (14) has suggested that: “It is time to *take* a patient’s history, and not just *make* a patient’s history... Let the patient be heard.” Patients’ preferences, needs and expectations may be influenced significantly by means of clinical communication and may, in turn, have an impact on the outcome of a specific intervention (1, 2, 9–11). With some exceptions (11, 15–17) surprisingly little research has been carried out on clinical communication/interaction aspects of the management of patients with LBP, including those with longstanding, comprehensive problems seen by specialists. What is the “drug” in the clinical encounter with patients with chronic LBP?

The main elements of 3 interdisciplinary Norwegian randomized controlled trials (RCTs) on the positive effect on the rehabilitation of patients with chronic LBP have been communication aspects. These RCTs have, in terms of a consultation model, focused on explaining pain mechanisms, advice on continuing with normal daily activities/light exercises, and

reassurance to reduce fear-avoidance behaviour (18–20). The main outcome measure in these studies was return to work. The beneficial outcome of these studies has, along with interest in the patient-centred clinical model and communication skills, prompted the present study.

The objective of the present combined qualitative and quantitative study has been to identify and describe the core elements (and style) of what patients with chronic LBP perceive as good clinical communication and interaction with their doctor (specialist) in a consultation, and to explore whether there were any special characteristics of consultations performed by doctors using consultation models with previously documented effect (return to work).

MATERIAL AND METHODS

In order to include a broad spectrum of patients and doctors (see below), the study was carried out at 8 outpatient spine clinics located in the southern and central part of Norway (4 of 5 main regions) between February 2000 and September 2001.

Participating doctors

Fourteen (11 males) specialists in neurology, rehabilitation medicine, orthopaedics, neurosurgery and rheumatology, with a mean age of 48 years (range 35–58 years) participated. They were recruited in connection with the first author's (EL's) visits to establish a Norwegian LBP network (the total number of such clinics in Norway was 13). A selection criterion was that they were head of their clinic, and hence normally had long-lasting clinical experience.

Three of the participating specialists within rehabilitation medicine had previously documented the effect of a combined mobilization/cognitive program in well-designed randomized controlled trials (18–20), and hence were included. In the present study they have practised the same consultation model, being the main element of the patient management program (14 of 35 consultations). All specialists were informed about the objectives of the study.

Participating patients

The patients were considered for enrolment in the study consecutively as they had an appointment at the outpatient clinic, based on gender, age, duration of pain, and education. They were then selected by EL to represent a variation in background characteristics (age, i.e. <30, 30–50, >51 years; gender, i.e. both; education, i.e. low, middle and high according to a list, and duration of LBP, i.e. <or >2 years) in line with qualitative research principles. Patients were informed before giving their consent that the interviewer was a doctor and that he did not work at the clinic. They were informed that the purpose of the study was to observe what takes place in the consultations and try to describe what patients perceive as a "Good Back-Consultation". They were also told that all information obtained from the consultation and interviews would be handled anonymously. Six of the first 10 selected patients refused to participate if the consultations were to be video- or audio-taped, which was therefore decided to be omitted.

Thirty-five patients (18 males with a mean age of 45.5 years; range 23–65) were included in the study. They were referred (first contact with the specialist) by their general practitioner for chronic LBP (duration >3 months). No patients refused to participate (if there was no taping of the consultations). Twelve patients had radiculopathy and 2 other patients had suspected serious spinal pathology (not verified). Mean duration of pain (from onset of the present period) was 2.7 years (range 6 months to 7 years).

Data collection

The main theoretical perspective for data collection and analysis was the patient-centred clinical model (9), and the authors' interest and knowledge in clinical communication (1, 6, 8, 9). Background patient

characteristics in terms of age, gender, occupation, referral diagnosis and duration of the present episode of LBP were recorded on separate standardized forms before the consultation and used for patient selection. The consultations lasted for 40–60 minutes, and were observed and recorded by one of the authors (EL). During the consultation, detailed notes were made with respect to medical history (kind of information), clinical examination (what was tested) and interaction between patient and doctor. EL subjectively judged this interaction on a self-made summary scale, called overall clinical competence, ranging from 0–10 (0=not good, 10=very good). Specifically, the physicians were observed with regard to how and to which extent they were actively listening to the patients non-verbally (e.g. body posture, eye contact, nodding, smiling), para-verbally (e.g. silence, voice, humming) and verbally (e.g. probing, using open-ended questions, echoing). On another scale (numerical 0–10) the extent to which the doctor asked specifically for patients' thoughts, preferences and feelings (patient-centredness) was recorded.

The structure of the consultations as carried out by the doctor in terms of opening and closing the consultation and informing the patient of what was going to happen was also noted. Not all collected quantitative data are presented separately, but are used to add information to the qualitative results. If either strong agreement or discrepancies between the qualitative and the observational quantitative data was noted, this is described in the results section.

Immediately after the consultation EL interviewed each patient using a semi-structured interview guide. The interviews lasted for 15–20 minutes, and detailed interview notes were taken. The guide had the following topics included based on previous research (see references above) and our own clinical experience:

- What do you think about the consultation in terms of:
 - The clinical examination.
 - The information you received about why it hurts and a possible diagnosis.
 - Medical treatment, and what you can do yourself to get better.
 - Information modes, for instance the use of models, scans or metaphors.
 - Associations between coping with LBP and life situation/quality of life.
 - Being reassured.
- How satisfied were you with this consultation (patient-satisfaction, score 0–10)?
- In general, what do you regard to be the most important characteristics of what we may call a "Good Back-Consultation"?

Data analysis

The responses to the questions above were noted and analysed by the interviewer (being an academic general practitioner with patient-centred perspective) using template analysis adapted from Crabtree & Miller (21). The first step was to make a code-book in terms of a list of topics regarding good clinical communication. Some of these codes were selected *a priori* as defined in the interview guide with its 6 main topics (see above) and 4 others were identified from the interview notes and then refined by reading the notes several times. The 4 new categories were: "Be taken seriously", "Patient-centred communication and interaction", "Giving test-related explanations and positive feedback", and "Organization and structure of the consultation". After this the interview notes were reorganized in line with the code-book, all comments by the same code appeared in one place and were then reinterpreted for meaning and main issues. The interviewer described the patients' views by summarizing the content of the patients' comments within each issue (21). The qualitative results are presented in terms of descriptions of main issues and with typical statements (also from the specialists) illustrating the descriptions. We also, as a supplement to the qualitative data, give numbers of individuals with statements related to the main issues.

The analyses (qualitative and quantitative) also looked for possible differences in consultations between 3 physicians who had participated in the RCTs (group A, 14 consultations) and the 11 other participating doctors (group B, 21 consultations). The results are combined with quantitative data regarding overall clinical competence, patient-centredness and patient-satisfaction. Quantitative comparison between the groups A and B are calculated and presented with mean values with

95% confidence interval (CI), median and *p*-values (level of significance <0.05) using a two-tailed Mann–Whitney test.

Ethics

Informed consent was obtained from all patients. The study was approved by the Regional Committee for Medical Research Ethics.

RESULTS

Qualitative results are first presented according to the categories that were found.

Medical history-taking and clinical examination

Almost all ($n=31$) of the patients thought that the medical history-taking and clinical examination had been thorough and satisfactory. This also corresponded with EL’s evaluation of the consultation, and statements such as “I can’t control it, but he seems to know what he’s doing” or “She revealed exactly where my pain has its origin” confirm this.

The observations of the consultations showed that these were performed in a strikingly similar way, including medical history-taking, inspection and testing moving patterns, muscle strength and tenderness, reflexes, sensibility and straight-leg raising test. The examination appeared, without exception, to be thorough, and most of the specialists, (but with variation both between and within them) used much of the time palpating muscles and intervertebral spaces in order to identify tenderness. Generally, any such tenderness was emphasized when it came to an explanation of pain mechanisms (see below). Three of 4 patients who had visited the same doctor expressed in the interview that the doctor “had hard hands” and that the examination had hurt. Three other patients expressed, in the interview, their worries that the doctor would conclude after the examination that there was nothing wrong, meaning “I’m a hypochondriac or just a psychiatric case”.

Giving test-related explanations and positive feedback

Several patients mentioned the importance of having explanations during the examination of why and what was being done and what was found: “Do you know why I am testing your reflexes? If the flux of signals goes from a stretched tendon via the nerve into the spinal cord and back again without any blockage, then the nerve is functioning normally. You have fine reflexes so there are no signs here of trapped nerves”. The importance of communicating such positive findings (through body language also) was striking from observing the examinations. The extent to which this was done, and how, was according to EL’s judgement, superior in group A compared with group B. Thus, the group A doctors gave positive feedback more extensively concerning “strength” (functioning well) and normal findings, e.g. “Your back seems to be strong and have good muscles even if it hurts” and “The way you move your spine is just fine”.

Explanation of causes of pain and a possible diagnosis

A main and general finding of this study was the importance to the patient of receiving an understandable explanation of the back pain or, if possible, getting a diagnosis. This was mentioned specifically by 29 of the 35 patients: “This was the first time I got an understandable explanation of why it hurts”. A key factor appeared to be that the patient was able to understand the explanation, i.e. that it was adapted to his or her concepts, knowledge and glossary. Such individual adaptation was frequently achieved if the doctor asked in a patient-centred mode: “Have you previously received an explanation of why it hurts or have you had any thoughts yourself regarding the cause of the pain?”

Another consistent finding, although less pronounced, was group A doctors’ use of simple explanations and metaphors: “Some of your back muscles are working all the time, like having a cramp in the leg, and your intervertebral disc has probably got ‘wears and tears’—what I call wrinkles. That is quite normal, but may hurt if nerves are getting irritated. You have probably got a prolapse. But the prolapse will shrink over time like a grape shrinks to a raisin”.

Another significant finding was how positively the patients regarded the physicians’ use of plastic models of the spine, posters or scans when explaining the pain mechanism. The extent to which the patient received an exact patho-anatomical or other “correct” taxonomy-based medical diagnosis appeared not to be essential. In general, the patients seemed to have greater confidence in explanations supported by clinical findings, such as tenderness, or based on scan findings.

Reassurance and favourable prognosis

A major concern for most patients ($n=27$) was that they might have a potentially serious underlying pathological condition causing the LBP. Such perceptions about serious conditions were mostly cancer, brittle bones/fractures, chronic rheumatic disorder, and trapped nerves with the risk of muscle weakness, and ending up in a wheelchair.

Effective reassurance, judged from observation and interviews, was achieved when the patients got clear information from the doctor that cancer or other serious diseases (many of the doctors used the term “red flags”) could with reasonably high certainty be ruled out: “I can’t find any evidence that anything dangerous is behind your back pain... and I think your prognosis is good. In a couple of months you’ll be much better or even pain-free.” However, many doctors mentioned that the pain could reappear in the future, and that this was fairly normal. The most effective type of reassurance turned out to be the type of communication that allowed the patient him- or herself to draw a conclusion from the explanation given: “OK, now I do understand. It’s nothing dangerous, and I will not end up disabled”. It also appeared to be of great importance to the patient that explanations given by various care providers held no major inconsistencies, to be told that pain did not necessarily mean harm, and that some increase of pain when

moving or doing exercises may be a sign of stimulating repair processes. The ability of the group A doctors to give confidence by enhancing reassurance seemed from the observations to be more pronounced compared with group B.

Psychosocial issues

Through the interviews it occurred that the patients' concept of psychosocial issues and that such issues had been discussed in most cases meant that the doctor had dealt with a possible correlation (in both directions) between daily life situation, including job, family, coping and quality of life aspects, role function and the patient's LBP. In 25 of 35 consultations the patients felt that this was not focused on at all or to a small extent and that they missed it: "The doctor was not interested in how my back problem affected my life, it is so important that the doctor also recognizes the connection between back and mind". Both from the interview analyses and consultation observations no obvious differences between group A and B physicians in handling of psychosocial issues were noticed.

Four patients expressed their concerns/frustrations that their back problem during the consultation was labelled as "just" being psychological or psychosomatic.

What can be done?

Patients were interested in 2 main issues: what the patient him- or herself could do to improve the LBP, and where to get help.

Very important information as perceived by a majority of the patients ($n=30$) was related to what kind of activity he or she preferably could or should do and what they should avoid to reduce pain and improve function. Again it appeared to be crucial that the patient received information/explanations enabling him- or herself to draw a conclusion that the advice is beneficial and not harming even if it hurts occasionally: "If you resume your normal daily activity, including work, as soon as you possibly can, there is substantial evidence to suggest that this will contribute to the healing process. Bones, joints and muscles will have improved function, become stronger and more flexible and therefore less painful; try to obtain a relaxed motion pattern for your body, and stretching is often good for you".

Doctors in group A, especially, emphasized to the patients: "Do practice what you like and feel is good for you... diversion from pain by doing or thinking about something else may be an effective painkiller". Some patients ($n=7$) expressed frustration during the interview because no new advice on self-help had been given during the consultation. On the other hand, patients tended to appreciate if the doctor asked specifically about what advice others had given. It worked as reinforcement if the same explanation or terms were used.

Four patients said during the interview that they expected passive external treatment because they previously had only got worse after following advice to stay active.

All patients were interested in obtaining information about what help they could get to reduce ailments and enhance

function, and approximately one-third ($n=12$) expressed that what they received was in agreement with their preferences. Approximately two-thirds ($n=25$) wanted to know whether surgery was a solution, and 5 patients were convinced that surgery was what they needed in order to get better. Those 5 said that all other options had been tried without any help.

Approximately half of the patients ($n=19$) wanted conservative treatment such as physiotherapy or a training program. Most patients ($n=30$) had already tried chiropractic/manual therapy one or more times. Only a few patients ($n=6$) thought about having further imaging examinations of the back, probably because most of them recently had had one or more such investigations carried out.

A constant finding (observation and interviews) from the discussions/negotiations between the physician and the patient about treatment options was the importance of meeting the patient's expectations and preferences (i.e. being patient-centred) in the decision-making process. This was true, in particular, when expectations had been explored but not taken into account, and if there was a mismatch between the doctor's suggestion and what was on the patient's agenda: "The doctor prescribed physiotherapy, but didn't ask at all about what I thought about that. I have tried such treatment several times without any effect at all. It only provoked more pain".

Patient-centred communication and interaction

A main finding was the perceived importance of how well the specialist expressed interest in what the patient told him or her, gave signals of empathy and active listening and, not least, that the specialist believed how painful the backache was. In sum: the importance of being seen, heard and believed, i.e. *being taken seriously* became evident both from interviews and observations of the consultations. Illustrative statements were: "I (the doctor) understand that all this pain has been very difficult for you, it's important for me as your doctor to know which thoughts you have had about what might help you, and can you tell me what worries you most about your back pain?"

These findings apparently cover, although not fully, to what extent the doctor demonstrated an ability to be patient-centred, i.e. actively seeking the patient's perspective in terms of thoughts, worries/feelings, preferences and expectations.

Two other communication aspects were found, both linked to what may be described as a "doctor-centred" approach: firstly, the use of advanced medical terms did not impress the patient, but merely provoked confusion and irritation, for instance: "Afferent and efferent signals in your neurons are disturbed". Secondly, the use of closed rather than open-ended questions, especially at an early phase of the consultation, and when dealing with more complex or difficult topics, such as psychosocial issues, seemed to have a negative impact on the communication. In a surprisingly high number of consultations the doctor closed the communication/information flow "effectively" by applying closed questions, and giving largely medical doctor-oriented information.

Organization and structure of the consultation

In only 3 consultations did the specialist announce what they were going to do in the consultation or talk about/summarize main findings. There was also a consistent lack of distinct opening, management and completing phases of the consultation, and very few ($n=2$) summarized what had taken place. In no cases was the patient asked directly whether he or she was satisfied with the consultation and whether his or her preferences and needs had been met. With regards to the structure and organization of the consultations there were no appreciable differences between the 2 specialist groups.

Five patients expressed frustration about a lack of information about what was going to take place in the consultation: “I wish the doctor could have told me what he was going to do or talk to me about”.

Two main findings of the study, called overall clinical competence, patient-centredness and patient-satisfaction, are also presented quantitatively, with comparison of group A and B, in Table I. There is, in general, high scorings for all 3 variables, and with higher values in group A, being statistically significant for patient-centredness.

Characteristics of “The Good Back-Consultation”

The last interview question to all patients was about what they thought were the most important characteristics of a good consultation with a back specialist; what I (EL) call “The Good Back-Consultation”. In ranked order, according to frequency, emphasis and stated importance by the patients, the list is as follows:

- To be taken seriously (be seen, heard and believed).
- To be given an understandable explanation of what is wrong.
- To have patient-centred communication (seeking patients’ perspectives/preferences).
- To receive reassurance and, if possible, be given a favourable prognosis.
- To be told what can be done (by the patient him- or herself and by the care provider).

DISCUSSION

Using qualitative method

The main objective of this study was to explore what patients with chronic LBP perceived to be the most important characteristics of good clinical communication and interaction in a consultation with a specialist. Little research exists on these issues. Consequently, it is useful to start with a qualitative approach (21, 22), because it focuses on individuals’ experiences as they occur in terms of thoughts, ideas, feelings, attitudes and perceptions, and emphasizes human behaviour, social interaction and context (23). Qualitative research results also provide a basis for subsequent larger quantitative verifying research allowing generalization. Often it may be advantageous to combine both methods (23).

One strength of our study is that a favourable outcome had been documented, using a similar consultation model as in the present study in well-designed RCTs, comprising one-third of the present consultations, meaning that we know fairly well that it works. However, it should be taken into consideration in the interpretation of the results that the number of specialists is only 3, and they are all specialists in rehabilitation medicine, perhaps representing a biased group.

We also think that the main results from our study show good pragmatic validity, being in accordance with common-sense experiences from daily practice. The number of consultations appears to be sufficient for a study using qualitative method(s) (22). This is in line with our impression that from the last consultations there were almost only repetitions of previous findings. We also regard the template method to be a well-accepted qualitative method, because, for instance, it allows, as we have done, to start with some *a priori* defined categories before data collection and analysis, and it is relatively quick, reproducible and easy to grasp for those sceptical to qualitative research. It has, however, been debated whether it is better to start with no assumptions (21, 22).

Another strength appears to be that we supplemented the findings using 2 different qualitative methodological approaches (observation and interviews), and that for the main findings in

Table I. Overall clinical competence and patient-centredness, as judged by one of the authors (EL) (0=not good, 10=very good) in 14 consultations with 3 physicians (group A) who had participated in randomized controlled trials on patients with chronic low back pain with significant effect (main outcome: return to work) compared with 21 consultations with physicians (group B) without such participation. Correspondingly, data for patient-satisfaction, as judged by the patients (0=not good, 10=very good), are given in the 2 groups

	Overall clinical competence		Patient-centredness		Patient-satisfaction	
	Group A	Group B	Group A	Group B	Group A	Group B
Mean	7.4	7.2	8.1	6.6	7.8	7.1
95% CI	6.5–8.3	6.5–7.8	7.4–8.9	6.0–7.2	7.0–8.7	6.6–7.7
Median	7.0	7.0	8.0	6.0	8.0	7.0
<i>p</i> -value	0.70		0.02		0.10	

CI =confidence interval.

terms of summarized clinical competence, patient-centredness and patient-satisfaction we also recorded quantitative data. Furthermore, the finding of better clinical and communication skills in the group A doctors is similar using qualitative and quantitative methodology, respectively. Additionally, there was a broad spectrum of both participating specialists (branches of speciality and geography) and patients (sociodemographic characteristics), thus enhancing population variability, a key characteristic for qualitative methodological approach (22). On the other hand, this should imply a need to be very cautious in making generalizations from our findings.

Limitations of the study

There are some obvious limitations of our study. We have, for instance, used neither audio- nor videotape (with complete transcripts) from the consultations, and are thus at risk of being biased from one author's views or perspectives, for instance believing a patient-centred model may be optimal as regards good clinical communication. However, within the clinical setting and limited resources available for this study, and because a substantial number of the initially selected patients for inclusion were reluctant to be tape-recorded, it was the only feasible way it could be performed.

Furthermore, only one of the authors has observed the consultations and analysed the data, giving inherent risk of bias. However, this approach was chosen because only one of us performed the observational part of the study and thus was able to combine and bridge the findings obtained from both qualitative methodological approaches. It is also possible that the behaviour of both the specialists and patients may have been influenced by the presence of an observer during the consultation. For instance, the specialist may have performed more thorough clinical examinations and tried to show more empathy, while patients may have avoided discussing personal issues.

We did not interview the specialists about their views and perceptions and therefore we do not know to what degree there are discrepancies between the specialists' and patients' views. Nor do we know to what extent our findings are representative of consultations with primary care physicians and acute LBP patients. With these limitations in mind the results should be interpreted with caution.

Important findings

To be taken seriously. A main finding of our study was the patients' need to be taken seriously during the consultation. This finding is in accordance with results from research on clinical communication and the doctor-patient relationship in general (1, 25, 29). It is also in line with the main result from another Norwegian study, arguing that a patient's need to be taken seriously is linked to a feeling that the care provider believes that the pain is real, i.e. that the patient is not regarded as being a hypochondriac suffering from *bad nerves* (17).

It is important to underline that the most effective way of obtaining this *being taken seriously*-outcome is probably not linked to applying a strict and specific communication technique, but merely reflects a general attitude of the care provider. This attitude is generally characterized by showing respect for the patient's values and autonomy (1, 3, 7, 10). The application of the patient-centred method probably does not demand more time in daily practice, compared with not using it (10). In this respect it is worth noticing that patient-centred communication in our study was ranked among the 3 most important characteristics of "The Good Back-Consultation", and is probably highly inter-correlated with the patient's feeling of being taken seriously.

However, we must emphasize that the term, definition, content, and practice of patient-centred care is currently under debate, and should not be regarded as something other than what may be called doctor-centred with a focus on medical disease history, diagnosis and medical treatment (also called biomedical medicine or doctor's agenda). Our interpretation of patient-centred care, in line with others (8, 10), is a balanced and adapted to the individual patient integration of 2 complementary agendas.

Pain explanation and its consequences. The second most important determinant of "The Good Back-Consultation" was getting understandable information of why it hurts. An explanation of this ranking is perhaps that we have interviewed a group of referred patients with long-standing pain who have met many care providers giving various and perhaps conflicting interpretations. This will often make the patient anxious and uncertain (14). Hurting is taken as a signal of harm. A fear of harm will often lead to avoidance of pain, described in the well-known term "fear-avoidance behaviour" (26). Consequently, it is, in line with our findings, important to explain with plain words and metaphors (27) and preferably models, posters and scans, the pain mechanism in a way that enables the patient him- or herself to draw the conclusion what it is and why it is not dangerous. This new confidence and certainty may be extended and in its turn lead to a second conclusion that varied and adapted activity is good for the patient, or as it was phrased in the successful Australian campaign (28): "Walk away from back pain ... don't take it lying down". The consequence may be improved coping and empowerment for the patient. The messages may as well be reinforced by providing the patient with written material, as shown by Burton et al. (29).

It may be argued that if we are giving such explanations to the large group of LBP patients with unspecific pain we are "lying" and going beyond scientific evidence. One way to do this in our opinion (and as many of the participating doctors did) is not to say what the exact pain explanation is, but: "This is what I think is the most likely explanation". From the observations in our study it appeared that a majority of the specialists included tension, tenderness and cramps of the back muscles as important elements of the pain genesis. Content and

phrases of many of these explanations or metaphors were fairly specific for patients with LBP, and we think each doctor should try to find (or develop) his or her own good metaphor(s) (27).

Clinical examination. In several international guidelines for the management of LBP patients, the importance of combining an initial diagnostic triage with good clinical communication has been stressed (16, 30). However, the communication/feedback that takes place during or after the clinical examination appears to be most important for the patients, and not as perhaps would be expected, how the doctors carry out the examination. This can hardly, regarding its contents, be evaluated by the patients in any case.

Potential for improvement. Based on our results, and from what we regard as generally-accepted evidence-based knowledge on clinical communication (1, 6, 24, 25), we think that for many of the observed consultations the most important potentials for improvement are as follows:

- Deal more with psychosocial issues and particularly how LBP affect various roles of daily life. This is also important because psychosocial factors are important predictors of prognoses and clinical course of LBP (30) and chronic LBP almost consistently has important psychosocial consequences.
- Use more open-ended questions, not least when dealing with psychosocial and complex emotional issues (24, 25).
- Improve the structuring of the consultation with more distinct opening, intersectional/management and closing phase of the consultation, not least with pre-announcing and declaring what is coming next in the encounter. This has been shown to give better patient satisfaction, compliance and recall (1, 24).
- Make more use of summarizing and repetition of what has happened during the consultation (24, 25).

Implications of the study

First, for the clinical practitioner, including the general practitioner, what is stated above should not be regarded as a complete model for communication and interaction with patients with chronic LBP, but merely as a tool for reflection on own communication with such patients, not least in a setting of learning/teaching, for instance with colleagues or medical students. Secondly, it may be used as a basis and facilitator for further research, for instance carrying out studies with improved methodological qualitative approach. Thirdly, studies on patients with acute LBP should be performed. Fourthly, larger quantitative verifying studies are also warranted so that generalizations may be allowed. Finally, we think RCTs studying the effect of communication training programs including many of the main elements of "The Good Back-Consultation" should be carried out.

In conclusion, this combined qualitative quantitative study has identified what we regard to be core characteristics of good clinical communication and interaction between specialists and patients with chronic LBP. Most important determinants of a "Good Back-Consultation" appeared to be the patients' perception of being taken seriously, giving an understandable explanation of the pain, applying patient-centred care, reassurance and being told what can be done. The findings may represent important potentials for enhancing consultations with patients with chronic LBP.

REFERENCES

1. Ley P, ed. Communication with patients. Improving communication, satisfaction and compliance. London: Croom Helm; 1998.
2. Blasi ZD, Harkness E, Ernst E, Georgiou A, Kleijnen J. Influence of context effects on health outcomes: a systematic review. *Lancet* 2001; 357: 757–762.
3. Stewart M. Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 1995; 152: 1423–1433.
4. Turner J, Deyo RA, Loeser JD, Von Korff M, Fordyce WE. The importance of placebo effects in pain treatment and research. *JAMA* 1994; 271: 1609–1614.
5. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. *Arch Intern Med* 1994; 154: 1365–1370.
6. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287: 226–235.
7. Malterud K. Allmennpraktikerens møte med kvinnelige pasienter. [In Norwegian]. "The general practitioner and the female patients". (Thesis). Bergen: Tano, 1990.
8. McWhinney I. Are we on the brink of a major transformation of clinical method? *Can Med Assoc J* 1986; 135: 873–878.
9. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000; 51: 1087–1110.
10. Stewart M. Towards a global definition of patient centred care. *BMJ* 2001; 322: 444–445.
11. Cherkin DC. Primary care research on low back pain—the state of the science. *Spine* 1998; 23: 1997–2002.
12. Waddell G. The back pain revolution. Edinburgh: Churchill Livingstone; 1998.
13. Weinstein J. The missing piece: embracing shared decision making to reform health care. *Spine* 2000; 25: 1–4.
14. Editorial. The diagnostic labelling of low back pain: hopeful speculation posing a fact? *The Back Letter* 2001; 16: 13, 20.
15. Borkan J, Reis S, Hermoni D, Biderman A. Talking about the pain: a patient-centred study of low back pain in primary care. *Soc Sci Med* 1995; 40: 977–987.
16. Espeland A, Baerheim A, Albrektsen G, Korsbrekke K, Larsen J. Patients' view on importance and usefulness of plain radiography of low back pain. *Spine* 2001; 26: 1356–1363.
17. Aabyholm A, Hjortdahl P. Being believed is what counts. *Tidsskr Nor Lægeforen* 1999; 119: 1630–1632.
18. Haldorsen EMH, Grasdahl AL, Skouen JS, Risa AE, Kronholm K, Ursin H. Is there a right treatment for a particular patient group? Comparison of ordinary treatment, light multidisciplinary treatment, and extensive multidisciplinary treatment for long-term sick-listed employees with musculoskeletal pain. *Pain* 2002; 95: 49–63.
19. Indahl A, Velund L, Reikerås O. Good prognosis for low back pain when left untampered. *Spine* 1995; 4: 473–477.
20. Molde Hagen E, Eriksen HR, Ursin H. Does early intervention with a light mobilization program reduce long-term sick leave for low back pain? *Spine* 2000; 25: 1973–1976.
21. Crabtree B, Miller WL. A template approach to text analysis: developing and using code-books. In: Crabtree B, Miller WL, eds. *Doing qualitative research*, vol. 3. Research methods for pri-

- mary care. Sage Publications: Newbury Park, CA; 1992: p. 93–109.
22. Kvale S. Interviews. An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage Publications; 1996.
 23. Øhman A. Qualitative methodology for rehabilitation research. *J Rehabil Med* 2005; 37: 273–280.
 24. Lipkin M, Putnam SM, Lazare A, eds. The medical interview. Clinical care, education, and research. *Frontiers of Primary Care*. New York: Springer; 1995.
 25. Maguire P, Pitceathly C. Key communication skills and how to acquire them. *BMJ* 2002; 325: 697–700.
 26. Vlaeyen J, Linton SJ. Fear-avoidance and its consequences in chronic musculoskeletal pain: a state of the art. *Pain* 2000; 85: 317–332.
 27. Mabeck C, Olesen F. Metaphorically transmitted disease. How do patients embody medical explanations? *Fam Pract* 1997; 14: 271–278.
 28. Buchbinder R, Jolley D, Wyatt M. Volvo Award Winner in clinical studies: effects of a media campaign on back pain beliefs and its potential influence on management of low back pain in general practice. *Spine* 2001; 26: 2535–2542.
 29. Burton KA, Waddell G, Tillotson MK, Summerton N. Information and advice to patients with back pain can have a positive effect—a randomized controlled trial of a novel educational booklet in primary care. *Spine* 1999; 24: 2484–2491.
 30. van Tulder M, Bekkering T, Breen A. European guidelines for the management of acute nonspecific low back pain in primary care. Available from: URL: http://www.backpaineurope.org/web/html/wg1_results.html