

Patients' Experiences Participating Within an Interdisciplinary Primary Care Program for Low Back Pain

Journal of Patient Experience
Volume 12: 1-11
© The Author(s) 2025
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/23743735241311752
journals.sagepub.com/home/jpx



Amédée Gogovor^{1,6,7}, Matthew Hunt^{2,3}, Richard Hovey⁴ ,
and Sara Ahmed^{2,3,5} 

Abstract

A common recommendation to improve the management of low back pain (LBP) is the use of interdisciplinary teams. However, many challenges remain in establishing interdisciplinary care, particularly in community-based primary care settings. This study explored patients' experiences with interdisciplinary care for LBP using an applied phenomenological research approach. Semistructured open-ended interviews were conducted with fifteen adults enrolled in a 6-month interdisciplinary LBP program within an integrated care network. The analysis included detailed descriptions of participants' experiences and interpretations by the researchers of the main themes: (i) challenging start—"It's intimidating," (ii) desire for flexibility—"I didn't need as much," (iii) better collaboration—"They are all together," (iv) grasping the pain issue—"They helped," (v) care was responsive to needs and experience—"Always centered on me, not general," (vi) meanings of recovery—"I'm able to function." Participants viewed the interdisciplinary LBP program as the culmination of a long journey toward recovery. The findings identified as important to patients contribute to our understanding of how to optimize patient-centered care for individuals living with chronic pain.

Keywords

patient experience, low back pain, chronic pain, interdisciplinary program, primary health care, phenomenology

Introduction

Healthcare support for people living with chronic health conditions remains far from optimal, with many reporting insufficient care and resources to manage their condition effectively.¹ This is also the case for individuals living with chronic pain.^{2,3} Low back pain (LBP) is the most common nonspecific chronic pain conditions, leading to disability and substantial public health costs due to medical expenses, work absence, and reduced quality of life.^{4,5} Managing LBP often requires a combination of nonpharmacological and pharmacological approaches.⁶⁻⁸

Clinical guidelines for managing LBP recommend nonpharmacological approaches such as self-management education, cognitive-behavioral therapy, exercise, and appropriate complementary and alternative medicine, followed by cautious medication use and potential surgery.⁶⁻¹⁰ Multidisciplinary and interdisciplinary programs are advised for those unresponsive to standard treatments.¹⁰ While multidisciplinary approaches involve various healthcare providers, interdisciplinary approaches emphasize coordinated services by a cohesive team in a single facility, improving patient outcomes.^{11,12}

Pain is a common reason for medical consultations, accounting for an estimated 40% of primary care visits.^{2,13} Primary care, offering better health outcomes and cost control, should ideally manage LBP early to prevent chronicity and optimize outcomes.¹⁴⁻¹⁷ However, primary care faces

- ¹ Department of Medicine, McGill University, Montreal, Quebec, Canada
- ² School of Physical and Occupational Therapy, McGill University, Montreal, Quebec, Canada
- ³ Centre de recherche interdisciplinaire en réadaptation (CRIR), Montreal, Quebec, Canada
- ⁴ Faculty of Dental Medicine and Oral Health Sciences, McGill University, Montreal, Quebec, Canada
- ⁵ Centre for Outcomes Research and Evaluation, RI - McGill University Health Centre, Montreal, Quebec, Canada
- ⁶ Department of Family Medicine and Emergency Medicine, Université Laval, Quebec City, Quebec, Canada
- ⁷ VITAM-Centre de recherche en santé durable, Quebec City, Quebec, Canada

Corresponding Author:

Sara Ahmed, School of Physical and Occupational Therapy, Faculty of Medicine and Health Sciences, McGill University, 3654 Prom Sir-William-Osler, Montreal, QC H3G 1Y5, Canada.
Email: sara.ahmed@mcgill.ca



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<https://creativecommons.org/licenses/by-nc/4.0/>) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access page (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

service gaps in managing chronic pain, including insufficient self-management support and inadequate education for primary care clinicians.¹⁸⁻²⁰

Interdisciplinary programs, endorsed by multiple guidelines, present a solution but face challenges in community-based settings.^{18,20,21} There is a need for effective implementation strategies and measurement of patient experiences to inform program efficacy.²² Understanding patient experiences through patient-centered care (PCC) can enhance the design and implementation of interdisciplinary chronic pain management.²³⁻²⁶ Existing patient experience frameworks and measures often overlook aspects critical to chronic disease management in primary care.^{24,27-29} Therefore, qualitative research focusing on patient experiences is essential.³⁰ This study aims to investigate patient experiences with an interdisciplinary program for LBP by exploring: what are the individual experiences of people living with chronic pain being treated for LBP using an interdisciplinary team (IDT) care approach?

Method

To better understand IDT care, we employed an applied qualitative phenomenological approach, studying the lived and prereflective experiences of individuals with LBP.³¹ We followed the Standards for Reporting Qualitative Research guidelines to report the study.³²

Study Design

Phenomenology is a philosophy of understanding that explores and gains deeper insight into human experiences.³³ In this way, “phenomenologists seek to reunite science with life and to explore the relationship between the abstract world of the sciences and the concrete world of human experience.”³⁴ This approach allows clinicians and researchers to “enter the world of illness as lived by patients” to explore their experience of illness or of healthcare.³⁴ We built on the assertion that preexisting ideas and experiences are essential to understanding a phenomenon.³⁵ Our preunderstandings of the phenomenon included prior work,¹² lower support for team-based care from the public and physicians compared to other health professionals,³⁶ and the asymmetrical patient-physician relationship.

Settings

This research inquiry was conducted within an interdisciplinary primary care program for individuals with LBP, part of a larger initiative on chronic pain care (Quebec, Canada).^{37,38} Four clinics participated, delivering a 6-month interdisciplinary care program with contributions from a nurse, physician, physiotherapist, and psychologist.

Participants and Sampling

The research participants were adults diagnosed with subacute or chronic LBP who were referred by primary care physicians. We used purposive criterion-based sampling to ensure maximum variation across several characteristics (Table 1).^{39,40} In applied phenomenological research, sample size prioritizes the quality and depth of participants' narratives. Considering population heterogeneity, selection criteria, and available resources, 15 participants were recruited for this study (Table 2).⁴¹⁻⁴³

Data Collection

An interview guide (Supplementary File S1), developed in English and translated into French, was based on literature review and program objectives. Mock pilot interviews were conducted with 2 individuals, not part of the study participants, including one with a Quebec native French speaking person to ensure the clarity of the interview questions once translated into French. Participants detailed their pain history and IDT care experience.

Recruitment was facilitated by the IDT clinics and through the identification of patient profiles using the REDCap system.⁶⁰ Each IDT clinic was contacted to obtain the REDCap IDs for patients scheduled for their 3- and 6-month visits. Once their eligibility was assessed compared with the selection criteria (Table 1), the IDs of selected patients were communicated to the IDT clinic staff. The staff of the clinics contacted the selected patients and confirmed their willingness to participate and their availability for a 30-to-60-min interview after their visit. This approach ensured that participants would be prepared and able to

Table 1. Criteria-Based Selection.

| Criterion | Justification |
|-------------------------------------|---|
| Age (<65, ≥65 years) | Prevalence of chronic pain and comorbidity increases with age ^{44,45} ; age is considered as a yellow flag ^{a,46} , determines the employment status and is a predictor of satisfaction ⁴⁷ |
| Sex and gender | Sex and gender affect pain perception, pain coping, pain reporting, and pain-related behaviors ⁴⁸ ; being female considered as a yellow flag ^{46,49} |
| Clinical sites (4 study sites) | There are always variations in program implementation across sites ⁵⁰⁻⁵³ |
| Risk (StarT Back Tool) ^b | The 3 risk-defined groups (low, medium, high) impact on clinical and economic benefits ^{54,55} |
| Adherence to the program | Participant adherence and responsiveness ^{56,57} |
| Ethnicity | Pain treatment and pain outcomes may vary by race or ethnicity ^{58,59} |

^aRisk factor for chronicization of acute and subacute low back pain and psychosocial barriers to recovery.

^bPhysical and psychosocial risk of poor prognosis.

Table 2. Characteristics of Participants.

| Participants ^a | Sex | Age (years) | Highest education | Employment status | Risk (STarT Back Tool) ^b | Pain duration ^c (weeks) |
|---------------------------|-----|-------------|-----------------------|-------------------|-------------------------------------|------------------------------------|
| Debra | F | 55-64 | College or university | Retired | Medium | 14 |
| Heather | F | 45-54 | College or university | Part-time | Low | 14 |
| Zachary | M | 65-74 | Secondary school | Retired | Medium | 52 |
| Samuel | M | 35-44 | College or university | Unemployed | Low | 62 |
| Rachel | F | 35-44 | College or university | On disability | Medium | 104 |
| Valerie | F | 55-64 | Secondary school | Retired | High | 33 |
| Michelle | F | 65-74 | College or university | Retired | Low | 60 |
| Charles | M | 75-84 | Secondary school | Retired | Medium | 68 |
| Hebert | M | 45-54 | College or university | Full time | High | 130 |
| Rita | F | 55-64 | Secondary school | Full time | Medium | 41 |
| Bernadette | F | 65-74 | Secondary school | Retired | High | 10 |
| Stella | F | 65-74 | College or university | Retired | High | 22 |
| Thomas | M | 65-74 | College or university | Retired | High | 9 |
| Helena | F | 25-34 | Secondary school | Unemployed | Medium | 25 |
| Maurice | M | 45-54 | Primary school | On disability | High | 4 |

^aPseudonyms.^bLow if total score = 0-3; medium if total score ≥ 4 and subscale ≤ 3 ; high if total score ≥ 4 and subscale ≥ 4 .^cMost recent episode. Abbreviations: F, female; M, male.

discuss their experiences in depth. Eligible individuals who agreed to participate were interviewed at 3- and 6-month visits or at 6-month visit only, for practical reasons. Interviews, conducted at clinics or by phone, ensured participants' comfort and willingness to share their experiences, and were audio-recorded. Information from participants who withdrew from the program was also collected.³⁷

Data Analysis

Interviews were transcribed verbatim, anonymized and entered into Qualrus software, then analyzed using an interpretative phenomenological approach, combining description and interpretation.⁶¹ This involved extracting significant data units expressions, sentences, or paragraphs that highlight key elements of the phenomenon, capturing essential aspects of the participants' lived experiences related to the subject under study, formulating meaning observations by answering the question "What does this sentence/segment reveal about the experience being described?" through an iterative process, and grouping similar themes into meta-themes. The 5 steps of the analysis are summarized in Supplemental Figure S2 (Supplementary File S2). Various strategies were used to enhance trustworthiness and credibility of the research findings: review of the transcripts to ensure their accuracy, continuing conversation with experts (MH, RH) during the analysis process, maintenance of a reflexive log.

Findings

The participants described their experience of IDT care as the culmination of a long journey to recovery in their search for a solution to their LBP condition. Participant synopses are provided to convey their stories (Table 3). Selected verbatim quotes illustrate the analysis.

Challenging Start: "It's Intimidating"

Two participants described their first IDT meeting as intimidating due to the presence of all 4 clinicians in the same room. Michelle reported: "It looked like an office where you would meet with bosses when applying for a job. But that's okay; it lasted how long? A second? The time it took to recognize the faces, to know who does what; it's always a bit intimidating [but] I've nothing negative to say." Maurice also noted: "I was... a bit nervous. At first, I didn't know anyone, not 1 person in the group of 4, but after that, like yesterday, we met again all together sometimes for the group of 4, then I was all alone with them. It wasn't long before my nervousness disappeared."

The presence of all clinicians and the delineation of their roles during the first IDT evaluation helped mitigate feelings of intimidation and nervousness. Michelle shared: "They explained the program to me, they explained each person's function, from then on I trusted them." Two participants echoed this sentiment: "At first, I was a bit nervous but after that I understood that it was a group of people who wanted to help me and treat my pain." (Maurice); "Usually (because) I get to know the person, and I get to know what they do, and I know that they're there to help. So that... makes it a little easier on me." (Helena).

Desire for Flexibility: "I Didn't Need as Much"

Participants acknowledged the importance of all clinicians but expressed a desire for flexibility to "use" them as needed. For example, some participants felt they did not need the services of a psychologist. Debra mentioned: "I didn't need as much from the psychologist... I mean, I am still trying to figure out the role of the psychologist in this program." Zachary simply stated: "No, I don't need [a] psychologist." In contrast, Michelle praised the

Table 3. Synopses of Participants.

| | Female participants | Male participants |
|---|--|--|
| Accepted their condition prior to referral to the IDT | <p>Michelle saw the advertisement in the local newspaper about the program and decided to take her chance by requesting her family physician to obtain a referral. Her LBP has impacted her life significantly, especially during acute episodes. She described having difficulty to stand up, to walk, to get in and out of a car, or to do household work. Michelle was not emotionally affected and her condition did not prevent her from going out because she is not a “whiner.” Before joining the program, she had visited several medical centers and allied health and alternative medicine professionals (kinesiology, physiotherapy, osteopathy) with no satisfactory outcomes but had to stop because of the cost. She seemed to have accepted her condition —“You have to learn to live with it”—and for her, living as a couple was a facilitator for coping with pain.</p> <p>Rachel was suffering from leg pain, but was barely affected by her back pain. She thought some level of back pain was normal given the type of work she was doing (“everyone has some kind of pain”) and did not take it seriously. She did not hesitate to blame herself for having made some “absurdities” in the past. Rachel did not like to take medication or visit a health center: when she decides to go to a physician’s office, “it is for a good reason.” She has experienced conflicting diagnoses for the leg problem and unsuccessful physiotherapy sessions before joining the program. For Rachel, her pain is chronic and will remain as “a scar.”</p> <p>Stella, a retired woman, understood and accepted her condition as an inevitable consequence of age and wear and tear and because the back problem is a family thing. The main impact the LBP had on her life was preventing her from standing up and thus all the related activities that are accomplished in the standing position like “running a vacuum cleaner or washing floors,” and almost all sports. But she felt blessed to have a husband who does most of the things for her. She did not want to get addicted to medication so she was trying hard to manage her condition without any pills. Stella is not a “complainer”: “I’m very hard on myself,” she said, and having experienced a lot of pain already in her life helped her.</p> <p>Bernadette first experienced LBP when getting out of a car 10 months ago. The initial pain was so intense that she described it as “30 out of 10.” At that moment, she was not able to do anything. It was impossible for her to stand up for more than a couple of minutes. She could not lie down or sleep on her back or left side. She had to walk with a chair on wheels. She was emotionally affected because she was afraid of staying in this condition.</p> <p>Helena is a dynamic young lady whose career was broken because of her lower back pain. She had to stop because she “was not able to give her patients the proper care that they deserve including doing transfers or lifting them, ... because that’s not fair to the patients.” Sometimes her lower back pain is so intense that she can’t even move or walk: “Usually</p> | <p>Charles was happy to be accepted in the LBP program. He has been living with LBP for more than a decade with recurrent episodes but he was not very affected by his condition when we did the interview, apart from some limitations such as long walking or traveling. “I endure it and that’s it” he said but having a mild persistent pain is harmful mentally a little bit. He tried chiropractic and osteopathic sessions, in addition to the medical treatment from his family doctor who does not believe in these alternative medicines. He conceded that his doctor was right because these alternative treatments “give more or less nothing.” For Charles, if his pain is around 3 or 4 (on a 10-point pain rating scale), then he is able to tolerate it. He admitted that he was not expecting a cure, as his family doctor told him, so his expectation with the program was to stabilize or improve his condition.</p> <p>Thomas was referred to the program for an LBP subsequent to a fall. His x-ray revealed some wear meaning that his condition will last forever that was why he was interested in a program that certainly would give him means to be (live) better. For Thomas, living with the pain was difficult to accept. His LBP prevented him from doing usual things such as taking a long walk, driving for a long period, or carrying things. Even for things that he continued to do, he had to do them differently. This resulted in stress and negative emotional affects. Thus, he was not expecting a total cure.</p> |
| Interrogative (skeptical) about their condition | | <p>Maurice was referred to the LBP program by his family doctor following his work accident. He accepted in order to improve his back because, as he said, medications were good to relieve his pain but their effect was ephemeral. He was obliged to stop working, and ultimately lost his job by the nonrenewal of his contract. He was limited in doing everything including moving, walking, and driving; referring to his pain as “so horrible” at the beginning. He was very stressed, including his family, not only because of the pain but also for the lack of income because his spouse was forced to stop working too. He saw his condition very hard to live, from twelve hours working shift to nothing. As a consequence, his is gaining weight that might trigger other health problems.</p> |

(continued)

Table 3. (continued)

| Female participants | Male participants |
|---|--|
| <p>when it gets to the point where it's unbearable, I just try to sit down or lie down and wait until the pain goes away and slowly try to get back up and try to continue what I'm doing." So she accepted to participate in the program to find solutions for her back problems with the goal of returning to work. She was very impacted by her condition: anger, frustration, stress.</p> <p>According to Valerie, her LBP was related to a spine surgery that she had a decade ago. She was disappointed at not being given a postoperative action plan by the surgeon or the hospital. Prior to being referred to the program, she had been seen in physiotherapy, osteopathy, and acupuncture with a partial satisfaction. She was disheartened by her persistent pain that preventing her from "doing anything" and was feeling really down so she did not know what to expect from the program.</p> <p>Debra described herself as a proactive person with a strong health-care-seeking attitude. She found out about this program herself and subsequently asked her family doctor for a referral. As a consequence of her LBP she had to reduce her traveling. She used 3 words to summarize her experience with LBP: manage, care, and support. By "manage," Debra referred to pacing herself in daily activities; by "care," she meant taking steps to look after herself like doing some exercises or wearing appropriate shoes; and by "support," she referred to the possibility of calling professional team members as a back-up plan after completing the IDT program.</p> <p>Heather is an active woman who was referred to the program by her family doctor. As far as she could remember, the only way the back pain had affected her life was in terms of sleep disturbance. However, she experienced this as very challenging: "When you don't sleep you're tired all day" she said. She was not expecting to get rid of her pain just by taking medications but was hoping that the physiotherapy sessions "would remove the pain." She really did not want to take medications so she was very comfortable with the self-management oriented program.</p> <p>Rita got the information about the program from the physiotherapist she was seeing for her LBP and was very excited upon being accepted. The condition somewhat affected her life especially regarding sports and dancing activities, but she did not "let herself influenced" by the condition. Before the physiotherapist, she had "shopped" around for chiropractic, massage and osteopathy care which provided her with momentary relief but no explanation of the cause of the pain. Thus, she was in search of understanding.</p> | <p>Samuel joined the program due to his lower back and joint pains, and wanted to understand his pain problems. Prior to the program, he was followed by a family physician and went through several medical consultations and tests (including x-ray, computerized tomography scan, tests with a physiatrist, and tests for rheumatism). Samuel has been living with the back pain for several years and has yet to find answers about why he has these pains, wondering if his LBP was a premature degeneration as a result of heavy physical work or due to a personal fragility. The LBP significantly impacted on his life including poor motivation in playing with his children, working around the house, or doing sports. He has been going through periods of discouragement, increased pain and irritability.</p> <p>Hebert thought that his chronic pain might be related to some difficulty to adapt to the cold weather even though he had some back pain while living in his native country. Before being referred to the program, he tried some complementary and alternative treatments (massage, osteopathy and acupuncture) with ephemeral results; in addition to self-medication with anti-inflammatory drugs and analgesics. He emphasized the impact of the LBP on his income because of work absences. The condition limited his ability to complete some tasks particularly in a standing position and it negatively impacted his affect to a certain degree. Hebert expressed his frustration with the health care system and how badly it works for him, particularly emergency room visits. Thus, he had no specific expectation before entering the program. He expressed that when you have problems in other areas of life (such as finances or within one's family), this will limit one's capacity to benefit from the program. He stated that, as was the case for him, the people most in need of the program often struggled to adhere to it because attending the program meant a loss of income due to missing work.</p> <p>Zachary was referred to the pain program from another care program. He was limited in all his daily activities as the result of his LBP, including being unable to participate in a group walking program that he used to do. However, according to Zachary, his LBP condition does not interfere with his emotional affects. Because he was already on a polypharmacy regimen, he did not want to take more pills for his pain. He tries to live with his LBP and hopes to be completely free from the pain thanks to the program.</p> |

Abbreviations: LBP, low back pain; IDT, interdisciplinary team.

psychologist's contribution: "She gave some tips because it's the stress too; I didn't have to see the doctor." Rita expressed a need for more time with the physiotherapist: "I would have liked to have a bit more time with the physiotherapist."

The role of the nurse was also not well understood by 2 participants. Helena noted: "I don't see a difference, to me they're just health care professionals so I don't know the difference between a nurse and a physician is because they're both there to help you with medical problems." Participants did not perceive a hierarchy within the team but some suggested adding a nutritionist and alternative medicine specialists, such as acupuncture and osteopathy.

Better Collaboration: "They Are All Together"

Participants appreciated the advantages of having all clinicians work together, noting benefits such as input from different providers and alternative solutions when needed. Heather remarked: "It was nice to have everybody's input ... So, for me that was very helpful. And if you have any questions, you have more than one person there to answer them, you know." For example, Rachel described what she appreciated about the program: "What I liked, I think I said it the last time, ... it's that they're all together." Charles even stressed the financial aspect of having all the care providers in the same location and that this arrangement avoided unnecessary costs for patients: "Perhaps it's better to have several at the same place ... because in reality it costs nothing. When you go to [different] places, there's no improvement but it costs me hundreds of dollars."

Grasping the Pain Issue: "They Helped"

Almost all participants felt that they were "*helped*" to better understand their condition, to learn what to do or not to do, or to "*see light again*." There are various ways to analyze the participants' use of "help." (i) Some participants had already accepted their condition before joining the program and sought help to better manage their pain. For example, Stella stated that "I would like something that would ... not cure it [LBP], but that I'm able to cope with it. You have to learn to cope with something. And I think a lot of things is right here" (Stella). (ii) Some participants were seeking help to understand their health problem. A participant expressed that in her account: "I appreciate them taking time out of their busy day to help me. They are all very nice, I really appreciate everything they were doing for me, they were able to answer pretty much any question I had to ask them. It did help quite a bit, and I would definitely refer, if anybody else had any problems, to come here" (Helena). (iii) Some participants sought people who would listen to them. Valerie shared this perspective: "In fact, it's just knowing that you are being followed, that you can talk to someone if things aren't going well, that's like 50% of the cure right there because if I hadn't had those people, as I said 2 or 3 times, I don't know where I'd be."

Care Was Responsive to Needs and Experience: "Always Centered on Me, Not General"

Participants praised the personalized approach of the IDT program, describing several meaningful facets: being listened to and understood, being asked relevant and individualized questions, and being treated kindly, with politeness and attentiveness. Helena noted: "They were all very nice to me and answered all my questions and everything." Stella described the individualized approach: "I felt that from A to Z, I had very good, personalized care." Samuel echoed: "I never felt as if we were in a general situation ...; I mean I always felt as if we were talking about me, that we found explanations, solutions, things improved ... In all the interventions I felt as if it was always centered on me, not general."

Participants also highlighted the completeness of care, the team taking sufficient time and not acting hurried, and how IDT care decreased feelings of isolation. Debra stated: "The difference (with usual care) I know is like I'm not alone to fight my problem. That's the first difference." Some participants described IDT as unique. Heather stated: "You can't compare the difference" between unidisciplinary (physician only) and IDT care. Rachel summed up her experience: "I mean the family doctor, it's not that he wasn't good but he wasn't a back specialist ... I recommend it to everyone who has back pain: 'Go to the [interdisciplinary] clinic'." One participant expressed a negative experience of being seen during a follow-up visit with another patient in the room: "It's just the whole situation with bringing another patient in with the physician, like I would prefer that not to happen in my case. I wasn't told ahead of time that it was going to happen. So, I would have preferred they ask me if I was comfortable with something like that first. Then I would have honestly said I would much prefer if it was just one-on-one" (Helena). This account underscores the importance of patient preference in person-centered care.

Meanings of Recovery: "I'm Able to Function"

Most participants viewed recovery as regaining function and managing pain rather than total pain mitigation. They described recovery in terms of performing daily activities and experiencing less pain. Valerie shared: "I'm able to function; which wasn't the case when I got here; I really didn't function, I had zero functioning. Now I think that I function at least 60%; that's a lot." Rita expressed a similar sentiment: "It's fantastic. You see, I feel a bit like crying when I say that because before and after ... oh my God ... I used to be very active before. When I fell, I had difficulty moving, what's happening to me ... Then having the tools, understanding my body, functioning ... For me, it's marvelous."

Some participants, particularly older ones, seemed to have accepted their pain and sought ways to better live with it. Stella stated: "You know, something that's totally worn can't be cured. It can be calmed, but not cured. It can improve, by exercise, by walking more, by just training."

Wear and tear.” Others reached this conclusion through interactions with IDT members. Valerie noted: “They taught me to manage this pain, that’s the most important thing, to manage it and live with it.”

Discussion

The findings from this study contribute to the growing body of knowledge on the benefits of team-based care for managing chronic conditions, particularly LBP. They also revealed the meaning of recovery in this inquiry where the use of phenomenological approach enhanced the exploration of the subjectivity of human experience with living with chronic pain and IDT care. Among the participants, those who accepted their condition before joining the IDT program were mostly looking for help to learn how to live better with their pain. These participants tended to be older and have had lived with their pain for a longer time. In contrast, the participants who were younger or with a shorter pain duration, sought to gain understanding of the cause of the pain and to be relieved from it.

While a team-based approach is recommended by pain treatment guidelines, the optimal composition or content of interdisciplinary care remains unclear.^{8,62,63} The composition of the primary care IDT with a nurse, physician, physiotherapist, and psychologist seemed adequate for several participants; only 2 suggested adding a nutritionist and alternative medicine specialists. However, participants appreciated the roles and importance of different clinicians differently, with some desiring flexibility in clinician involvement. Being treated by an IDT composed of several healthcare members is relatively infrequent in the context of ambulatory and chronic disease management settings in Canada and other high-income countries.^{20,64,65}

A singular finding from this inquiry is the intimidating aspect of the first IDT evaluation, similar to experiences in hospital ward rounds of health professionals and residents.⁶⁶ Providing information to patients before their first visit about the program, team members, and their roles could help reduce uncertainty and anxiety.^{67,68} Tools like animated videos, interactive quizzes, or leaflets on IDT care and team roles might be helpful. The presence of all team members at the initial evaluation is warranted to help patients mitigate this feeling and better understand the roles of different professionals.

The participants in our study suggested that there were advantages of IDT care. Having all the care providers in the same location prevented the participants from needing to start over and over to tell their story to each of the clinicians. Participants also saw IDT as an opportunity to be heard and IDT appears to fulfill this need with the combined contributions of a group of health care professionals (synergistic effect). The desire to be heard was so intense for some participants that sometimes the interviewer was thanked for his time during the interview as if he was part of the care team. This aspect of listening has been highlighted

by several authors particularly with respect to alleviated suffering.⁶⁹⁻⁷² Even IAPO calls on healthcare stakeholders to listen to and engage with patient populations affected by chronic pain.⁷³ By attempting to suspend and set aside preconceptions, clinicians can better understand and appreciate the world of illness inhabited by their patients.⁷¹

Participants also saw IDT as very responsive to their needs and personalized in its approach. This is consistent with the conclusion from Foster et al that “Patients viewed the combined contributions of a GP [general practitioner] and other health professionals in team care as thorough and reassuring.”⁷⁴ This finding also supports many carative factors of Watson’s theory of human caring.^{75,76} The importance of understanding the patient’s lived experience is fundamental to PCC.^{75,77} Several elements of PCC²⁶ emerged from the participants’ accounts: the importance of respect for patients’ values, preferences and expressed needs; information, communication, and education; and emotional support. The findings seem to confirm the belief that team-based care is the primary and immediate healthcare setting where PCC occurs.⁷⁸

For most participants, recovery meant regaining function and managing pain, rather than total pain mitigation. They provided examples of functioning (eg, walking, moving, managing daily routines) that align well with the components of the International Classification of Functioning, Disability and health.⁷⁹ Similar findings were reported for individuals living with myalgic encephalomyelitis and chronic fatigue.⁸⁰ For Zhong Hui, the process of recovery begins with self-cultivation (learning about one’s condition and taking steps to improve it).⁸¹ In this sense, IDT care helped the participants to better understand their condition. The IDT program appeared to be facilitating, for some participants, response shifts in their expectations from seeking cure to learning to cope with their pain condition. Response shift is defined as a change in the meaning of one’s self-evaluation in terms of values, standards of measurement, or redefinition of constructs.⁸²

Finally, our assumption that the particular patient–physician relationship may constitute a barrier to IDT care was not supported by our participants’ accounts. The traditional paradigm of medical care has been based on a dyad of one doctor and one patient. This construction, and associated expectations of clinicians and health professionals, however, does not seem to have been an impediment to an IDT care approach for our participants. Possible implications for IDT programs, based on our findings and conclusions, are summarized in Table 4. Clinical practice should assess patients’ readiness for IDT care, reduce anxiety through clear previsit information, and offer flexible follow-up tailored to patient needs. Emphasizing person-centered care and incorporating functional status alongside pain assessments are essential to improving outcomes for individuals with LBP.

Limitations

Participants in this inquiry only included individuals who remained in the IDT program. Due to practical reasons, all

Table 4. Implications for IDT Programs.

| Findings | Possible implications |
|--|---|
| Two types of participants: those who accepted their condition before joining the IDT program and those who did not | ■ Assess state of acceptance and readiness for IDT to adapt care approach |
| Fear/uncertainty experienced at first IDT evaluation; Role of clinicians in IDT care not well understood | ■ Develop information tools (animated video, quiz, leaflet) on IDT care to be disseminated to patients prior to the visit |
| Team members necessary but not seen as equally important (request for more flexibility) | ■ Ensure the presence of all team members at the first IDT evaluation |
| Lack of other categories of professionals | ■ Collaboratively agree with patients on necessity to adapt follow-up visits to patient's interests and needs |
| Interdisciplinary care is person-centered | ■ Ensure the availability of other key professionals for referral |
| | ■ Include training on PCC approach and a PCC measurement tool for performance monitoring that include the following main elements: politeness, attentiveness, friendliness, good listening, tailoring of questions and care |
| Being able to function again or better as main meaning of recovery for individuals with LBP | ■ Include a measure of functional status alongside pain assessment tools for ongoing monitoring |

Abbreviations: IDT, interdisciplinary team; PCC, patient-centered care; LBP, low back pain.

but 4 interviews were conducted at the clinics. However, we used dedicated rooms to conduct the interviews in and we can confirm that there was an environment of trust between the participants and the research team. We were not able to conduct interviews with people who withdrew from the IDT program. Among those participants who withdrew, some might not have felt ready or been interested to participate actively in a self-management oriented program, or were expecting a program that offered a ready-made solution by the team to rid them of their pain. As documented in the literature,^{83,84} sex and gender affect pain perception, pain coping, pain reporting, and pain-related behaviors. Although 9 of the participants were female, we did not explore the impact of sex on the findings, and we did not collect gender specific information. As pointed out by van Manen, “it should be acknowledged that phenomenological research is always incomplete and tentative because the researcher cannot possibly capture a given experience in its entirety nor describe how all people will experience a particular event.”⁸⁵

Conclusion

This inquiry to explore patients' experiences while participating within an interdisciplinary care team is part of an integrated and interdisciplinary primary care program for the prevention and the management of LBP. Consequently, the findings may assist clinicians to understand patients' perspectives and help improve the process of care; to inform the design and implementation of IDT programs, and to devise patient and interprofessional education programs on team-based care. Integrating constructs and concerns that are important to patients is essential for efforts to improve the delivery of care and patient health outcomes.

Acknowledgments

The authors would like to thank the participants who contributed to this research.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.


Ethical Approval


This study was approved by the Research Ethics Board of the McGill University Health Centre (#MPCUSM-12-220 GEN).

Funding

The interdisciplinary primary care program was supported by the *Fonds Pfizer-FRQS-MSSS sur les maladies chroniques*. AG was supported by an FRQS doctoral award.

ORCID iDs

Richard Hovey  <https://orcid.org/0000-0001-9534-4807>

Sara Ahmed  <https://orcid.org/0000-0001-5172-6790>

Statement of Human and Animal Rights

All procedures in this study were conducted in accordance with the Research Ethics Board of the McGill University Health Centre (#MPCUSM-12-220 GEN) approved protocols.

Statement of Informed Consent

Written informed consent was obtained from the participants at their first visit at the start of the program for anonymized information to be published in this article.

Supplemental Material

Supplemental material for this article is available online.

References

1. Pan American Health Organization. *Innovative Care for Chronic Conditions: Organizing and Delivering High Quality Care for Chronic Noncommunicable Diseases in the Americas*. PAHO; 2013.
2. Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain:

- concepts, challenges, and compromises. *Pain*. 2020;161(9):1976-82.
3. Institute of Medicine. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. The National Academies Press; 2011.
 4. Markman JD, Czerniecka-Fox K, Khalsa PS, et al. AAPT diagnostic criteria for chronic low back pain. *J Pain*. 2020;21(11-12):1138-48.
 5. Croft P, Blyth FM, van der Windt D. *Chronic Pain Epidemiology: From Aetiology to Public Health*. Oxford University Press; 2010.
 6. Koes BW, Backes D, Bindels PJE. Pharmacotherapy for chronic non-specific low back pain: current and future options. *Expert Opin Pharmacother*. 2018;19(6):537-45.
 7. Foster NE, Anema JR, Cherkwin D, et al. Prevention and treatment of low back pain: evidence, challenges, and promising directions. *Lancet*. 2018;391(10137):2368-83.
 8. Qaseem A, Wilt TJ, McLean RM, et al. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2017;166(7):514-30.
 9. Stochkendahl MJ, Kjaer P, Hartvigsen J, et al. National clinical guidelines for non-surgical treatment of patients with recent onset low back pain or lumbar radiculopathy. *Eur Spine J*. 2018;27(1):60-75.
 10. Chou R, Deyo R, Friedly J, et al. Nonpharmacologic therapies for low back pain: a systematic review for an American College of Physicians clinical practice guideline. *Ann Intern Med*. 2017;166(7):493-505.
 11. Gatchel RJ, McGeary DD, McGeary CA, Lippe B. Interdisciplinary chronic pain management: past, present, and future. *Am Psychol*. 2014;69(2):119-30.
 12. Gogovor A, Burnand B, Ahmed S, Montague T, Peytremann-Bridevaux I. Team effectiveness in patient health management: an overview of reviews. *Int J Clin Med*. 2012;3(7):614-27.
 13. Lincoln LE, Pellico L, Kerns R, Anderson D. Barriers and facilitators to chronic non-cancer pain management in primary care: a qualitative analysis of primary care providers' experiences and attitudes. *J Palliat Care Med*. 2013;S3(1):1-7.
 14. Koes BW, van Tulder M, Lin CW, Macedo LG, McAuley J, Maher C. An updated overview of clinical guidelines for the management of non-specific low back pain in primary care. *Eur Spine J*. 2010;19(12):2075-94.
 15. Kringos DS, Boerma W, van der Zee J, Groenewegen P. Europe's strong primary care systems are linked to better population health but also to higher health spending. *Health Aff (Millwood)*. 2013;32(4):686-94.
 16. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
 17. World Health Organization. *A Global Review of Primary Health Care: Emerging Messages: Global Report*. WHO; 2003.
 18. Boulanger A, Clark AJ, Squire P, Cui E, Horbay G. Chronic pain in Canada: have we improved our management of chronic noncancer pain? *Pain Res Manage*. 2007;12(1):39-47.
 19. Kirby K, Dunwoody L, Millar R. What type of service provision do patients with chronic pain want from primary care providers? *Disabil Rehabil*. 2009;31(18):1514-9.
 20. Agence d'évaluation des technologies et des modes d'intervention en santé. *Management of Chronic (Non-Cancer) Pain: Organization of Health Services*. AETMIS; 2006.
 21. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press; 2001.
 22. Law AV, Bounthavong M. Patient satisfaction and health and disease management. In: Esposito D, ed. *Reliability and Validity of Data Sources for Outcomes Research & Disease and Health Management*. ISPOR; 2013:206-19.
 23. National Clinical Guideline Centre. *Patient Experience in Adult NHS Services: Improving the Experience of Care for People Using Adult NHS Services: Patient Experience in Generic Terms*. National Clinical Guideline Centre; 2012: 335.
 24. de Silva D. *Measuring Patient Experience*. The Health Foundation; 2013.
 25. Gerteis M, Edgman-Levitan S, Walker JD, Stoke DM, Cleary PD, Delbanco TL. What patients really want. *Health Manage Q*. 1993;15(3):2-6.
 26. Gogovor A, Valois MF, Bartlett G, Ahmed S. Support for teams, technology and patient involvement in decision-making associated with support for patient-centred care. *Int J Qual Health Care*. 2019;31(8):590-7.
 27. Jenkinson C, Coulter A, Bruster S, Richards N, Chandola T. Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Qual Saf Health Care*. 2002;11(4):335-9.
 28. Staniszewska S, Boardman F, Gunn L, et al. The Warwick Patient Experiences Framework: patient-based evidence in clinical guidelines. *Int J Qual Health Care*. 2014;26(2):151-7.
 29. Wong ST, Haggerty J. Measuring patient experiences in primary health care: a review and classification of items and scales used in publicly-available questionnaires: Centre for Health Services and Policy Research. Accessed 28 September, 2018. <http://chspr.ubc.ca/pubs/report/measuring-patient-experiences-primary-health-care-review-and-classification>.
 30. Weaver M, Patrick DL, Markson LE, Martin D, Frederic I, Berger M. Issues in the measurement of satisfaction with treatment. *Am J Manage Care*. 1997;3(4):579-94.
 31. Adams C, van Manen M. Phenomenology. In: *The Sage Encyclopedia of Qualitative Research Methods*. Sage Publications, Inc.; 2008:615-9.
 32. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-51.
 33. Cassidy E, Reynolds F, Naylor S, De Souza L. Using interpretative phenomenological analysis to inform physiotherapy practice: an introduction with reference to the lived experience of cerebellar ataxia. *Physiother Theory Pract*. 2011;27(4):263-77.
 34. Baron RJ. An introduction to medical phenomenology: I can't hear you while I'm listening. *Ann Intern Med*. 1985;103(4):606-11.

35. Reiners GM. Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *J Nurs Care*. 2012;1(5):1-3.
36. Ahmed S, Gogovor A, Berman E, et al. Changing healthcare: stakeholder perceptions of the burden of chronic disease and the value of teams, measurements and communication. *HealthcQ*. 2009;12(2):e1-e13.
37. Ahmed S, Visca R, Gogovor A, et al. Implementation of an integrated primary care prevention and management program for chronic low back pain (LBP): patient-reported outcomes and predictors of pain interference after six months. *BMC Health Serv Res*. 2024;24(1):611.
38. Gogovor A, Visca R, Ware MA, et al. Determinants of patient experience with low back pain interdisciplinary care: a pre-post interventional study. *J Pain Res*. 2019;12:3203-13.
39. Patton MQ. *Qualitative Research & Evaluation Methods*. Sage; 2002.
40. Coyne IT. Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *J Adv Nurs*. 1997;26(3):623-30.
41. Mason M. Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qual Soc Res*. 2010;11(3):1-19.
42. Creswell JW, Plano Clark VL. *Designing and Conducting Mixed Methods Research*. 2nd ed. Sage Publications; 2011.
43. Morse JM. Determining Sample Size. *Qualitative health research*. 2000;10(1):3-5.
44. Reitsma ML, Tranmer JE, Buchanan DM, Vandekerckhof EG. The prevalence of chronic pain and pain-related interference in the Canadian population from 1994 to 2008. *Chronic Dis Inj Can*. 2011;31(4):157-64.
45. Schopflocher D, Taenzer P, Jovey R. The prevalence of chronic pain in Canada. *Pain Res Manag*. 2011;16(6):445-50.
46. Negrini S, Fusco C, Atanasio S, Romano M, Zama F. Low back pain: state of art. *Eur J Pain Suppl*. 2008;2(1):52-6.
47. Jackson JL, Chamberlin J, Kroenke K. Predictors of patient satisfaction. *Soc Sci Med*. 2001;52(4):609-20.
48. Greenspan JD, Craft RM, LeResche L, et al. Studying sex and gender differences in pain and analgesia: a consensus report. *Pain*. 2007;132(Suppl 1):S26-45.
49. van Hecke O, Torrance N, Smith BH. Chronic pain epidemiology and its clinical relevance. *Br J Anaesth*. 2013;111(1):13-8.
50. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009;4(50):1-15.
51. Fixsen DL, Naoom SF, Blase KA, Friedman RM, Wallace F. *Implementation Research: A Synthesis of the Literature*. University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231); 2005.
52. Peters DH, Adam T, Alonge O, Agyepong IA, Tran N. Implementation research: what it is and how to do it. *Br Med J*. 2013;347(f6753):1-7.
53. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment Health*. 2011;38(2):65-76.
54. Foster NE, Mullis R, Hill JC, et al. Effect of stratified care for low back pain in family practice (IMPACT Back): a prospective population-based sequential comparison. *Ann Fam Med*. 2014;12(2):102-11.
55. Hill JC, Whitehurst DGT, Lewis M, et al. Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. *Lancet*. 2011;378(9802):1560-71.
56. Domitrovich CE, Greenberg MT. The study of implementation: current findings from effective programs that prevent mental disorders in school-aged children. *J Educ Psychol Consult*. 2000;11(2):193-221.
57. Duerden MD, Witt PA. Assessing program implementation: what it is, why it's important, and how to do it. *J Ext [On-Line]*. 2012;50(1):1-8.
58. Anderson KO, Green CR, Payne R. Racial and ethnic disparities in pain: causes and consequences of unequal care. *J Pain*. 2009;10(12):1187-204.
59. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296-301.
60. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)-a metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform*. 2009;42(2):377-81.
61. Smith JA, Osborn M. Pain as an assault on the self: an interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychol Health*. 2007;22(5):517-34.
62. Almeida M, Saragiotto B, Richards B, Maher CG. Primary care management of non-specific low back pain: key messages from recent clinical guidelines. *Med J Aust*. 2018;208(6):272-5.
63. Gereau RWT, Sluka KA, Maixner W, et al. A pain research agenda for the 21st century. *J Pain*. 2014;15(12):1203-14.
64. Pain Australia. National Pain Strategy 2010. Accessed 23 January 2013. https://s3.amazonaws.com/rdcms-iasp/files/production/public/Content/NavigationMenu/Advocacy/InternationalPainSummit/Australia_2010PainStrategy.pdf
65. Choiniere M, Dion D, Peng P, et al. The Canadian STOP-PAIN Project – Part 1: who are the patients on the waitlists of multi-disciplinary pain treatment facilities? *Can J Anaesth*. 2010;57(6):539-48.
66. O'Hare JA. Anatomy of the ward round. *Eur J Intern Med*. 2008;19(5):309-13.
67. Kiesler DJ, Auerbach SM. Optimal matches of patient preferences for information, decision-making and interpersonal behavior: evidence, models and interventions. *Patient Educ Couns*. 2006;61(3):319-41.
68. Hudak PL, Wright JG. The characteristics of patient satisfaction measures. *Spine*. 2000;25(24):3167-77.

69. Hovey RB, Dvorak ML, Burton T, et al. Patient safety: a consumer's perspective. *Qual Health Res.* 2011;21(5):662-72.
70. Komesaroff P. The many faces of the clinic: a Levinasian view. In: Toombs SK, ed. *Handbook of Phenomenology and Medicine.* Kluwer Academic; 2001:317-30.
71. Toombs SK. *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient.* Kluwer Academic Publishers; 1992.
72. Toye F, Belton J, Hannink E, Seers K, Barker K. A healing journey with chronic pain: a meta-ethnography synthesizing 195 qualitative studies. *Pain Med (Malden, Mass).* 2021; 22(6):1333-44.
73. International Alliance of Patients' Organizations. *Policy Briefing #7 - Pain Management.* IAPO; 2017.
74. Foster MM, Mitchell GK. 'The onus is on me': primary care patient views of Medicare-funded team care in chronic disease management in Australia. *Health Expect.* 2015;18(5):879-91.
75. Lusk JM, Fater K. A concept analysis of patient-centered care. *Nurs Forum.* 2013;48(2):89-98.
76. Watson J. Watsons theory of human caring and subjective living experiences: carative factors/caritas processes as a disciplinary guide to the professional nursing practice. *Texto Contexto Enferm.* 2007;16(1):129-35.
77. Gerteis M, Edgman L, Daley J, Delbanco TL. *Pickering/ Commonwealth Program for Patient-Centered C. Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care.* Jossey-Bass; 1993.
78. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-Centered Medicine: Transforming the Clinical Method.* 3rd ed. Radcliffe Publishing; 2014:426.
79. Ustun TB, Chatterji S, Kostansjek N, Bickenbach J. WHO's ICF and functional status information in health records. *Health Care FinancRev.* 2003;24(3):77-88.
80. Devendorf AR, Rown AA, Jason LA. Patients' hopes for recovery from myalgic encephalomyelitis and chronic fatigue syndrome: toward a "recovery in" framework. *Chronic Illn.* 2020;16(4):307-21.
81. Chan AK-L, Zhong Hui. The Internet Encyclopedia of Philosophy. Assessed 15 June, 2017. <http://www.iep.utm.edu/zhonghui/>.
82. Mayo NE. *Dictionary of Quality of Life and Health Outcomes Measurement.* International Society for Quality of Life Research (ISOQOL); 2015.
83. Fillingim RB, King CD, Ribeiro-Dasilva MC, Rahim-Williams B, Riley JL 3rd. Sex, gender, and pain: a review of recent clinical and experimental findings. *J Pain.* 2009;10(5):447-85.
84. Mogil JS. Sex differences in pain and pain inhibition: multiple explanations of a controversial phenomenon. *Nat Rev Neurosci.* 2012;13(12):859-66.
85. Van Manen M. *Phenomenology of Practice: Meaning-Giving Methods in Phenomenological Research and Writing.* Left Coast Press; 2014.