

“But when I come home...”: How patients with chronic musculoskeletal pain account for their absent pain during naturally occurring clinical consultations

Trine C.B. Andersen, Olaug S. Lian

Department of Community Medicine, UiT The Arctic University of Norway, Tromsø, Norway

Correspondence: Trine C. B. Andersen, at Department of Community Medicine, UiT The Arctic University of Norway, Hansine Hansens veg 18, 9019 Tromsø, Norway.
E-mail: Trine.c.andersen@uit.no

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ABSTRACT

When patients’ embodied experiences cannot be conveyed to clinicians in real-time, the challenges of reaching a shared understanding between patient and clinician are enhanced. In this study, we explore how patients with chronic musculoskeletal pain manage the situation of knowing that they regularly experience pain, yet exhibit minimal signs of it during clinical consultations. Utilizing a multimethod, conversation analysis approach and an interactional perspective, this paper analyzes 10 naturally occurring consultations at a specialized rehabilitation clinic in Norway. The analysis shows that patients account for the absence of pain by referring to i) specific events, ii) pain tolerance, and iii) pain periods. Such accounts were typically triggered by null findings (i.e., the absence of findings in technological and physical tests) in the physical examination and clinicians’ positive summaries of patients’ bodily conditions. Patients resist clinicians’ positive stance by accounting for absent pain, cautiously challenging the clinicians’ epistemic stance. If clinicians do not pursue patients’ accounts, this might lead to a misalignment between patient and clinician which can obstruct efforts to reach a shared understanding of the pain. These findings may have general relevance for clinical consultations where patients’ symptoms are difficult to measure and validate biomedically. Understanding how patients account for absent pain can enhance clinician-patient communication and improve clinicians’ understanding of patients’ everyday circumstances and thereby improve the outcome of consultations.

Introduction

To provide appropriate clinical care for patients presenting with pain, it is vital for clinicians to understand patients’ experiences. However, understanding another person’s pain, including its severity and how it affects everyday life, is a difficult task. That is because pain is an individual experience not directly observable and measurable from the outside, and often difficult to describe verbally in a way that captures the nature and the severity of the embodied experience (Charon, 2021). To grasp patients’ pain and work towards a shared understanding (Street, 2021) of patients’ pain experiences, clinicians often rely on patients’ descriptions and physical presentation (Heath, 1989). When that pain cannot be reproduced during the clinical consultation, reaching a shared understanding can be particularly challenging.

Chronic musculoskeletal pain (CMP) is defined as “ongoing pain felt in the bones, joints and tissues of the body that persists longer than 3 months” (Booth et al., 2017), and it affects up to 33 % (or 1.75 billion) of the world’s population (WHO, 2022).

“Chronic musculoskeletal pain” is a collective term describing various conditions of different etiologies and prognosis. The conditions cover both i) known tissue pathology or structure such as osteoarthritis or rheumatoid arthritis and ii) unknown pathologies such as fibromyalgia, chronic widespread pain, and low back pain, which is one of the most common forms of CMP (Koechlin et al., 2019).

Apart from being very unpleasant, CMP often leads to stiffness, swelling, and reduced mobility, complicating and intensifying suffering during the performance of daily activities. Furthermore, CMP conditions can increase drug consumption, are a leading cause of disability, result in high frequency of sick leave, and significantly diminish quality of life (El-Tallawy et al., 2021). Collectively, CMP conditions thus comprise as a major public health problem as they place a significant burden on patients, society, and the healthcare system.

Musculoskeletal pain can be associated with much uncertainty, especially for those with undiagnosed pathologies (Lian & Robson, 2017; Pienaar et al., 2021). As there are limited treatment options for CMP with unknown pathologies, one of the main purposes of the consultations is to reassure patients that their condition is not dangerous and encourage them to stay active (Andersen et al., 2024). When these patients present with pain that neither is present at the time of the consultation nor triggered by physical examinations, clinicians tend to consider the null findings (i.e., the absence of findings in technological and physical tests) as positive and reassuring. Yet, to patients who regularly experience pain, the absent pain paradoxically contradicts their daily reality, and they consider it accountable, meaning that an explanation or justification is needed to make sense of that phenomenon (Robinson, 2016). Absent pain, in the context of pain consultations where clinicians would expect to find some degree of pain, is such a phenomenon. Little research has been done on how patients and clinicians set out to reach a shared understanding of pain that cannot be reproduced during the consultation. This study aims to address this gap in the literature by exploring clinical interaction in relation to the phenomenon of absent pain.

Our study is based on 10 naturally occurring consultations with patients who experience chronic musculoskeletal pain (CMP) with unknown pathologies and who find themselves in the situation of knowing that they regularly experience pain, yet exhibit minimal signs of it during the clinical consultation. Our intentions are to explore the interactional dynamics between clinicians and CMP patients and to identify interactional factors that might facilitate and obstruct the goal of reaching a shared understanding between clinician and patient. While exploring how patients account for their absent pain during the consultations, how clinicians respond to their accounts, and to what extent they manage to align their understanding, we reflect on the epistemic problem of absent pain.

Shared understanding

Shared understanding “is accomplished interactively as clinicians and patients each provide relevant information” (Street, 2021, p.1831) and co-construct accounts that enable a diagnosis and a treatment. With a shared understanding, the information from the clinician’s biomedical world and the patient’s life world are aligned (Street, 2021). Generally, it is understood that an important goal for medical communication is to reach a shared understanding between the clinician and patient (Street, 2021). This is necessary both to achieve shared decision-making

(SDM) (Pieterse et al., 2023) and to provide patient-centered care (PCC) (Epstein & Street, 2011). SDM and PCC are used to empower patients by supporting them to actively participate in the consultation and decision-making processes. By aiming towards a shared understanding, the outcome of the consultation might become more meaningful and valuable to the patient (Epstein & Street, 2011; Pieterse et al., 2023).

To reach a shared understanding, patients and clinicians employ various information-giving strategies. Clinicians can, for example, attempt to simplify information by highlighting important elements or enhancing persuasiveness by emphasizing the credibility of the information (Menichetti et al., 2021). Patients, on the other hand, might directly express their concerns and feelings (Beach & Dozier, 2015), tell their “story” (Mishler, 2005), or reference a third party (Lian et al., 2024). Despite these strategies, patients and clinicians often disagree about the information shared in the consultation, and Street argues that more focus should be applied to communicative actions patients take to achieve a shared understanding with the clinician (Street, 2021).

Pain communication

Studies on pain communication distinguish between descriptions of pain and expressions such as a sudden gasp, grimace, or pain cry (Heath, 1989). Conversation analysis studies show that there are various dimensions of pain display and that participants in clinical consultations orient to these as a way to construct the nature and intensity of the pain.

The order of events is important. A sudden pain cry as the clinician palpates the patient’s body, for instance, can serve to directly transfer the patient’s embodied experience to the clinician and justify their visit (Heath, 1989; Weatherall et al., 2021).

The interaction in the physical examination is therefore an important element in patient-clinician communication about pain. While it does not mimic the natural circumstances of everyday life, it provides an opportunity for the patient and clinician to simplify communication about pain (Heath, 1989) and to reach a better shared understanding (Street, 2021). If, as is the case for our study, the pain cannot be reproduced in the physical examination by manipulating or palpating the patient’s body, the clinician must rely on the patient’s account of past experiences and expectations about future pain. The consultation can thus pose a problem to patients as the knowledge of their embodied experience cannot be transferred to the clinician’s biomedical perspective, preventing a shared understanding from being easily constructed.

Studies specifically relating to patients with chronic pain have mostly focused on the management of pain rather than its experience (Enthoven et al., 2021; Geraghty et al., 2021). Studies that do investigate the experience of pain have focused on patients’ and clinicians’ pain perception and how pain is rated individually, based on pre-defined scales (Jenkins et al., 2022; Ruben et al., 2015). While these studies show a potential misalignment associated with pain perception and a tendency for clinicians to underestimate patients’ pain (Miron-Shatz et al., 2020), they do not provide insight into how patients and clinicians attempt to handle this misalignment.

Materials and Methods

Data gathering took place between January and March 2022. In total, 21 complete consultations between patients and clinicians

were observed and audio recorded at a specialist outpatient rehabilitation clinic in a large regional hospital in Norway. Of these 21 consultations, 16 included patients with CMP (nine women and seven men). Among the 16 CMP-consultations, 10 contained dialogue sequences related to absent pain (one or several sequences, amounting to 23 sequences in total). These 10 consultations constitute the dataset for this study. Additionally, post-consultation interviews with both clinicians and patients were conducted, providing supporting data to enhance the analysis.

Participants

Seven clinicians (two doctors, one occupational therapist, and four physiotherapists) participated in the study. After presenting the project to the clinical staff in a meeting, consenting clinicians were recruited to the study. Patients were eligible for inclusion if seeking help for fatigue or CMP and between 18 and 60 years old. Selection of participants was randomized by inviting all eligible patients in the data gathering period, but participation bias may have occurred, as those who decided to participate might differ in unknown patterned ways from those who did not. Patients who were not fluent in Norwegian, or had severe learning disabilities, were excluded from the study. The age of the patients in the dataset ranged from 20 to 59 years, with 35 as the average for women and 48 for men. The patients' highest level of education varied significantly—three completed secondary school, three had a bachelor's degree, two had post-graduate education, and two had only primary education—indicating great variability in their socioeconomic backgrounds. Back pain was the most common problem in the dataset, affecting over half the patients. Other conditions included isolated cases of neck, shoulder, hip, pelvic, and wrist pain. At the time of the consultation, two patients were on sick leave, two were working part-time, and six were working full-time. Most patients had been on sick leave at one point due to their pain.

Procedures

Prior to the data collection, all participants were informed about the research objectives and the interview process by TA and provided the opportunity to ask questions. Afterwards, written consent was collected from all participants. Following consultations, patients and clinicians were immediately interviewed in the clinic. All observations and interviews were conducted by TA. On average, consultations lasted 101 minutes (range: 63–142 minutes). Interviews averaged 30 minutes (range: 13–53 minutes) for patients and 29 minutes for clinicians (range: 12–48 minutes). All consultations and semi-structured interviews were transcribed verbatim by TA, and data were fully anonymized; all references to patients' or clinicians' names or uniquely identifying circumstances were removed or changed.

The semi-structured interviews aimed at exploring patients' and clinicians' experiences of the consultations, and participants were encouraged to share both positive and negative aspects. Using a semi-structured interview-guide provided flexibility to adjust question sequence and to ask open-ended questions. The interview guide covered topics such as expectations, experience, information/explanations, clinician-patient partnership, choice, mutual trust, respect, understanding (either offered, received, or requested), perspective on the future, and satisfaction. After identifying a collection of dialogue sequences where patients accounted for absent or a low level of pain, these extracts were transcribed in detail using conversation analytical (CA) conven-

tions (see Jefferson, 2004). Transcribed data have been translated directly into idiomatic English because of space limitations and readability (for transcription containing the original Norwegian see supplementary material). English translation was done by TA and checked by OSL.

Analysis

Observational data has been described as “the methodological gold standard” for studying clinical consultations (Timmermans, 2020, p. 269). Through observational data, we explore how actual clinical consultations were conducted *in situ*, rather than relying on hypothetical descriptions.

Additionally, the interviews provided an insight into the patients' and clinicians' individual experiences and understanding of the encounters. This is useful on its own, but also in terms of interpreting the observational data and informing the initial reflexive thematic analysis (RTA) (Braun & Clarke, 2022). NVivo was utilized to code five consultations before producing a final codebook which was used to code all consultations. Through a systematic process involving transcription, reading and re-reading of the data, the initial analysis was first performed by TA in collaboration with OSL. Through RTA, a total of 23 dialogue sequences where patients accounted for absent pain or a low level of pain were identified. Five representative dialogue sequences are presented in depth in the results section. Using a multimethod approach, these data extracts were transcribed in detail and analyzed based on CA principles and qualitative methodology (see transcription guide in supplementary material) (Heritage & Maynard, 2006; Jefferson, 2004). This included examining patients' accounts for the absent pain, clinicians' responses, and the sequential placement of the account in the wider interaction.

In dialogues, meanings emerge through reciprocal exchanges of speech acts that derive meaning from each other. By breaking a chain of speech acts in a dialogue, the ongoing dynamics of the interactional flow is lost. Therefore, we mainly worked with dialogue sequences. Analysis provided an understanding of how patients' accounts for absent pain functioned in the interaction and how clinicians responded.

Dialogues between patients and clinicians were analyzed based on an interactional and contextual perspective (Snow, 2008). We focused on reciprocal action between two actors in corresponding roles, including how they mutually influence one another during the interactive process and how their communication is influenced by the normative constraints inherited in the social field in which they interact (i.e., the clinical consultation) (Heritage & Clayman, 2010). The interactional perspective has been effectively employed in studies such as Heritage (2005) and Lian et al. (2021), where communication patterns were crucial in shaping medical encounters and outcomes. Additionally, Heritage and Clayman (2010) have shown how integrating interactional analysis with contextual factors can provide a holistic approach to understanding the ways communication shapes, and is shaped by, its institutional contexts. Exploring how patients and clinicians “navigate the structural constraints and imperatives that their contradictory locations give rise to” (Wainwright et al., 2015, p. 19) allows us to understand patients' and clinicians' actions in light of the cultural context in which they are embedded.

Ethical considerations

Patient information and consent procedures were approved by the local Ethics Committee and the data protection officer

(NSD reference no. 807617). Informed written consent was given by all participating patients and clinicians prior to the consultation. All participants were informed of their right to withdraw from the study at any time. Due to the sensitive nature of the data, participants' identities are anonymized through the use of pseudonyms and by minimizing identifiable information.

Results

During the physical examination, clinicians palpate patients and have them perform various exercises. The aim is to reproduce the pain patients describe in the history-taking phase, but many clinicians also take it as an opportunity to positively comment on various aspects of the patients' physical condition. Looking at our data, it was clear that patients in this context frequently face a situation where they know they are regularly experiencing pain, but they are not necessarily experiencing it at that moment in the consultation, as expressed by Karl in the post-consultation interview:

Had been very interesting to do the same exercises during the periods when it is a lot of pain. [...] That is what I think is a bit like hopeless with this problem because, normally, I function completely fine, but then when it is the periods with pain, then the contrast gets so big.

Karl knows that he has periods with intense pain, but cannot show it as he is in what he describes as a "good period," meaning he is currently experiencing little or no pain. Exercises that Karl performs in the examination, therefore, do not produce the same amount of pain he regularly experiences, and he cannot convey the intense pain experience to the clinician. Both in subsequent self-reports and in the consultation itself, patients show frustration with this issue of absent pain.

During the post-consultation interviews, some patients even express that they were unsure the clinicians fully understood their pain and how much it affects them. Karl for instance says:

[...] I don't think we [clinician and Karl] have quite the same picture in our heads of how the pain is actually experienced or looks like—how it can best be described.

In such cases, patients were frustrated that their pain was not understood, and in the consultations, they tried to adjust the clinician's understanding by treating the absent pain as accountable. Patients thus accounted for absent pain by describing specific events, pain tolerance, and pain periods.

Specific events

"Specific events" refers to instances where patients attribute the absent pain to a distinct, identifiable temporary cause such as recent physical activity or a particular life event, thereby distinguishing it from their typical pain experience. Patients' accounts for absent pain mostly happened during the physical examination as a response to palpations, physical exercises, or positive summaries. For example, during the physical examination prior to Example 1, Ingrid did not express much pain. The clinician notices the absence of pain, and continuously summarizes the null findings and Ingrid's apparently good bodily condition, culminating, as the clinician finishes the physical examination, by emphasizing satisfaction (Line 1):

Example 1. [Con02] (C2=Clinician, Ingrid=Patient with back, hip and neck pain)

1	C2:	Very nice. UH great. No, but I am very happy.
2	Ingrid:	Yes, but that's good heh heh heh heh (.). That bodes well.
3	C2:	It bodes very well, I must tell you.
4 →	Ingrid:	Well, now I have been exercising yesterday to stretch
5 →		this here a bit, so it could be that that's why it
6 →		seems like it's a bit looser.
7	C2:	No, but [then. There's nothing that is=
8	Ingrid:	[But uh.
9	C2:	=better than uh (1.3) that you stretch a bit those uh:(.)
10		sore muscles. It is often something that is (2) is smart to
11		maintain when you feel that stiffness and such.
12	Ingrid:	Yes. Should I just put on some clothes?

Ingrid initially responds positively, saying that the clinician's satisfaction bodes well (Line 2). When the clinician confirms this (Line 3), Ingrid refers to the exercises she did "yesterday," which is a potential reason why she "seems like a bit looser" (Lines 4-6). Hence, she accounts for the null finding by attributing it to a specific event. Ingrid uses the word "now" (Line 4) as a temporal marker of the current situation, being only applicable on this day. She does not always feel this good, and the current situation does not reflect her everyday experience. The clinician responds to this account by pushing back against it, attempting to reassure Ingrid that a more positive stance is justified by focusing on how positive it is that working out has a good effect and highlighting the benefit of exercise (Lines 9-11). Ingrid and the clinician disagree about what this absence of pain indicate, and Ingrid fails at persuading the clinician that something is significantly wrong. Recognizing that she will not change the clinician's perspective, Ingrid redirects her attention to finishing the physical examination.

In another consultation (Example 2), the physical examination begins by the clinician asking the patient, Freja, how it is to undress (Line 1), meaning if she experiences pain. Pain when bending over to take clothes on or off is common among patients with back pain, so this would be expected:

Example 2 [Con08] (C1=Clinician, Freja=Patient with back and neck pain)

((Physical examination begins. Patient undresses))		
1	C1:	How is it now when you get undressed? Is it fine then?
2	Freja:	It's fine. I have- I have not done any physical activity
3 →		cause I have kept quite calm.
4	(.)	
5	C1:	Yes.
6	Freja:	Lately.
7	C1:	Mhm.
8	Freja:	So okay.
9	C1:	Yes, can you just begin with walking a bit back and forth
10		here, cause now I shall see how- I shall comment as we go
11		and explain [what I look at.
12	Freja:	[Okay.

Freja responds that “It’s fine” (Line 2), after which her turn could be over. However, she elaborates by saying that she has not done any physical activity (Line 3), adding “lately” three lines later. This indicates a temporal orientation to the clinician’s question which focuses on what Freja is experiencing at that moment. Unable to report pain, Freja accounts for what recent event might be the reason for the absent pain. She thus attributes feeling “well” to having “kept quite calm lately,” implying that physical activity would cause pain in the future. Returning to the clinician’s question, Freja summarizes saying “So okay” (Line 8). The clinician does not respond to her account for the absent pain, continuing with the physical examination. Again, it seems that the patient fails to persuade the clinician that the pain experience does not represent her normal experience, and the patient instead accepts the clinician’s continuation of the examination.

In contrast to the previous extracts, Lukas, in Example 3, would like his shoulder examined as a preventive measure. He has previously had the same problem in the other shoulder and wants to avoid that the problem progress in the same manner again:

Example 3 [Con01] (C1= Clinician, Lukas= Patient with shoulder pain)

((patient shows movements that hurt))	
1	C1: Like uh (.) up here. If you have it in- the arm in.
2	How does it feel?
3	Lukas: Well, it is a little bit, but it’s going well really.
4 →	It is not a problem yet.
5	C1: Mhm.
6 →	Lukas: So uh, this time around thought I would be out early so
7 →	I got (.) uh yes so it did not take that long time.
8	C1: Yes: but [name] what are your expectations to the appointment
9	here today?

When asked if a certain movement produces pain (Lines 1-2), Lukas says, “a little bit” (Line 3) and expands by saying “It is not a problem yet” (Line 4). Following up, he orients to the problem of only experiencing a minimal amount of pain by referring to a specific event where the same pain, with time, became troublesome. While Lukas is not currently experiencing significant pain, he anticipates potential future pain (Line 6). By linking his current minimal pain to a past problem (specific event) that escalated over time—implying that without intervention the same might happen again—he justifies his presence in the clinic. In response, the clinician asks about his expectations of the consultation (Line 8). This might be a way of starting to deal with the possibility that Lukas’ implied expectations (from the prior turn) cannot be met. The subject is thus changed from the absent pain to expectations, without any recognition of Lucas’ explanation.

These extracts show how patients use specific events to account for absent pain during consultations. Furthermore, common among the examples presented above, is the sequential structure. The extracts begin with the clinicians’ turns, which either claim a no-problem perspective or pose a question regarding the patients’ presenting complaint. Patients respond in a way that cautiously resists the no-problem perspective, often by going beyond what is made relevant by the clinicians’ turn (Stivers & Heritage, 2001). In response, the clinicians either pursue the patients’ version, move on with the consultation, or reiterate the no-problem perspective. After that, there are two main possibilities: patients ac-

cept the clinicians’ stance or resist further. Often, patients accept the stance, at least initially, as seen in Example 1 where the patient accepts the clinician’s reply by saying “Okay” and then, in that case, initiate moving on with the consultation (“Should I just put on some clothes?” [Line 12]). However, the same sequence might occur again later in the consultation as patients once more attempt to cautiously resist the no-problem perspective.

Pain tolerance

“Pain tolerance” refers to instances where patients attribute the absent pain to an adjustment in their capacity to endure pain, hinting at discrepancies between their pain threshold and how pain is typically assessed. Sometimes, patients refer to their pain tolerance and how this might be different from other peoples’ experience, as seen in Example 4. Here, the clinician initially summarizes when and how the patient, Nora, experiences pain and then switches temporality by asking about the pain experience “now today” (Line 2). As Nora is not experiencing pain “now today,” she orients to this problem by hesitating and moving “today” to the beginning of the sentence, starting her turn with it (rather than saying “It is actually very little today”) and thereby emphasising the temporal aspect (Line 3). She also uses the word “actually” to indicate that the absent pain is not the norm. In Line 7, Nora answers the original question (Lines 1-2) by conforming to the scale format given by the clinician. She treats the scale as accountable as she explains that her placement on the pain scale does not correspond with how other people would perceive the same pain (Line 9-14).

Example 4 [Con17] (C8=Clinician, Nora=Patient with back pain)

1	C8: (...) On u:h the same scale from one to ten where would
2	you say that they [the pain] are like now today ?
3 →	Nora: (1.2) Today it is actually very little and I feel nothing now-
4	yes, I am hurting a bit above (bussen).
5	(0.8) But not in a way it bothers.
6	C8: No.
7	Nora: One to two kind of u:h.
8	C8: °One to two°.
9 →	Nora: But I have also said it this autumn that, that which
10	has become my (2) zero- if you had put my back
11	pain into someone who never has had hurt in
12	the back, then it had been a completely different
13	number. Because I think that I just walk around
14	and I’m used to it.
15	C8: Yes.
16	Nora: I know that I have a little bit of pain all the time.
17	C8: A bit of pain all the time. Do you ever feel that it
18	is not painful at all?
19	Nora: It has taken me the last couple of weeks but then
20	there have been a couple times when I thought that
21	“Oh, I do not have pain at all exactly now”.
22	C8: No, right.
23	Nora: But that has been(.) just like the last: month maybe.
24	C8: So is it actually right to say that (1) like
25	normally then it is more like two three?
26	Nora: Yes.

The clinician responds by reverting to a more generalizing time-frame using the word “normally” (Line 25) and referring to the previous month instead of today (Line 23). The clinician thus seems to have understood that how Nora felt that day did not represent her normal pain experience. The clinician acknowledges and adapts the understanding of Nora’s pain based on her resistance and, as such, differs from discourse in the previous extracts.

Pain periods

“Pain periods” refers to instances where patients attribute the absent pain to fluctuations in their pain, highlighting that the current state only reflects their being in a temporary “good” period of their condition. In Example 5, Karl refers to his good and bad periods. Early in the consultation, he said that he experiences stiffness and a little pain all the time; however, at the moment of the consultation, exercises that are normally troublesome (Line 1-2) do not produce any pain (Line 3). This is not the first time Karl has to admit that a movement does not cause pain, which is indicated as he says, “that is fine *too*” (Line 3).

Example 5. [Con05] (C4= clinician, Karl= Patient with back pain)

1	C4:	Try to bend forward. This especially the exercise
2		which troubles you. How is it?
3	Karl:	That is fine too. (.) I just feel that I-
4	C4:	You have to be careful, yes?
5	Karl:	Mhm.
((19 lines omitted with patient doing the same exercise and getting bodily praise from C4))		
25	C4:	Yes, and stand up and forward like that.
26	Karl:	And then a little out here and then out to the side.
27	C4:	Okay and then sit up here.
28		((pause 4 sec))
29	→Karl:	But what is a bit like (.) frustrating is that
30	→	the good periods then I actually function quite
31		well [uh and then the pain is triggered and then
32	C4:	[Yes
33	→Karl:	I have a period where I really do not function.
34	C4:	How long? How many days?
35	Karl:	Depends on how much painkiller, but uh but take
36		three four days. A week almost.
37	C4:	What do you do in the meantime?
38	Karl:	Then I do try to do the little I feel helps it.
39		That I try to function in everyday life with studies and
40		such, but that I set myself up for more walks uh.
41	C4:	So you do some things anyways.

After the clinician has praised Karl’s physical condition, Karl goes through a series of movements which are uncomfortable, but does not seem to produce a lot of pain (Line 6-27). Together, the praise and the absence of pain during movements imply a no-problem perspective. After a moment of silence, Karl attempts to pre-emptively resist the no-problem perspective while the clinician is examining his body (Line 28). Karl does so by indicating that it is frustrating not to be able to demonstrate his pain because he would have to be in a bad period which is when he “really do(es) not function” (Line 29-33). The clinician acknowledges Karl’s state-

ment by asking a follow-up question about the duration of the pain and what Karl does in the meantime (Line 34 and 37). When Karl’s response indicates that he can still be active, the clinician returns to a no-problem perspective, concluding that he can “do some things anyway,” which would imply that the situation is not too severe. Karl’s cautious resistance thus does not seem to change the clinician’s perspective on his pain experience.

Discussion

This paper reflects the difficulty patients face in convincing clinicians that their pain is a significant issue in their lives, although it is absent at the moment. Through analysis of real-time consultations between clinicians and CMP patients, we have identified a pattern where patients orient to this problem of absent pain by accounting for it. Common among all the presented extracts is that the patients attribute null findings to temporal aspects of their condition, e.g., that they have recently been on holiday or generally experience periods of pain. They do so by attributing it to one of three temporal explanations: i) specific events, ii) pain tolerance, or iii) pain periods.

Patients’ accounts are often prompted by a positive summary by clinicians or a failure to reproduce the pain through palpation or exercises. Finding themselves saying “no” when clinicians ask if a certain movement or palpation produces pain, the patients reach a point where they account for the absent pain. We see this as an attempt to influence the clinicians’ understanding of the severity of the pain and the impact it has on their everyday life. By accounting for the absent pain, patients cautiously resist the clinicians’ positive stance towards their problem. However, in many cases, clinicians push back against patients’ accounts by reiterating the “no-problem” perspective (e.g., Example 1). In such instances, there is a misalignment between what the patients are trying to achieve and the persuasive work clinicians are doing to reassure patients that the more positive stance is justified.

In CMP consultations, one of the primary objectives for clinicians is to reassure patients by removing their fears or doubts and motivate them to live their lives as normally as possible (Andersen et al., 2024). In previous work (Andersen et al., 2024), we have shown how relying on and emphasizing null findings in reassurance attempts might have adverse effects. This is due to a lack of congruence between what patients experience and the biomedical knowledge that clinicians rely on. Where clinicians consider null findings in physical examinations to be reassuring, patients sometimes see null findings as discouraging because they represent uncertainty about causes and treatments (Andersen et al., 2024). Furthermore, when clinicians push back against patients’ accounts for absent pain by reiterating the no-problem perspective, this might be seen as a failed attempt at reaching a shared understanding of the pain from the patients’ perspective.

By aligning clinicians’ understanding with patients’ experience, clinicians might better comprehend patients’ conditions, allowing them to provide more successful reassurance and tailor interventions to improve pain management. Additionally, shared understanding of patients’ problems fosters patient trust and satisfaction (Lian & Hansen, 2016). Example 5 shows an interaction that works towards shared understanding, demonstrating how a clinician might pursue the patient’s perspective by asking questions and by confirming the patient’s understanding. By doing so, the clinician and patient together adjust their shared understanding of the patient’s pain.

The epistemic problem of absence of pain in consultations

The findings of this research parallel other studies where conditions cannot be explained through biomedical findings, making it difficult to diagnose what patients are suffering from. In the more extreme cases, these conditions become contested as both clinicians and society doubt that they exist. Examples of this could be myalgic encephalomyelitis/chronic fatigue syndrome (Lian & Rapport, 2016) or long COVID (Russell et al., 2022). Patients' experiences with these conditions are not necessarily measurable or identifiable through biomedical methods. For this reason, patients with long COVID, for instance, report experiencing "disempowerment through dismissive healthcare interactions and medical gaslighting" (Russell et al., 2022, p. 6).

The interaction between patients and clinicians reported in our study highlights some basic characteristics of the clinical consultation relating to the asymmetrical epistemic positions of patients and clinicians. This epistemic imbalance is amplified when patients' experiential knowledge does not align with the more authoritative biomedical and clinical knowledge of clinicians. Asymmetrical institutional roles of patients and clinicians in clinical consultations can prompt patients to "redress their subordinate and disadvantaged epistemic position" (Lian et al., 2024, p. 791). This involves presenting themselves as knowledgeable and claiming influence in a way that shapes the conversation and outcome of the consultation, without challenging the institutional and epistemic position of the clinician (Lian et al., 2024, p. 791). When patients account for absent pain and cautiously resist clinicians' no-problem perspective, they face the risk of challenging the epistemic position of the clinicians. This might also explain why most patients do not resist further after the initial account. When clinicians respond by continuing the consultation or reiterating the no-problem diagnosis, further resistance might be too challenging. The epistemic imbalance between patients' experiential knowledge and clinicians' professional knowledge thus amplifies the interactional challenges of these situations.

Street (2021, p. 1832) points to the need for more knowledge about how to assess and improve "concordance between the clinician's and patient's individual perceptions of the information exchanged." Earlier studies have highlighted important features of patient communication, which might be vital for clinicians to know in order to achieve this goal (Landmark et al., 2017; White, 2018). We contribute to this body of knowledge by identifying how patients account for absent pain. Understanding how CMP patients with no pathology account for the absence of pain in ongoing pain consultations sheds light on the difficult task that is pain communication. Our study has affirmed that to comprehend how a shared understanding of pain is reached or not reached in a clinical setting, it is important to pay attention to specific communication features which might influence the interaction. By looking at how patients account for absent pain in the moment of an ongoing consultation and how clinicians respond to their accounts, we gain knowledge of the interactional dynamics of their interaction. As such, we are able to identify factors facilitating and obstructing the process of reaching a shared understanding between clinician and patient. Such understanding is vital for their collaboration. If a shared understanding of patients' pain is not reached, patients might feel misunderstood and rejected, and the clinical outcome of the consultations is likely to be less positive.

Practice implications

The findings of this paper have practical implications for clinical consultations with patients presenting with CMP as well as other kinds of symptoms that cannot be conveyed to clinicians in real-time. While the physical examination provides an opportunity for the patient and clinician to simplify communication about the pain and reach a better shared understanding, it also can pose a problem for the patient that the clinician should be aware of. A lack of concordance between clinician and patient can result in misdiagnosis, poor pain management, and a lack of trust in the healthcare system. Understanding why and how patients account for absent pain may enhance clinician-patient communication, enabling clinicians to provide better reassurance and deliver care that truly addresses patients' needs, thereby leading to more satisfying consultations. To reach a shared understanding, clinical guidelines specific to CMP could be developed, including empathetic questions that are designed to explore patients' pain experience, even in moments where pain is not present. For example, clinicians might ask: What I hear you say is that the level of pain you're showing today does not reflect what you usually feel. Is this right? Can you help me understand what your typical pain experience is like compared to today? On days like today where your pain is less visible, how do you feel others, including clinicians like me, understand your condition?

By including questions that explicitly acknowledge and validate the gap between pain display and the patient's usual experience, clinicians and patients can co-construct a shared narrative that enhances communication and trust. These efforts have the potential to ensure that clinical care better addresses the patient's needs and leads to more satisfying consultations. Further research into specific communication strategies addressing the variability of chronic pain might help develop such a protocol. Additionally, studies examining how reaching a shared understanding impact long-term outcomes for CMP patients could provide valuable insights for improving clinical care.

Strength and limitations

This paper provides unique insight into the negotiation of pain conditions between patients and clinicians in naturally occurring clinical consultations. In addition to observation of consultations, post-consultation interviews were carried out with both patients and clinicians. Studies rarely include both methods, and doing so strengthens our dataset by providing insights about various interpretations of the interactions. The interviews were carried out in the clinic, which might have influenced the participants towards a more positive stance. Furthermore, the sample size for the paper was too small to compare subgroups (such as gender and age) or to be confident about the generalizability of the observed patterns. It is therefore possible that there are categories for how patients account for absent pain other than the ones described here. Further studies could investigate this as well as how the findings apply in other national contexts.

Conclusions

When patients' embodied experiences cannot be conveyed to clinicians in real-time, the consultation poses a problem for both parties. For patients, it becomes increasingly challenging to account for their pain, and for clinicians, it becomes increasingly difficult to understand it. Working towards a shared understand-

ing, which is always a difficult task, thus meets an additional challenge. This paper has shown how patients who regularly experience pain try to navigate interactions with clinicians when their pain is absent at the moment of the consultation and how clinicians respond to their accounts. Through our analysis, we have shown how patients, prompted by clinicians' no-problem perspective, treat the absence of pain as something to be accounted for by attributing it to either specific events, pain tolerance, or pain periods. While clinicians perceived the absence of pain as positive and reassuring, patients found it misleading and frustrating that the clinicians did not understand their experience. Patients' attempts to correct this misalignment by accounting for the absent pain were often disregarded by the clinicians. By looking at how patients account for absent pain, we gain a better understanding of where and how efforts to reach a shared understanding might fail, leaving patients feeling misunderstood and rejected and, possibly, with poorer clinical outcomes. The results of this study may also be relevant to consultations dealing with other conditions and symptoms that cannot be conveyed to clinicians in real-time.

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Online supplementary material:

Transcription conventions.

Norwegian translation of Examples 1-5.