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Introduction to a new series of narrative reflections in chiropractic

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KEY WORDS: narrative, chiropractic, low back pain, health service accessibility, interprofessional relations, patient advocacy, disabled persons, self disclosure, professional role, attitude of health personnel, interprofessional collaboration, materiality, rehabilitation

Introduction à une nouvelle série de réflexions narratives en chiropratique

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MOTS CLÉS : narration, chiropractique,douleur lombaire, accessibilité des services de santé, relations interprofessionnelles, défense des droits des patients, personnes en situation de handicap, auto-divulgation, rôle professionnel, attitude du personnel de santé, collaboration interprofessionnelle, matérialité, réhabilitation

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Introduction

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"The unexamined life is not worth living." - Socrates

Jasmine is a 32-year-old female who is living with back pain during pregnancy. This is her second pregnancy and her first time in life experiencing back pain. She worries that her back pain will worsen over time. Consistent with their training, Jasmine's chiropractor unconsciously follows best practices in patient-centered care, including the act of active listening mannerisms.

Over the course of several weeks of visits, Jasmine opens up and begins to speak with the chiropractor about more than just back pain. Her back pain is improving, and she begins to feel better. Her mood improves and she begins to smile more often during her chiropractic visits. Her pain progressively decreases, and she gives birth to a healthy baby boy. She notes having lingering, mild postpartum back pain. She continues to visit the chiropractor periodically over the following few months. Jasmine describes a decreasing perceived need for chiropractic visits and ultimately discharges herself from care. At her last chiropractic visit she joyously cries and hugs the chiropractor revealing to the chiropractor that her first pregnancy resulted in a stillbirth. Unbeknownst to the chiropractor, Jasmine describes that the chiropractor's kindness, listening, and empathy provided a safe space for her to internally grieve, experience healing, and return to a life at peace. Upon reflection, the chiropractor experiences a profound meaningfulness in healing that is found through human connectedness. This experience has transformed the chiropractor, who now consciously recognizes the true value of engaging in patient- and relationship-centered care.

Insights into illness and healing can be shared and experienced through narrative acts, described as "narrative medicine".[1] Narrative medicine is grounded in biopsychosocial and patient-centered care frameworks.[2] Narrative medicine provides a pathway to appreciating the interpersonal binds between various aspects of health, disease, clinical care, and learning in the health professions.[2] Narrative medicine can enable individuals to confer reflection, empathy, compassion, professionalism, and trustworthiness to clinical practice, professionalism, and learning, which may otherwise not be as obtainable.[1,2]

Narrative medicine can take on many different forms. According to Charon, there are at least five main forms of narrative medicine with varying intentions and methods.[1] Narrative writings can include non-fictional or fictional essays on patient care or professional practice with intent to provide a lesson or enhance perspectives and reflection.[1] In addition, narrative medicine can involve story telling of an individual's experiences and perspectives (e.g., patient, clinician, student, layperson) with an intent to enhance reflection, professionalism and diversity of perspectives. Lastly, narrative medicine can be expressed through various mediums, such as short essays, poems, songs, pictures, or films.

The practice of narrative medicine is increasing in the health professions, as well as health professions education.[1,3] For example, the journals *JAMA* and *Health Affairs* have longstanding series of narrative medicine entitled, *"A piece of my mind"* and *"Narrative matters"*, respectively.[4,5] Narrative medicine has been fostered in health professions education and has been shown to yield favorable changes in attitudes, perceptions, knowledge acquisition, skills, and collegial collaboration that is transferable to professional practice.[3] Despite the increase in narrative medicine in health professions, including peer-reviewed literature, narrative medicine in chiropractic related scientific literature is limited.

In the spirit of Socrates pursuit of lifelong reflection and learning, we introduce a new series of narrative medicine in chiropractic, titled "*Narrative reflections*". We invite chiropractic clinicians, educators, students, patients, and community members to submit brief narratives to the *JCCA*. This series of narratives in chiropractic is dedicated to telling stories that explore experiences and perspectives in health, health care, learning, and the chiropractic profession through brief non-fictional or fictional narratives. It is our hope that this creative series of narratives facilitates reflection and communal learning, embracing the convergence of humanities and chiropractic healthcare. Please consider sharing your meaningful and reflective experiences in clinical practice, chiropractic education, community engagement, or other professional practice in this creative series (see Box 1 for suggested template).

Box 1.
Author template for narrative reflections in chiropractic.

Title Page

- Short, informative title
- No abstract is needed
- Keywords
- Patient authorization (if applicable)

Narrative

- Personal vignettes, fictional or non-fictional stories, short poems, or photo-story exploring the experiences or perspectives of clinicians, patients, community members, educators, or students taken from a wide range of experiences within the chiropractic profession
- ≤ 3 authors
- ≤ 1500 words, ideally 750-1000 words for vignettes and stories
- ≤ 5 references

Navigating fragmented care pathways in complex spine cases: a reflective clinical narrative

Nora Bakaa, DC, PhD

As clinicians, we may encounter a patient whose worsening spinal symptoms are overlooked— drowned out by a fragmented and overburdened health care system. These silent struggles can lead to delayed diagnoses and prolonged suffering. In such moments, our role extends beyond diagnosis and treatment. By leaning on trusted interprofessional relationships and engaging in meaningful advocacy, we have the power to amplify the patient's voice, bring clarity to clinical uncertainty, and ensure that their voice is heard.

Case summary

Hope (pseudonym) is a 45-year-old physically active woman with a five-year history of progressively worsening neck and low back pain, bilateral numbness in both upper and lower extremities, and marked functional decline. Over the last five years, she visited the emergency department multiple times, was prescribed different pain medications, told to go on bed rest, and referred by her physician to a pain clinic, where she received drugs and injections, all with little to no relief. Two separate referrals to orthopedic surgeons did not result in a diagnosis nor further intervention, but referral back to pain management. When I saw Hope, she reported episodes of urinary incontinence, severe sleep disturbance, gait instability, and difficulty with sitting, driving, and walking. Her MRI showed cervical spinal stenosis and degenerative changes in the lumbar spine. Despite these findings and obvious red flags, her care remained focused on pain control. Concerned about her clinical presentation, including a positive Hoffman's sign, brisk reflexes, multilevel sensory deficits, and motor weakness, I arranged for her to be seen by a neurosurgeon, with whom I had a trusting relationship. Upon consultation, we agreed on a diagnosis of lumbar spondylolisthesis with instability and proceeded with spinal fusion surgery.

When I first met Hope, I could tell she had already given up. It wasn't just the pain, though it was obvious and profound; it was the quiet resignation in her voice, the way she said, "I've already seen everyone." She wasn't looking for another opinion. She wasn't even expecting to be believed. She was tired. A woman in her 40s who had once run 5Ks and worked full-time now struggled to stand from a chair. She had been through every rung of the system: emergency departments, pain clinics, multiple specialists. No one had given her answers—no one had taken responsibility for her care.

Our first few sessions were not about treatment in the traditional sense. There were no hands-on techniques, no protocols—*just conversation*. Instead, the focus was on understanding her history, her frustrations, and the profound sense of abandonment she carried. She had lost faith in the process, and rushing into physical care would have ignored the emotional burden that preceded it. Those early sessions were foundational. They were not passive; they were essential. They gave her space to be heard and gave me space to understand what had not been working.

Hope's symptoms were complex: constant numbness in her hands and intermittent numbness in her legs, pain in the lower back that severely limited her function, and even episodes of urinary incontinence. Red flags were present, but the system's response was rote. She was offered injections, NSAIDs, and repeated referrals back to the same pathways that had already failed her. Her imaging showed cervical stenosis, but the source of her most debilitating symptoms, her low back pain and leg symptoms, remained unexplained.

What struck me was that she no longer expected anyone to help. Hope had become background noise—a "chronic pain" file passed between providers, each treating their part but not the whole, not the patient. I did not diagnose Hope—that came later. Instead, I did what had not yet been done: I paused. I looked at the full trajectory. I asked why nothing had helped and whether something might be missing. I referred her to a trusted neurosurgeon; someone I knew would take a more comprehensive look at Hope's case. Ultimately, we ordered flexion-extension imaging, which revealed lumbar spondylolisthesis with instability. While the surgeon initially followed standard protocols, including another trial of injections despite her poor response in the past—a sequence not uncommon in spine care[6]—they ultimately confirmed the diagnosis and initiated the process for spinal fusion surgery.

At this decision point, nearly two years had passed since I first saw her. But this stage of her care was different. The process became more hopeful, anchored in clearer provider communication, focused on functional goals, and individualized strength-based rehabilitation. She was no longer navigating the system alone. Her care became coordinated. Hope now regained a sense of agency and participated more actively in her recovery, even before the operation. Upon self-reflection, it was not about *solving the problem but rather* struck by how easily she had been forgotten, dismissed as another patient with chronic pain. Hope was treated but not *cared for* by the system. Her case showed me, again, that we must challenge default assumptions, especially when patients are not improving. We must recognize that when someone has exhausted the system, they need more than another treatment; they need someone who will advocate.

Hope's case exemplifies the toll of repetitive, low-value interventions when care lacks continuity and diagnostic clarity. Despite presenting with serious symptoms, she was repeatedly cycled through standard pain management pathways without progress. Unfortunately, this is common in musculoskeletal care, where patients often receive redundant treatments without integrated decision-making.[7,8] The resultant cumulative impact is not just clinical, but personal, leading to frustration, isolation, and loss of trust in the healthcare system.

This experience reminds us that clinical advocacy is care. When patients are exhausted and unheard, sometimes the most impactful thing to do is pause, listen again, look again, and be willing to question why the current approach is not working. Especially for patients with overlapping or non-linear presentations, our role must include facilitating interprofessional collaboration and refusing to accept stagnation. True team-based care requires intentional communication, shared responsibility, and humility.[9,10]

Hope's recovery did not begin in the operating room. It began when she was finally seen as a whole person by a team willing to work together. This is what person-centered spine care can, and should, look like.

Chiropractors with disabilities – an unspoken reality and unrealized opportunity

Scott Dunham, DC, MSc, MEd

Twenty-seven percent of Canadians over the age of 15 live with a disability.[11] As a chiropractor, we've all had those days in practice where we simply aren't at our best but forge on determinedly, putting our energy and efforts into treating patients. But what happens when these rough days become weeks, when disgruntlement turns to depression, or when injuries become permanent impairments? Is there any value of a chiropractor with a disability?

These were the questions I grappled with as I navigated an identity shift from a chiropractor to a chiropractor living with a disability. I found myself undergoing a metamorphosis of sorts, orienting myself to both sides of the gurney, as they say in medicine, with seemingly much more in common with those who I cared for than other chiropractors. I thought to myself - in the age of person-centred care and a renewed focus on the importance of empathy, surely the experience of living with a disability could strengthen relationships with both patients and colleagues alike.

I was diagnosed with Multiple Sclerosis in 2010 and continued teaching students and treating patients. I was determined not to let this diagnosis define me. The reluctance to identity as someone living with a disability fueled my perseverance in practice, my pursuit of additional degrees, and my continued participation in contact sports into my 30s and 40s. But I did so through an ableist lens, as if living with a disability was something to conceal or to be ashamed of. I disclosed my condition selectively to some of my closest patients, friends, colleagues, and students, which strengthened those relationships. However, for the most part I kept to myself, not wanting to wear that label or acknowledge my own story. Back then I desperately wanted to be a "normal" chiropractor.

It turns out that chiropractors living with disabilities is extremely rare. A 2022 study of diversity within the chiropractic profession in Canada found that only 3% self-report as living with a disability.[12] A total of 7.2% of Canadian physiotherapists and 12.4% of Ontario nurses identify as someone living with a disability.[13,1,4] When comparing these rates to the general Canadian population (27% of Canadians identify as living with a disability), something doesn't add up.

I continued to ruminate on this disparity following my diagnosis. Is it that people living with disabilities aren't attracted to the health professions for employment? Is it that students in health professions education get weeded out through the rigours of academia or unintended ablest messaging? Are practitioners living with disabilities less effective or viewed as unqualified by patients? Are practitioners just hesitant to report personal disabilities, even on anonymous surveys? All of these could possibly explain a disproportionate reported prevalence of health practitioners living with disabilities.

Self-reporting of disability status by health professionals is likely affected by the negative stigma of the term "disabled" and not wanting this attribute part of their professional identity. Biases and prejudices affect how we view others but also play a role in how we view ourselves. A total of 82.4% of physicians have reported beliefs that people living with significant disability have a lower quality of life than those living without disabilities.[15] So in retrospect, my internal dialogue concerning my future and doubts of my abilities may have been predictable, if not still disappointing.

In health care the role duality of doctor and patient can be difficult to navigate while also maintaining genuine displays of empathy towards one's own patients. I certainly struggled with this as I navigated my own evolving identity, trying constantly to balance the relative importance of who I was versus what I did for a living. But some days it was hard caring about a patient with a rolled ankle while I suffered with bouts of neuropathic pain and unrelenting fatigue.

My perspective changed when I recognized the impact I could have by informing and educating other health professionals living with disabilities, and the powerful opportunity of sharing their story. As a chiropractor I firmly believe that education is our most transformative and powerful intervention because of its ability to change personal habits, mindsets, and world views. The impact of our words and our actions is immeasurable, as is the positive effect when bringing our authentic selves to our work. Patients need to see themselves reflected in healthcare providers charged with their well-being. With their continued presence, chiropractors, healthcare professionals, and students living with disabilities have an enormous opportunity to change society's belief of the value and contributions of those living with disabilities.

Whether in healthcare, education, advocacy, or other fields – there is a vital opportunity for the chiropractor living with a disability. Representation matters and I believe that 27% of the Canadian population would wholeheartedly agree.

Linoleum

Melissa Atkinson-Graham, PhD

How often do you think about flooring materials as conditions of possibility? Probably infrequently, but for me, constantly.

My life can be traced in linoleum flooring. Patterned flecks of beige on beige, splotches of grey connecting blue and green borders, speckles of white and black stretching across corridors. All have been underfoot in so many of the moments that have mattered in my life.

I can recall the streaky taupe pattern of the six by six tiles in the office where a resident told my mother that metastasis was a sign of remission – the ecru linoleum that lined the copy room where I found out I won my first national research grant – the cold grey smudges of the anatomy theatre floor that held my gaze for weeks on end to keep me from crying – the squeaks my clogs would make across the linoleum in the hospital hallways where the sexual harassment I experienced as an intern was treated as an inconvenience – the wheat coloured sheets of vinyl that curved slightly along the bottom of the white plaster walls in my clinic room where, for the first time, a patient of mine told me he was dying.

We forget that these surfaces of blood and grief, urgency and collapse, direction and dirt are also surfaces of connection. That where the tile goes and does not go, how the linoleum borders or breaks from a wall, plays a role in our actions and our experiences.

More than matter, anthropologists have long described that the materials of our built environments convey “promise, transformative potential, aesthetic effect, and affective force.”[16] The materials used to construct and furnish the spaces where we work and dwell influence the kinds of experiences, emotions, and social relations that can materialize in those spaces. When we pay attention to the materials all around us, anthropologists argue that we can begin to “better understand relationships between people and things, where objects are not just passive physical artifacts, but operate in entangled connections and have the power to construct identity, ascribe meaning, collect memories, preserve heritage and knowledge, and generate action.”[17]

We have only to consider what it would feel like, or the kinds of relationships that might take shape, if our clinic rooms were clad in floor to ceiling stainless steel. What forms of connection would be possible against a backdrop of cold, hard edges, undiffused light, and the imagined hum of a freezer fan.

Back to flooring, and back a few years ago to a nursing station in Northern Manitoba with its speckled greenish grey tiles that stretched the entirety of the building. One, contiguous material connecting seven distinct clinical services.

It is of no coincidence that it was in this material context where I experienced integrated practice. There was symbolic and material force in the way the linoleum stretched, uninterrupted, between prenatal care, public health, the emergency department, and my clinic room. The industrial grade flooring was a conduit of connection, signaling the inseparability of our services.

Those great swaths of shared tile that shaped my year in the North provided a pathway to interprofessional collaboration. The same linoleum tiles that offered a surface for a movement assessment were the same tiles that connected me to the attending on call when a constellation of signs and symptoms suggested the need for urgent brainstem imaging. The same tile that steadied my chair as I sat in an intake, listening to a person begin to make sense of the deep emotional undercurrents shaping their experience of chronic pain, was the same tile that we walked together to the counselling office down the hall. Two providers standing on the same surface with a person in need. Our scopes of practice defined like those specks of grey and brown, with no material separation between our work of helping this person in pain.

The expanse of linoleum in the station meant that there were no material distinctions between practices – no changes from vinyl to wood laminate, to terrazzo that would demarcate practical siloes. Even the wall colours were mostly the same – an aesthetic modelling of healthcare as emergency care, primary care, mental health services, and rehabilitation.

I often wonder what that year would have been like if my room in that part of the province was tiled differently. Would I have felt as connected? Would I have been imagined as part of a broader interdisciplinary practice? Would I have spent as much time in the offices of my colleagues, discussing complex cases and collaborative management, seated atop the same linoleum that would later allow me to fidget on my stool as I worked away on charting? Would I have understood, materially, how important integrative practice is for the people whose health I sought to support? Would I have understood, materially, how important it is to practice the limits of my scope – to know that when a person needs more than what I can, or should, offer, that I am always already connected to other professionals who can support such needs for care.

In the company of my tiled histories, I wonder now what practical significance we might find in flooring. What forms of connection are possible when we pay attention to the materials that shape and contain our practices, and what material change might we materialize?

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