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Editorial

Improving musculoskeletal pain care for Australia's first peoples: better communication as a first step

Ivan Lin [a], Charmaine Green [a], Dawn Bessarab [b]

[a] Western Australian Centre for Rural Health, University of Western Australia, Geraldton; [b] Centre for Aboriginal Medical and Dental Health, University of Western Australia, Perth, Australia

In Australia there are stark disparities in a range of health and socioeconomic indices between Aboriginal and non-Aboriginal Australians.[1] Musculoskeletal pain amongst Aboriginal Australians has received less attention than other health conditions, yet the prevalence and burden are high, access to care is relatively low, and the quality of care is suboptimal.[2] Evidence for effective musculoskeletal pain management increasingly supports the type of care that physiotherapists provide.[3] Better access to physiotherapy could reduce the burden of musculoskeletal pain for Aboriginal people and communities. Better engagement by physiotherapists in Aboriginal musculoskeletal pain care should be a priority.

Access to care is influenced by a range of geographical, financial, social and cultural factors;[4] however, there is increasing awareness about the role of interpersonal factors, including patient/practitioner communication, in facilitating or impeding access.[5] A simple and practical step that physiotherapists can take to improve care quality and enhance access for Aboriginal people with musculoskeletal pain is to focus on the effectiveness of their communication. Arguably, ineffective communication is the biggest barrier for Aboriginal people with musculoskeletal pain when seeking care. Re-framing patient communication as a 'clinical yarn'[6] has the potential to improve access to physiotherapy care and outcomes for Aboriginal people with musculoskeletal pain.

Musculoskeletal pain is an important and poorly recognised issue in Aboriginal healthcare

Like a number of health concerns, the prevalence of musculoskeletal pain conditions is higher amongst Aboriginal Australians when compared with non-Aboriginal Australians. The rate of back pain is 1.1 times higher, osteoarthritis is 1.2 to 1.5 times higher, and rheumatoid arthritis is 1.0 to 2.0 times higher.[2] The overall burden due to musculoskeletal pain conditions is also higher: 1.4 times that of the non-Aboriginal population.[7] Aboriginal people are potentially at higher risk of disabling musculoskeletal pain because disabling musculoskeletal pain conditions often co-exist with other health conditions and are associated with socioeconomic disadvantage.[7,8] Despite this, access to care is low. For example, Aboriginal people with hip and knee osteoarthritis access primary care at around half the rate of non-Aboriginal people (3.2 versus 6.5 per 1000 encounters for knee osteoarthritis, 1.2 versus 2.3 per 1000 encounters for hip osteoarthritis) and rates are lower again for hip/knee arthroplasty.[2] Although there are limited data for other musculoskeletal pain conditions or physiotherapy, access to care is likely to be similarly low. This is problematic because interventions provided by physiotherapists — such as facilitating self-management, exercise and activity — are recommended for musculoskeletal pain care[3] and can prevent the development of other chronic conditions or mitigate their impact.[9]

Effective communication is critical for musculoskeletal pain outcomes and access to care

Effective communication is fundamental to healthcare interventions and results in better outcomes for patients and clinicians.[10] In pain care, effective communication is critical. Aside from allowing accurate diagnoses to be made and increasing patient concordance with care, more effective communication is associated with small but significant reductions in patients' pain.[11] Therefore, effective communication underpins high-quality musculoskeletal pain management.

Ineffective communication is a problem and consistently reported as one of the biggest barriers for Aboriginal people when accessing healthcare.[12–14] Communication issues include: clinicians using medical jargon and not involving patients in decision-making; language barriers; a failure to use interpreters when needed; patients' experiences of racism and prejudicial care; and divergent perspectives on health between Aboriginal patients and clinicians.[12–14] Suboptimal communication is a primary reason why Aboriginal people with low back pain[14] and other health conditions[12,13] choose to walk away from healthcare. Ineffective communication is a barrier to Aboriginal people with musculoskeletal pain receiving high-value care and accessing care.[3] A practical and relatively straightforward step for physiotherapists to improve musculoskeletal pain care and encourage better access to care is to improve their communication.

Clinical yarning: a framework for communication in Aboriginal healthcare

Clinical yarning is a framework and some tools with which to help physiotherapists and other clinicians communicate with Aboriginal patients. For Aboriginal people, having a yarn means having a talk in a way that is relaxed, reciprocal and mutual.[15] A number of studies have reported that Aboriginal patients prefer yarning approaches to communication in healthcare.[14,16] Clinical yarning combines Aboriginal communication preferences for yarning with the clinical communication needed to provide healthcare. Clinical yarning reframes clinical communication as a social, diagnostic and management yarn. An open-access article outlining the clinical yarning

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framework is available.[6] This editorial provides an overview and highlights the skills relevant to physiotherapists.

In a practitioner-centric patient interview, a physiotherapist might have in their mind a list of the information content they need to gather (eg, the location and nature of pain) and then proceed to question the patient in order to gather information (eg, 'What is your pain like?'). In a clinical yarning approach, the topic of the consultation is the same (eg, the patient's pain) but the process is different. In the first instance, the physiotherapist chooses to engage in a way that is more patient-friendly and at the forefront is the intention to develop a respectful and trusting relationship. The primary way of doing this is the *social yarn*. A social yarn may or may not have direct relevance to the reason why the person is there and it may be non-existent, brief, or extensive; it depends on cues provided by the patient. Topics for a social yarn could include where each party (physiotherapist and patient) are from, the weather, other seasonal factors, shared acquaintances, recent community events, and sport; the topic depends on the patient and the skills of the physiotherapist to recognise social yarning cues and engage the patient with genuine interest about them as a person. Typically, skills to facilitate the social yarn include: introducing oneself respectfully; being welcoming, open and friendly; finding common ground; sharing information about yourself; positive non-verbal communication; demonstrating an awareness of local Aboriginal culture (eg, seasonal factors); and giving attention to the patient's physical comfort.

The second part of clinical yarning is the *diagnostic yarn*. The aim of this is to gather the necessary information upon which to base clinical decisions. The diagnostic yarn should feel like a comfortable conversation as opposed to a question/answer session, which may be considered impolite and during which patients may feel interrogated.[12] In a diagnostic yarn the physiotherapist aims to facilitate a narrative telling of the patient's health story. The skills favoured in the diagnostic yarn include: open-ended questions with non-judgmental deep listening; allowing silence for the patient to think about their response; recognising and responding to verbal and non-verbal patient cues; providing empathy; and utilising techniques to validate the patient's story and encourage further disclosure such as summarising, paraphrasing, prompting, and affirming (eg, nodding).

The final part of clinical yarning is the *management yarn*. The aim of the management yarn is to explain health information in a way that makes sense to the patient and that allows them to engage in their management. The skills in the management yarn include: checking the patient's initial understanding about their health issue; explaining health information in a direct and 'straight up' manner without jargon; and using contextually suitable explanatory aids such as metaphors, models, or visual/audiovisual aids. Most importantly, the patient is involved in coming to solutions about their management. For example, a suitable metaphor for a patient who has mechanical knowledge might be to relate a stiff osteoarthritic knee to an engine part:

Physiotherapist: *Think of your knee like an engine. How can we stop an engine seizing up?* Patient: *Run it regularly. Keep it moving.* Physiotherapist: *That's right. What do you think you can do to help your knee?* Patient: *Keep it moving or move it more. Keep it running!* Physiotherapist: *Yes! Let's talk about options to do that.*

Yarning approaches are becoming more widely used in Aboriginal health research, healthcare delivery, health promotion, and community engagement.[15,17,18] Clinical yarning is a patient-centred communication framework in the (cultural) context of Aboriginal healthcare and aligns with other patient-centred communication approaches that are supported by research.[10]

Implementing clinical yarning in musculoskeletal pain physiotherapy

Although we have said clinical yarning is a simple strategy for physiotherapists to adopt, in reality improving clinical communication can be challenging as it requires effort, reflection and persistence. The most common strategy used is education.[19] Behavioural skills approaches that involve active, practice-based learning such as role play, feedback and small-group discussions are most effective.[20] As clinical yarning combines clinical and cultural perspectives, education programs should be facilitated by people with cultural and clinical knowledge. Co-facilitation by an Aboriginal person (cultural knowledge) and physiotherapist (clinical knowledge) is recommended, although an Aboriginal physiotherapist could possess both these areas of knowledge. Facilitator(s) should also have knowledge of the clinical yarning framework and skills to facilitate clinical communication education through small-group adult learning, role play and feedback.

Introducing clinical yarning education programs into physiotherapy education, and researching the impact, are future priorities. One perception is that clinical yarning consultations will take more time; however, research suggests that patient-centred communication is more time efficient.[10] This is consistent with experience that clinical yarning facilitates a more efficient exchange of information and allows deeper insights into a person's health situation. More development and investigation of clinical yarning is needed. Current work is, in part, addressing this, including developing an eLearning program to introduce learners to the knowledge/theory aspect of clinical yarning; however, there is more work to be done.

Further considerations

Although clinical yarning is an important way to overcome communication-related barriers to high quality musculoskeletal pain care, physiotherapists should be cognisant of other potential barriers, including: institutional racism and discrimination; mistrust of health services; inadequate Aboriginal health staff; and financial barriers.[5,21] Providing musculoskeletal pain care in partnership with Aboriginal Community Controlled Health Services has the potential to improve access to care by addressing a number of institutional barriers.[2]

Conclusion

In Australia, striving for equitable musculoskeletal pain health includes recognising and addressing the unmet burden of musculoskeletal pain in Aboriginal communities. Whilst a comprehensive approach is multilevel, the first step — and a simple and practical way for physiotherapists to improve the quality of and access to care — is to improve the effectiveness of communication. Clinical yarning provides a framework and some tools for physiotherapists to do this. Such approaches should be adopted if the disproportionate burden is to be addressed.

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Correspondence: Ivan Lin, Western Australian Centre for Rural Health, University of Western Australia, Geraldton, Western Australia, Australia. Email: ivan.lin@uwa.edu.au

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