Low back pain (LBP) has a substantial impact on individuals, societies and healthcare systems. Internationally and in Australia, LBP is the leading cause of disability and accounts for one in 10 consultations in Australian general practice. The point prevalence of LBP is high and it often persists: one in four people have LBP and 42–75% of people report ongoing pain 1 year after an episode. Aboriginal Australians are 25% more likely to report a back problem than non-indigenous Australians and in most cases, LBP is long term in nature. However, the issues for Aboriginal people with chronic low back pain (CLBP) have not received substantial attention to date. This is despite the disabling effects CLBP can have, reducing Aboriginal peoples’ participation in employment, sport, family interactions and cultural activity, and negatively affecting emotional wellbeing.

Good communication between patients and healthcare practitioners (HCP), such as general practitioners, medical specialists, physiotherapists and nurses, is fundamental to successful CLBP care. Effective communication improves satisfaction and wellbeing of patients and HCPs by heightening respect, enhancing interpersonal relationships and improving patient compliance with treatment. Patients with CLBP desire an explanation of what is being done during an examination, understandable information about the cause of pain, reassurance and an opportunity to discuss psychosocial issues and practical diagnostic implications. Despite such aspirations, communication is often suboptimal, resulting in reduced patient satisfaction, a lack of understanding of health information, less active participation in care and reduced treatment compliance.

Communication is consistently identified as a significant barrier for Aboriginal people to access equitable healthcare. Miscommunication is pervasive and often unrecognised by HCPs in their interactions with Aboriginal people. The quality of communication is also a critical factor for Aboriginal people deciding to access healthcare, fully understand a medical condition or procedure and take medication as prescribed.

No previous work has reported the issues of communication between Aboriginal people with CLBP and HCPs; understanding the communication processes is essential if evidence-based care is to be provided. This paper aims to address this gap by examining communicative barriers and identifying ways communication could be improved from the perspective of Aboriginal people with CLBP.

Methods
A clinical ethnographic approach was used that related participants’ lived experience of illness to that of clinical, ‘scientific’ understandings. Cultural security was a further consideration, referring to research conducted in a manner respectful of Aboriginal cultural values and beliefs that incorporates an Aboriginal cultural lens within which participants feel ‘secure’.

Full methodical details have been reported previously. Ethical approval was sought and granted by the Western Australian Aboriginal Health Ethics Committee (reference number 114-10/05) and Curtin University Human Research Ethics Committee (reference number HR147/2005).

The research was undertaken in one rural and two remote Western Australian towns (Table 1). Purposive sampling of Aboriginal adults with CLBP...
was undertaken. Participants were identified by
word of mouth through local Aboriginal community
organisations, through networks of project staff
and a search of the clinical records of Aboriginal
Community Controlled Health Services. This was
augmented by snowball sampling where existing
participants recommended others from within their
social and family networks. Eligible participants
were Aboriginal adults with CLBP (pain in the low
back region with or without accompanying leg pain
that had lasted >3 months or occurred episodically
over a 6-month period).18

Data were collected between 2007 and 2010.
The primary data collection method was through
in-depth, semi-structured interviews using ‘yarning’,
a form of culturally appropriate conversation that
is relaxed, narrative-based and emphasises the
value of story-telling.19 Interviews were conducted
in English or Aboriginal English (a dialectal form
of English that reflects Aboriginal language and
culture with some speech patterns of standard
English as well as Aboriginal languages) by male
or female Aboriginal co-investigators and the
first author. One yarning topic was participants’
experiences of healthcare (eg. ‘Tell me about seeing
the doctor/the hospital/the clinic for your pain?’).
Interviews lasted from 30 minutes to 2.5 hours,
were audio-recorded and transcribed along with
research notes.

Analysis was undertaken in NVivo (QSR
International Pty Ltd. Version 9, 2011). The analysis
was undertaken concurrently with data collection
and was inductive with the aim of understanding
participants’ experiences of healthcare. Emerging
themes informed later research yarns that
were used to explore the theme amongst other
participants. A ‘describe-compare-relate’20 process
was used initially in which emergent themes were
described first, then compared between different
groups of participants and then related to other
sources of information (eg. literature on LBP
care). Primary comparisons were made between
participants who were more or less disabled
(informed by the multidimensional classification
of Dunn et al21 and our previous analysis7), lived
in different study sites and were demographically
different (eg. age, sex). Initial analysis was
reviewed by the interprofessional research team
and Aboriginal co-investigators. Preliminary findings
were discussed during follow-up interviews with 19
available participants as a form of ‘member-check’.
Each of these steps involved a re-examination of
the data until final analysis was completed.

Results

Thirty-two Aboriginal adults (21 men and 11
women) with CLBP participated (Table 1).
Communication between participants and HCPs
was a major theme that emerged and was most
commonly discussed by those who were more
disabled. Barriers related mainly to communication
content and included miscommunication, absence
of communication and the use of medical
terminology. Enablers predominantly related to
the style of communication: a two-way dialogue,
listening, yarning and being ‘straight up’.

<table>
<thead>
<tr>
<th>Table 1. Participant characteristics</th>
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<tbody>
<tr>
<td><strong>Location:</strong></td>
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<tr>
<td>Regiontown†</td>
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<tr>
<td>Goldstone*</td>
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<tr>
<td>Desertedge*</td>
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<tr>
<td><strong>Gender:</strong></td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<td><strong>Age groups:</strong></td>
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<tr>
<td>20–29 years</td>
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<td>30–39 years</td>
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<tr>
<td>40–49 years</td>
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<tr>
<td>50–59 years</td>
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<tr>
<td>&gt;60 years</td>
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<tr>
<td><strong>Disability level:</strong></td>
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<tr>
<td>High</td>
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<tr>
<td>Moderate</td>
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<td>Mild</td>
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<td><strong>TOTAL</strong></td>
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*Town names are pseudonyms
†Regiontown: a regional centre, population 35,000, approximately 10% were Aboriginal.
Goldstone: population <1000, the majority of town residents were Aboriginal.
Desertedge: population <500, the majority of town residents were Aboriginal.

Participants were dissatisfied with information
they were given about their pain when it did not
meet their expectations of an explanation and/or it
contravened participants’ own understandings that
were based on personal experience. Dissatisfaction
was common when advice given was discordant
or contrary with best practice. The findings of
radiological imaging were of particular concern.
Participants felt frustrated and confused when
radiological imaging findings were not explained,
inconclusive or there was contradictory advice
(Table 2, A). Participants who were dissatisfied
with their pain explanation, based on radiological
imaging findings, expressed confusion, frustration
and, in some cases, disengagement with healthcare
(Table 2, B). Miscommunications also occurred
when the advice provided did not result in the
outcome patients were led to expect (Table 2, C, D).

Absence of communication

Providing information is essential for patients to
make informed decisions about care; however,
an explanation about treatment was regularly
lacking. The absence of communication relating to
a procedure (Table 2, E) and follow-up appointments
usually occurred where participants travelled to the
city for specialist appointments (Table 2, F) or where
specialists visited a patient’s residential town (Table
2, G).

Medical terminology and language

Issues

Participants did not understand information about
their pain or medical procedures when these
were explained using medical terminology. This
was a primary concern for several men who had
undergone spinal surgery (Table 2, H). One man
who had multiple surgeries without improvement
and had previously believed they would ‘drill his
leg to free up the nerve’ had seemingly given
up on seeking an explanation from the surgeon
(Table 2, I). Others noted that for some Aboriginal
patients, an interpreter was required. Some HCPs
were not aware of this barrier or how to access an
appropriate interpreter (Table 2, J).

Enablers to communication

Positive experiences mostly related to the style of
communication. Positive communication occurred
when there was a dialogue between participant
and HCP, conceptualised and described by some
participants as a yarn (see below). Participants
were more satisfied when they felt they were
being heard and interactions were a two-way
Table 2. Participant comments relating to communication barriers

<table>
<thead>
<tr>
<th>Miscommunications when information provided was incongruent with evidence-based care</th>
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<tbody>
<tr>
<td>A.</td>
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<tr>
<td>B.</td>
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<tr>
<td>C.</td>
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<table>
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<tr>
<th>Absence of communication</th>
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<tr>
<td>E.</td>
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<tr>
<th>Use of medical jargon instead of plain English</th>
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<tbody>
<tr>
<td>H.</td>
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<td>I.</td>
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Discussion

Our study found that for Aboriginal people with CLBP, successful communication was fundamental to satisfactory care and developing a positive relationship with an HCP. Communication was especially important for those who were more disabled. One of the consequences of unsatisfactory communication was that participants became frustrated and disengaged with healthcare. To improve communication, HCPs need to consider both the content and style of communication. Communication barriers were increased when content was not consistent with participants’ own experiences and recommended treatment for CLBP. Two important communication barriers were related to radiological imaging and the relationship
between CLBP and body weight. Reliance on radiological imaging for an explanation about CLBP is not evidence-based. Imaging should not routinely be used in CLBP, as most findings are commonly seen in pain-free populations and patients may be worse off if misinformed about the meaning of diagnostic findings. Similarly, the relationship between body weight and CLBP is equivocal and factors such as physical activity may be more important than body weight per se. Participants’ own experiences, when weight loss did not influence pain, reinforced this communication barrier. Successful communication about CLBP must be evidence-based, which requires HCPs to have up-to-date knowledge about CLBP. Although seemingly self-evident, this is of concern as CLBP is a complex condition to manage and healthcare is often discordant with evidence.

Communication was sometimes absent, representing a significant gap in healthcare. Participants’ lack of understanding and inability to recall explanations about procedural interventions raises concerns about informed consent. An absence of communication following appointments with urban specialist medical services has been reported recently. We also found a lack of communication following appointments with specialist medical services in the same town, suggesting other barriers may exist between hospitals, specialist medical services, primary care services and patients.

As reported elsewhere, participants valued a clear explanation about the cause of pain and information that did not include medical jargon. Communication that emphasised listening on the part of the HCP and that was a two-way interaction, referred to as a ‘yarning’ style of communication, was valued. Yarning has been described as a method in Aboriginal health research with social, research and therapeutic elements. Yarning, in contrast to a traditional question/answer medical consultation, is conversational and non-confrontational. The storytelling nature shares similarities with emerging approaches using narratives and metaphors to explain persistent pain conditions. The conversational nature of yarning provides a means to checking what patients understand about CLBP and summarising what has been said. Reinforcing spoken information with culturally appropriate CLBP information in other formats (eg. written, visual and audio-visual materials) is also recommended.

Previous studies report the importance of the social, cultural and political context in which communication occurs, including historical factors, mistrust, racism and tensions between cultural and biomedical forms of knowledge. We have focused on interpersonal communication; however, improving the patient experience requires consideration of these broader issues. Reducing language barriers by working with language and cultural intermediaries (eg. interpreters, liaison workers, Aboriginal Health Workers) has the potential to improve communication and deliver culturally secure care.

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### Table 3. Participant comments about an effective ‘yarning’ communication style

**Dialogue with the HCP and a HCP who listened**

| A. | ‘He asked me what sort of tablets I want. Do I want strong painkillers or what? I say no just give me my extra strength paradeine eh ...’ (D5: Desertedge woman aged 56 years with moderately disabling CLBP) |
| B. | ‘... she’d pay attention to that old fella. You know him and he’d tell her then. And he’ll tell her all the private men’s business …’ (R14: Regiontown man aged 68 years with mildly disabling CLBP) |
| C. | ‘And she’s good because we talk about strategies about how, I suppose deal with it you know?’ (R10: Regiontown woman aged 35 years with moderately disabling CLBP) |
| D. | ‘[I like the doctor to] take time to look at you, listen to you’ (G6: Goldstone man aged 73 years with moderately disabling CLBP) |

**Yarning with a HCP in community/social settings**

| E. | ‘Other one down there, oh ... old Doctor Ben, “oh what’s wrong with you now?” (laughs). [He says] “Where are you hurting?” So you’re yarning with him … Claudia [usual doctor] and Ben [usual doctor], they’ll have a yarn with you. They ask how ya going and what ya doing, how the people where you, you know been and that.’ (G1: Goldstone man aged 62 years with mildly disabling CLBP) |
| F. | ‘He’s down the pub old Doctor Ben. Doesn’t go down the pub much. If you do he’ll pull up alongside ya, “How come I never seen you up there for a while?” Good old Doctor Ben.’ (G1: Goldstone man aged 62 years with mildly disabling CLBP) |

**The community knowing the doctor**

| G. | ‘... everybody just talks about her [doctor], say [positive] things about her.’ (R15: Regiontown woman aged 52 years with mildly disabling CLBP) |

**Being honest**

| H. | ‘[I see] only [doctor] Bill. Because Bill’s a straight up person to me, he doesn’t beat around the bush, he just tells me straight up… he speaks up, speaks up properly you know. He’s like a blackfella. Doesn’t muck around.’ (D2: Desertedge man aged 42 years with highly disabling CLBP) |

**Personality factors that enhance communication**

| I. | ‘[she was good] because that was her attitude, she was that open friendly person, her personality’ (R14: Regiontown man aged 68 years with mildly disabling CLBP) |
One of the strengths of this research is that it was undertaken in three different rural and remote locations. While similar issues may be present in parallel settings, caution is recommended when applying these findings to other places. A study limitation is that we were unable to fully explore the implications of CLBP and communication with Aboriginal women and younger people.

Conclusion

Good communication is fundamental to providing quality care to Aboriginal people with CLBP. Attention to both communication content and style is important. Successful communication requires HCPs who have up-to-date knowledge about CLBP and support their communication with culturally appropriate supplementary information. Patient-centred communication that is a two-way dialogue and emphasises careful listening by HCPs is needed. A yarning style may be a useful framework. Although focusing on the perspective of Aboriginal people, these findings are likely to be relevant to other populations with CLBP.

Key points

- Good communication is critical to delivering evidence-based care to Aboriginal people with CLBP.
- To improve communication with Aboriginal patients, GPs need to have up-to-date knowledge of CLBP (content) and ensure communication is a two-way dialogue in which they apply careful listening skills (style).
- Adopting a yarning style may be a useful approach for GPs in their interactions with Aboriginal patients.

Authors

Ivan Lin BSc (Physiotherapy), MManip Ther, PhD, Assistant Professor, Western Australia Centre for Rural Health, University of Western Australia; and School of Physiotherapy, Curtin University, Perth, WA. ivan.lin@cucrh.uwa.edu.au

Peter O’Sullivan DipPhysio (Otago), PGradDipMTh PhD (Curtin), FACP, Professor of Musculoskeletal Physiotherapy, School of Physiotherapy, Curtin University, Perth, WA

Julie Coffin Dip Ed, MPH (JCU), PhD (ECU), Associate Professor Aboriginal Research, and Coordinator, Centre for Aboriginal Research Excellence (CARE), Western Australia Centre for Rural Health and Telethon Institute of Child Health Research, University of Western Australia; and Geraldton Regional Aboriginal Medical Service, WA

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