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'I can sit and talk to her': Aboriginal people, chronic low back pain and healthcare practitioner communication

Background

Chronic low back pain (CLBP) is a complex issue to manage in primary care and under-researched in Aboriginal populations. Good communication between practitioners and patients is essential but difficult to achieve. This study examined communication from the perspective of Aboriginal people with CLBP in regional and remote Western Australia.

Methods

Qualitative, in-depth interviews were conducted with 32 adults with CLBP who identify as Aboriginal. The approach and analysis were informed by clinical ethnography and cultural security.

Results

Barriers to communication related to communication content, information that was not evidence-based, miscommunications, communicative absence and the use of medical jargon. Enablers related to communication style described as 'yarning', a two-way dialogue, and healthcare practitioners with good listening and conversational skills.

Discussion

Health practitioners need to consider communication content and style to improve interactions with Aboriginal people with CLBP. A 'yarning' style may be a useful framework. Findings may be pertinent to other populations.

Keywords

population groups; back pain; communication

Low back pain (LBP) has a substantial impact on individuals, societies and healthcare systems. Internationally and in Australia, LBP is the leading cause of disability¹ and accounts for one in 10 consultations in Australian general practice.² The point prevalence of LBP is high and it often persists: one in four people have LBP³ and 42–75% of people report ongoing pain 1 year after an episode.⁴ Aboriginal Australians are 25% more likely to report a back problem than non-indigenous Australians⁵ and in most cases, LBP is long term in nature.⁶ 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.⁷

Good communication between patients and healthcare practitioners (HCP), such as general practitioners, medical specialists, physiotherapists and nurses, is fundamental to successful CLBP care.⁸ Effective communication improves satisfaction and wellbeing of patients and HCPs by heightening respect, enhancing interpersonal relationships and improving patient compliance with treatment.⁹ 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.¹⁰ 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.¹¹

Communication is consistently identified as a significant barrier for Aboriginal people to access equitable healthcare.^{12–14} 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.^{12–14} 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.¹⁵ 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'.¹⁶ Full methodical details have been reported previously.^{7,17}

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'.

Barriers to communication

Miscommunications

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 1. Participant characteristics

Characteristic	Participants
Location: [*]	
Regiontown [†]	16
Goldstone [#]	9
Desertedge [^]	7
Gender:	
Male	21
Female	11
Age groups:	
20–29 years	1
30–39 years	5
40–49 years	12
50–59 years	8
>60 years	6
Disability level: ^{4,21}	
High	6
Moderate	13
Mild	13
TOTAL	32
[*] 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.	

Table 2. Participant comments relating to communication barriers**Miscommunications when information provided was incongruent with evidence-based care**

A.

'... I've had that many ultrasounds, cat scans, X-rays, nothing there. And all the bloody chiropractor said to me my spine actually comes down like that instead of coming [out] usually it goes that way so they reckon comes outwards, but mine comes in towards my stomach...that's the reason she didn't want to touch me till I'd seen the specialist ...' (R7: Regiontown man aged 49 years with moderately disabling CLBP)

B.

'...it's the same story I get from them all the time [HCPs]. That's why I don't bother going up there too often [clinic] anymore cause I just seem to sit listening to the same story ... It's the wear and tear of your bones. (R16: Regiontown man aged 54 years with highly disabling CLBP)

C.

'... you go to this bloody doctor here, Kim [pseudonym], and he just sits there and says "oh get your weight off and the backaches will stop". I can remember I was only 7.5 stone and my back, well, agony eh. Before I got diabetes and everything. I was a skinny woman ... and I still had the ... back pain.' (D5: Desertedged woman aged 56 years with moderately disabling CLBP)

D.

'They wanted me to lose weight. I lost the weight and it [the pain] was still the same so I put the weight back on (R11: Regiontown woman aged 53 years with moderately disabling CLBP)

Absence of communication

E.

'...well only one bloke I see in Perth who'll, all I do is walk into the clinic and then they tell me to lay down and then that's it. Bang. Finished, there you can go. I was lying on that bed for 6 hours and frightened to move' (D2: Desertedged man aged 42 years with highly disabling CLBP)

F.

'Like I say you go down, you come back and you don't hear any results you know. You think well what the f***** hell, what did we go down in the first place for?' (R7: Regiontown man aged 49 years with moderately disabling CLBP)

G.

'... that was about 3 or 4 years ago, a bone specialist come up here. I seen him at the hospital there, but I never even got a report back from them or anything' (R16: Regiontown man aged 54 years with highly disabling CLBP)

Use of medical jargon instead of plain English

H.

'...well I'm not sure, what they, he [the surgeon] did ... it was all big terminologies.' (R2: Regiontown man aged 53 years with moderately disabling CLBP)

I.

'Well I don't, I can't really understand 'em [medical specialists in Perth] you know. I just go yeah, yeah, righto' (G4: Goldstone man aged 48 years with highly disabling CLBP)

J.

'The English language is his second language. If you're (doctor) not going to get down to the nitty gritty and explain to him properly you should not talk to him. I said [to the doctor] you need to get a family member to come in and you talk to the family member and she will, or he will, explain to the old fella.' (D6: Desertedged man aged 35 years with mildly disabling CLBP)

discussion. Listening on the part of HCPs was most important (*Table 3, A*). HCPs who were perceived to listen to their patients gained greater disclosure of information (*Table 3, B*), enabled participants to take an active role in their management and share in treatment decisions (*Table 3, C*). Conversely, the perception of not being listened to resulted in participants feeling dismissed without having had their concerns heard and was a reason for dissatisfaction with care. Having enough time during the consultation was a critical factor for dialogue and listening (*Table 3, D*).

Yarning

Some participants characterised positive interactions with an HCP as a yarn, which referred to a more conversational and relaxed style and had professional (relating to health status/condition) and social elements (*Table 3, E*). Participants in remote settings emphasised the social elements of yarning and this occurred in the community as well as during clinical consultations (*Table 3, F*). Interactions with HCPs less established in the community, for example fly in/fly out locum doctors, were less satisfactory. Doctors were highly regarded when they were seen to 'know the people' and when people within the community felt they knew the doctor (*Table 3, G*).

In addition to yarning, three men emphasised the importance of being 'straight up', a style of communication akin to being direct and honest (*Table 3, H*). Lastly, communication was enhanced by factors including friendliness, showing respect and empathy (*Table 3, I*).

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.^{17,22} 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.⁵ 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.²³

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.¹² 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^{10,24} and information that did not include medical jargon.¹³ Communication that emphasised listening on the part of the HCP and that was a two-way interaction,²⁵ 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.¹⁹ 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.²⁶ The conversational nature of yarning provides a means to checking what patients understand about CLBP and summarising what has been said.²⁷ Reinforcing spoken information with culturally appropriate CLBP information in other formats (eg. written, visual and audio-visual materials) is also recommended.^{8,13,27}

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.¹²⁻¹⁴ 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.¹³

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 panadeine eh ...' (D5: Deserted edge 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: Deserted edge 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.

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