AALBORG UNIVERSITET

Ethnic children and adolescents with musculoskeletal pain – what challenges does a general practitioner experience in the meeting with these patients?

A qualitative study

Kandidatspeciale udarbejdet af Ditte Borrisholt, medicinstuderende
Hovedvejleder: Michael Skovdal Rathleff
Projektvejleder: Negar Pourbordbari

Resumé

Formål og introduktion: Muskelskeletsmerter er en hyppig tilstand blandt børn og unge. Hos de børn og unge, der udvikler kroniske muskelskeletsmerter, er der risiko for en række negative konsekvenser både fysisk, emotionelt og socialt. På trods af hyppigheden og betydningen for patienterne er der fortsat mangel på viden omkring gruppen af børn og unge, der udvikler muskelskeletsmerter. Det er ikke tidligere undersøgt, hvordan etnicitet spiller ind i forhold til muskelskeletsmerter blandt børn og unge. Formålet med dette studie var derfor at undersøge hvilke udfordringer, praktiserende læger oplever, når børn og unge med anden etnisk baggrund med muskelskeletsmerter kommer til dem i praksis.

Metode: Studiet er et kvalitativt studie med interviews af otte praktiserende læger i Danmark med fokus på lægernes oplevelser med etniske børn og unge med muskelskeletsmerter. Interviewene havde en varighed på 15-20 minutter og var baseret på en semi-struktureret interviewguide (se bilag 2). Interviewene blev lydoptaget og efterfølgende transskriberet. Derefter blev data analyseret ved hjælp af systematisk tekstkondensering.

Resultater: Under analysen af data viste det sig, at fem overordnede problemstillinger gjorde sig gældende i mødet mellem den praktiserende læge og barnet eller den unge med anden etnisk baggrund med muskelskeletsmerter. For det første var der blandt lægerne en oplevelse af, at disse patienter har nogle andre – og ofte højere – forventninger til, hvordan udredning og behandlingsplan skal se ud. Det kan være svært for patienterne at se en given tilstand an, og ofte er der et stort ønske om yderligere undersøgelser i form af for eksempel billeddiagnostik. Endvidere er der ofte et ønske om medicinsk behandling, og mange af de etniske patienter har svært ved at acceptere fysioterapi som en egentlig behandling. Samtidig er mange etniske patienter meget autoritetstro over for den praktiserende læge, og dette kan skabe frustrationer for patienterne, når forventninger ikke bliver indfriet. Derudover oplevede mange læger, at patienterne har en anden og ofte mangelfuld viden om kroppen, som stiller større krav til den praktiserende læge, når han eller hun skal forklare sig over for patienterne, og at dette kan være udfordrende i en tidspresset hverdag. Samtidig oplevede lægerne en tendens til, at etniske patienter kan være mere bekymrede for deres smerter end tilsvarende danske patienter, hvilket også kan have sammenhæng med en manglende viden. En tredje problemstilling, der gjorde sig gældende, var et anderledes familiemønster, som kan have en større betydning under konsultationen, end når danske børn og unge med muskelskeletsmerter kommer til læge sammen med deres forældre. Flere af de

interviewede læger oplevede, at familien spiller en stor rolle i etniske familier, og at en behandlingsplan skal præsenteres for og accepteres af hele familien, før den kan træde i kraft. Den fjerde problemstilling knyttede sig til patienternes beskrivelse af symptomer, som lægerne ofte oplevede anderledes og mere dramatisk end blandt tilsvarende danske patienter, hvilket man må holde sig for øje, når en diagnose skal stilles. Den sidste problemstilling omhandlede sproglige udfordringer, som fyldte meget for nogle af de interviewede læger. Der var tale om udfordringer både i forhold til tolkning og til den forståelse, som knytter sig til kulturelle forskelle.
Konklusion: Studiet viser, at praktiserende læger oplever flere forskellige udfordringer i mødet med etniske børn og unge med muskelskeletsmerter i form af høje forventninger om undersøgelser og behandling, mangelfuld forståelse for sygdom, udredning og behandling, et anderledes familiemønster med stor betydning for konsultationen, en anden måde at beskrive symptomer på, samt sproglige udfordringer. Disse udfordringer kan have en stor betydning for konsultationen og compliance, hvorfor det er vigtigt, at der arbejdes videre på at undersøge og afhjælpe disse problemstillinger for at kunne optimere behandling og dermed prognose for denne patientgruppe.

Abstract

Aim: Musculoskeletal pain is common among children and adolescents. Despite this, there is a lack of knowledge of the phenotype of the children and adolescents who consult in general practice with musculoskeletal pain. The aim of this study was to investigate what challenges a general practitioner experience in the meeting with ethnic children and adolescents with musculoskeletal pain.
Methodology: Eight general practitioners in Denmark were interviewed individually based on a semi-structured interview guide with questions aimed at the ethnic children and adolescents' descriptions of pain, their expectations for the general practitioner, and the possible challenges in the meeting between the general practitioner and these patients. Data from the interviews were analysed using systematic text condensation.
Results: Results showed that general practitioners experienced five different challenges in the meeting with ethnic children and adolescents with musculoskeletal pain. Firstly, the general practitioners experienced higher treatment requirements among this particular patient group, and it can be difficult to the general practitioner to comply these. At the same time, some ethnic patients see the general practitioner as an authority to a greater extent than most Danish patients. Secondly, these patients often have an inadequate understanding of disease, which the general practitioner has to take into account when explaining causes and possible treatments to the patients. Moreover, some GPs experienced that some of the patients are more concerned about their pain than similar Danish patients. A third challenge of importance to the consultation was family patterns, and attention must often be paid to the whole family during the consultation. The general practitioner also experienced challenges in relation to the patients' descriptions of symptoms, which for some can be more dramatic. Finally, the general practitioners experienced different linguistic challenges.

Conclusion: This study shows that general practitioners experience five different challenges in the meeting with ethnic children and adolescents with musculoskeletal pain, and that these challenges can affect the consultation, treatment plans, and compliance. The study provides indication of further research in the field to optimize the meeting between general practitioners and ethnic children and adolescents with musculoskeletal pain.

Introduction

Musculoskeletal (MSK) pain is common among children and adolescents. 8-32% of child and adolescent populations experience MSK pain weekly, while up to 39% experience MSK pain monthly [1]. Some adolescents are predisposed to develop chronic and ongoing symptoms, and these adolescents may experience a range of negative consequences including impact on their physical, emotional, and social functioning, as well as on their overall quality of life [2].

In primary care, pain accounts for 22-39% of appointments during childhood and adolescence, of which MSK pain alone accounts for 11% of medical visits in youth aged 11-14 years, and the prevalence of MSK pain complaints is seen to increase with pubertal development with adolescents having the highest risk [2]. From the age 5-9 years to the age 10-14 years, there is an almost four-fold increase in years lived with disability because of MSK conditions [3].

A systematic review and meta-analysis from 2016 by Huguet et al. has explored childhood and adolescence risk and prognostic factors for MSK pain [1]. The review included 36 studies investigating a large number of factors, many of them with low evidence. Nevertheless, the results showed that low socioeconomic status may not be a risk factor for the onset of MSK pain in the short term but a risk factor in the long term. High BMI, taller height, and having joint hypermobility were shown not to be risk factors for the onset of MSK pain. Also, the results showed that experiencing negative emotional symptoms and regularly smoking may be risk factors for the onset of MSK pain [1].

Holley et al. investigated the transition from acute to persistent MSK pain in children and adolescents in a prospective study [4]. They found that two biopsychosocial factors, female sex and impaired conditioned pain modulation (CPM), predicted the transition from acute to chronic MSK pain [4].

A study by Fabian et al. investigated the association between ethnicity, catastrophizing, and qualities of the pain experience [5]. They define catastrophizing as a negative emotional and cognitive response to pain that involves elements of magnification, helplessness, and pessimism. Results from this study showed that pain responses and catastrophizing varied by ethnicity. However, the study only included adults and did not specifically focus on MSK pain.

To my best knowledge, no previous studies have investigated the associations between ethnicity and MSK pain complaints among children and adolescents in general practice. Because the proportion of immigrants and descendants in Denmark has been increasing [6], it is reasonable to believe that more of these patients is seen in general practice in the future.

The aim of this study is therefore to gather information about general practitioners' (GP) experiences with ethnic children and adolescents with MSK pain in order to explore any possible challenges with this specific patient group.

I am a medical student with interest in general medicine, and the study is my master thesis. It is my first qualitative study, and I have no previous experience of interviewing.

Methods

Design and participants

To investigate what challenges GPs experience in the meeting with ethnic children and adolescents with MSK pain, a qualitative interview study was conducted.

Thirteen GP clinics in Denmark were contacted by phone and shortly informed about the study. Then, written information was sent by email (see appendix 1), and the GPs were invited to participate in an interview. The clinics were encouraged to answer the invitation, and if they did not answer, I called the clinic again.

Initially, the intention was to interview only GPs from GP clinics in Aalborg in order to interview the GPs face to face in their clinics. It was though challenging to recruit enough GPs in Aalborg, mainly because several GPs replied that they did not have time for an interview, or that they had insufficient experience with the specific patient group. Therefore, GPs in other parts of Denmark were contacted and invited to participate in the study via Facetime.

Interviews

Data were drawn from eight single interviews with GPs in Denmark. The interviews lasted 15-20 minutes, and they were based on a semi-structured interview guide. The interview guide contained questions aimed at the ethnic children and adolescents' descriptions of pain, their expectations for the GP, and the possible challenges in the meeting between the GP and these patients (see appendix 2). Before interviewing the participants, the interview was pilot tested on a GP trainee with six years of clinical experience.

As described in the introduction, there is a big increase in years lived with disability because of MSK conditions from the age of 10 years. Therefore, the interviewed GPs were asked to base their answers on their experiences with children and adolescents from the age of 10 years and to age of 19 years, which is the upper limit of adolescence defined by WHO [7].

The interviews were recorded on audio-files and afterwards transcribed verbatim.

Analysis

The analysis was based on an inductive approach, i.e. unaffected by already existing theories [8].

Data was analysed using systematic text condensation (STD) – a method for cross-case thematic analysis of qualitative data. The method is based on four steps developed by Kirsti Malterud [9].

Figure 1: Systematic Text Condensation (STC)

In the first step, all data was read through to get an overview. The aim here was to go from chaos to preliminary themes. Data has to be read with an open mind and with sharp awareness to the participants' voices. Table 1 shows the emergent themes from the first step in my analysis.

Table 1. Emergent themes
The GP as an authority
Parents as authorities
Inadequate understanding of disease
Symptom description
Expectations for treatment
Family patterns
Logistical and financial problems
War traumas and torture
Problems with language and interpretation
Patient frustration
The GP lacks knowledge
The GP feels helpless

In the second step, I went from themes to codes by identifying and sorting meaning units that illuminated the study question. A meaning unit is a text fragment containing information about the research question [9]. The coding process included identifying, classifying, and sorting meaning units potentially related to the previously negotiated themes. According to Kirsti Malterud, the optimal amount of code groups is three to five, and I therefore was aware of identifying maximum five code groups in order to keep an overview of the data.

The third step implied abstraction of meaning units within the code groups establish in the second step. The meaning units of the actual code group was sorted into a few code subgroups. Reviewing every meaning unit within the subgroup, the content was reduced to a condensate – an artificial quotation maintaining, as far as possible, the original terminology applied by the participants. Finally, an authentic illustrative quotation for each subgroup was identified. Figure 3 shows my results from the analysis' step two and three with code groups and code subgroups.

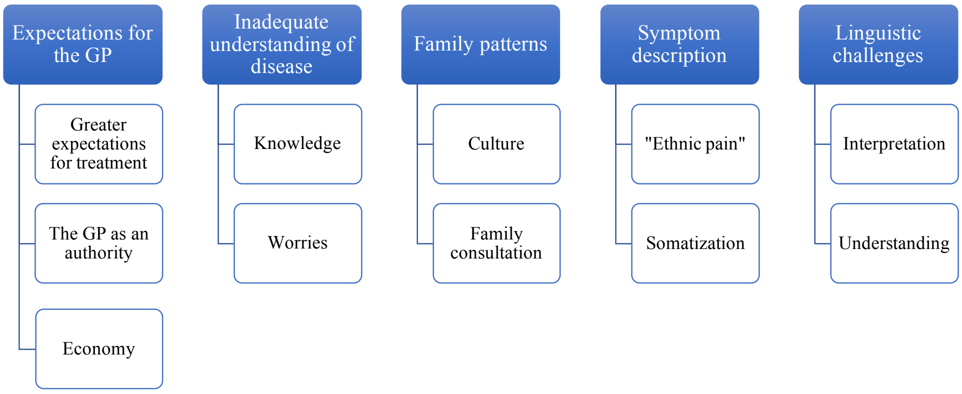

Figure 2: Code groups and subgroups

In the fourth and final step of analysis, data was reconceptualised by putting the pieces together again. It is important that the synthesized results reflect the validity and wholeness of their original context [9]. The category heading is the final result.

Ethics

Because of the study being an interview study not including any human biological material, it did not require approval from National Videnskabsetisk Komité. Furthermore, it did not require approval from Datatilsynet, because the study is a student assignment, and because the participating GPs have given their written consent.

Results

I found that the interviewed GPs experience five different challenges in the meeting with ethnic children, adolescents, and especially their parents, when they consult the GP with MSK pain. Expectations for the GP, family patterns, and linguistic challenges are topics that were mentioned by all included GPs. The challenges are often complex, but there were more common features in the GPs' descriptions.

Ethnic patients with MSK pain have different expectations for treatment

Seven of the GPs in the study experience higher treatment requirements among ethnic children and adolescents with MSK pain. Many patients demand a more aggressive approach to investigation and treatment e.g. diagnostic imaging and medicine, and some patients find it difficult to get the answer 'we have to wait and see' – a commonly used phrase in Denmark, when it comes to MSK complaints, according to one of the GPs in the study. Also, five GPs told me that physiotherapy as a treatment is difficult to accept among these patients, as pointed out by one of the GPs:

> "Når man nu taler om smerter i bevægeapparatet, så vil det jo tit handle om noget fysioterapeutisk eller noget ergonomisk. Og der har jeg tit indtryk af, at der hos indvandrere, der er det ikke en behandling. Det er ikke okay. Der er piller, det er behandlingen" (GP 1).

These different expectations for treatment among this patient population often make it challenging for the GP to help the patient solve his problem. One GP told me how he does not find it difficult to make a treatment plan, but that he often finds it difficult to make the patient follow this plan – maybe because it does not meet his expectations.

Among all of the GPs that mentioned this issue, it was though clear that these different expectations mainly originate from the parents and to a lesser extent from the children and adolescents.

Although ethnic patients have these high expectations for treatment, four of the GPs described that these patients, to a greater extent than Danes, see the GP as an authority. This means that they most often want to accept the treatment plan made during consultation. Especially one GP pointed this out:

> "Altså jeg oplever i hvert fald en stor tillid til at få noget ud af at komme. At de kan få en afklaring, en plan. Jeg synes egentlig, at alle dem, jeg kan komme i tanke om af anden etnisk baggrund, der oplever jeg sådan en tillid i forhold til min autoritet, min faglighed, en villighed til at acceptere, at det har en gyldighed, hvad jeg siger" (GP 8).

The phenomena described above may raise some frustrations among some of these ethnic patients, because they on one hand may find it difficult to understand the less active approach used in Denmark, and on the other hand they see the doctor as an authority to such an extent that they most often want to accept the GP's plan.

Two GPs mentioned how the economic aspect can be a contributing factor to the fact that physiotherapy is not seen as a real treatment of MSK pain. One of them explained:

> ”Og så er der altid det økonomiske aspekt, at generelt så er deres økonomi jo dårligere, og det spiller jo ind (…) Det er jo en del af compliance" (GP 1).

This is an aspect that the GPs have to take into account when making treatment plans.

Ethnic patients with MSK pain have an inadequate understanding of disease

Six of the GPs in the study agreed that ethnic patients in general have another way of understanding the body and how it works. This means that the GP has to describe a given condition, investigation or treatment in another way, that is understandable to the patient. One GP explained:

> "Altså jeg oplever i hvert fald, at ikke-etniske danske har en anden begrebsverden, altså det er måske også mest de voksne, men måske også børnene, at de siger mere, at de har ondt i knogler. Altså de bruger nogle andre ord, de har en anden begrebsforståelse. Og måske en anden forståelse af, hvor smerter kommer fra, om det er muskler eller knogle eller ja. I hvert fald hvis vi taler om bevægeapparatet" (GP 6).

Another GP said that he always has to be aware of the fact, that these patients often have other experiences than most Danes, for example according to ergonomics and physical activity. It might therefore be difficult for the patient to understand why physical exercises are often used as a treatment of MSK complaints in general practice in Denmark. A third GP told me that due to a lack of time it is easy to forget that these patients often have this different understanding, and therefore, things may not always be explained in the most optimal way to the patient. This may affect compliance.

Two GPs mentioned a tendency that some ethnic patients are more concerned about their pain, and one of them explained:

> "Generelt så er de jo ofte vildt bekymrede og kommer akut, fordi de har et eller andet smerte, de er bange for, hvad det er. Og det tror jeg også er fordi, at de enten ikke har nogen at snakke med det om, eller fordi de har en anden forståelse af, hvordan man reagerer på smerte og forholder sig til den, men mange er meget bekymrede" (GP 6).

The other GP explained that a possible reason for these concerns could be a lower level of education among some ethnic groups.

The GPs however agreed that the inadequate understanding of disease, like the expectations mentioned above, mainly originate from the parents.

The whole family consults the GP

All GPs in the study told me that ethnic children and adolescents almost always consult the GP together with their parents. One GP said that this is just how you do – you go to the GP with your children, also the older ones. For many ethnic minorities in Denmark, the family is seen as one unit, and this must be taken into account during the consultation with ethnic children and adolescents. Six of the GPs saw a tendency that the parents in these families, to a larger extent than for Danish parents, are the ones to lead the conversation during consultation:

> "Det kan måske også have noget med kulturen at gøre, altså det kan godt være, at danske børn er opdraget mere til, at de har en stemme og til selv at kunne sige deres mening og selv redegøre for tingene, og det er i hvert fald ikke mit indtryk, at udenlandske børn nødvendigvis er vandt til, at de får ordet. Jeg synes mere, at de sådan tit kigger over på forældrene, og hvor de så svarer eller redegør for det. Også de der lidt større teenagebørn" (GP 3).

Besides having to be aware of the whole family during the history, the different family patterns among ethnic patients must be taken into account when it comes to making a treatment plan for the patient:

> "Altså hvis det er et barn, vi snakker om, så er det meget almindeligt, at forældrene, det er det jo også med danskerne, men etniske, der tænker jeg, at det er meget vigtigt, at forældrene er enige i den plan, der bliver lagt, ellers så bliver den ikke fulgt. Så kommunikationen, hvis det er et barn over 10 år af anden etnisk herkomst, går to veje – den går også til forældrene" (GP 4).

Three of the GPs described how the above-mentioned phenomenon must be seen in the light of how long the families have been in Denmark. In families who have been here for a short period, the family culture from their home countries still has a major influence, whereas families who have been here in several years are more similar to Danish families.

A more dramatic description of symptoms

Half of the interviewed GPs in the study mentioned how they experience ethnic patients describing their pain more dramatically than Danish patients, and three of them used the term 'ethnic pain'. This term is used for ethnic patients who seem to exaggerate their pain [10]. However, it was clear that the GPs were very careful to use this term, and one GP said that he does not want to be prejudiced. The same GP explained:

> "Når jeg ser dem i lægevagten, så synes jeg tit med etniske unge, hvis det er muskelskeletale smerter, jamen så er vi lige nødt til at trække 5 procent fra" (GP 4).

Here there is also a tendency that the longer these ethnic patients have been in Denmark, the more they describe their symptoms similar to Danish patients.

Two GPs in the study with only a few ethnic patients in their clinics, told me that they do not experience any differences in the way, these patients describe their pain. But for some of the GPs, the difference was clear:

> "Mit indtryk er nok, at når de beskriver smerte, vil det være mere diffust. Eller dramatisk. Dramatisk, som at det bliver betonet kraftigere på en eller anden måde. Det kan gøre voldsomt ondt" (GP 1).

The topic about symptom description and ethnic pain seemed frustrating for some of the GPs, because it can be difficult to find out how serious the pain really is, and because it is easy to be prejudiced. One GP directly said that he did not want to be prejudiced, and the remaining GPs seemed to carefully consider their words, when they told me about their experiences on this topic.

Another aspect of describing pain among ethnic patients was somatization, which was mentioned by four of the GPs. They all described how this phenomenon is seen among the particular group of ethnic patients, who have had some unpleasant experiences during war and escape. This is something the GPs have to be aware of, when they see these patients with MSK pain and a history of war or escape:

> "Nogle af dem er somatiserende. De udtrykker deres psykiske problemer i nogle fysiske oplevelser, altså for eksempel ondt i maven, ondt i benene og sådan noget" (GP 2).

Linguistic challenges on more levels

During the interviews, it became apparent that especially two linguistic aspects are challenging for the GPs. The first aspect is about interpretation, as mentioned by all GPs in the study. Three GPs described how important information is lost despite of help from professional interpreters, which can be very frustrating. Nevertheless, all GPs agreed that the use of interpretation is very important in the meeting with these patients – even for a longer period than we might expect:

> "Først og fremmest så skal man være sikker på, at der ikke er en sproglig barriere. At der er tolke til, når der er behov for det, og altså, der er behov for tolke meget længere, end når de sådan kan lidt af det der her-og-nu-dansk, altså købe ind osv. For det at gå til læge, det er meget mere komplekst" (GP 1).

As described above, ethnic children and adolescents most often consult the GP together with their parents, and in that context, it is important to be aware of the fact that the parents often have more difficulties understanding and speaking Danish. One GP explained how she finds it difficult, when she is able to communicate with the patient, but the parents do not understand what she says. And as mentioned earlier, more of the GPs emphasized the importance of the parents agreeing in the treatment plan to make the patient follow it – therefore, it might be very relevant for the GP to consider the use of interpretation, and to use it whenever needed.

The other aspect of the linguistic challenges is difficulties in understanding due to cultural differences, which cannot always be solved by the help of an interpreter. One GP described, how these ethnic patients often use different terms, and she pointed out the importance of taking your time and use very simple words:

> "Man skal måske forsøge at bruge et simpelt sprog og et simpelt ordforråd for at forsøge at få dem til at forklare sig bedst muligt, så man er sikker på, at man forstår dem rigtigt. Man skal i hvert fald nogle gange spørge dem på tre forskellige måder, inden man er sikker på, at vi snakker om det samme" (GP 6).

Another GP explained that some ethnic patients come from a culture, where they are not used to follow any guidelines or treatment plans, and in relation to that he also emphasized the importance of enough time and simple but thorough explanations.

Discussion

Validity, transferability and reflexivity

Several of the GPs contacted during recruitment refused to participate due to a lack of time, and it proved to be challenging to recruit enough GPs. Therefore, there has been a minor focus on variation regarding experience and location among the GPs, which might have shown more aspects of the topic. On the other hand, I found similar descriptions during all interviews, which strengthens the external validity.

In her description of STC, Kirsti Malterud explains how it is an advantage to be two or more researchers to analyse qualitative data [11]. The aim is not to make consensus, but to make the analysis more nuanced. I have analysed all data myself, so there might be nuances that I have not been able to find. However, my study has been relatively small and manageable. Also, I have interviewed the GPs face to face or via Facetime, which gave me important nonverbal information, that would have been difficult to pass on to another researcher. Especially, I noticed when the GPs had to think about which words to use, when talking about the patients' description of symptoms. It was clear to me, that more GPs carefully considered how to tell me about their experiences without sounding prejudiced. I also noticed the non-verbal communication during the thinking breaks that often arose in relation to my question about the patients' expectations for the GP. I here sensed how the GPs thought about specific examples to be able to describe their experiences. This helped me assess whether the GPs actually had experience with the discussed issue. Finally, the face to face interviews helped me assess whether the GPs had understood my questions. Sometimes I had to rephrase my questions or give examples to help the GP answer my questions.

Analysing qualitative data can be very complex, and the researcher's experience and preconceptions can have a big impact on the study, ranging from designing the interview guide to presenting the results [8]. Therefore, I chose to analyse my data by using STC. STC is a method that is applicable to a wide range of qualitative empirical data, and also, it is very applicable for researchers without comprehensive training, such as students [9]. The method has helped me analyse data and present my results in a clear and transparent way to the reader.

What significance can the results have?

I found that GPs experience several challenges in the meeting with ethnic children and adolescents with MSK pain. One of these is that ethnic patients seem to describe their pain in a different way than Danish patients, as more GPs experience a more dramatic pain description among ethnic patients. As mentioned above, Fabian et al. have previously investigated the relationship between ethnicity, catastrophizing, and qualities of pain experience in a quantitative study [5]. They found that pain responses varied by ethnicity among adults, which may explain some of the differences in symptom description experienced by the GPs in this study. Also, they found that catastrophizing significantly varied by ethnicity [5]. Ethnic groups with minority status may be more prone to engaging in negative coping strategies such as catastrophizing, and this may have a relation to the ethnic patients' expectations of a more aggressive treatment of MSK pain – another challenge experienced by the GPs in this study. As described in the introduction, a part of the definition of catastrophizing is that it involves elements of helplessness, and therefore, the patients may tend to expect the GP to 'do something' instead of the 'wait and see'-approach.

In 2014, the report 'Lige adgang til sundhed' was published by Institut for menneskerettigheder [12]. The report contained an analysis of the general meeting between GPs and patients from ethnic minorities, with no focus on any particular disorder. Furthermore, the report did not specifically focus on children and adolescents. The analysis was based on qualitative interviews with five GPs, a questionnaire survey among a number of GPs, a request sent to all regions in Denmark to answer some questions, and two working group meetings with experts and professionals in the field. Results from the report confirm several of the results from the current study. Results from the report showed that ethnic patients often see the GP as an authority, and that the Danish tradition of equal dialogue and the intention of patient involvement can be frustrating for the patients [12]. Moreover, the report showed that ethnic patients often require treatment, as seen in the current study. It also showed how ethnic patients often need more explanation and guidance than Danish patients, due to a poorer knowledge of health, disease and the health care system – a result also seen in the current study [12]. I found that GPs experience linguistic challenges on more levels in the meeting with ethnic children and adolescents, which was also a result in the report [12]. It pointed out both the interpretation issue and the understanding due to cultural differences. Finally, the report 'Lige adgang til sundhed' confirms the result from the current study, that some ethnic patients have a different way of describing their symptoms, which can be challenging for the GP, because it can be more difficult to assess the symptoms [12].
Overall, several of the identified challenges in the current study are similar to the results from 'Lige adgang to sundhed'. Thus, the results are comparable with focus on children and adolescents with MSK pain.

A study by Wilson et al. have investigated the association between parental history of pain and catastrophizing and their' adolescents' pain, somatic symptoms, catastrophizing, and disability [13]. The study did not focus on ethnicity, but the results indicated that parental pain status and cognitions were associated with adolescent pain perceptions, somatic symptoms, and pain-related disability among early adolescents. In my study, the GPs experience that ethnic family patterns play a different, and maybe greater, role during the consultation, and that more of the experienced challenges in the meeting with ethnic patients originate from the parents. It is not possible to conclude if the above-mentioned association is applicable in the current study, but due to the importance of family pattern in ethnic families, it is possible that this association may play a significant role. It could be interesting to further investigate the association in relation to ethnic families.

The study shows that GPs experience several complex challenges in the meeting with ethnic children and adolescents – challenges that may have a major impact on the consultation and on the treatment of the child's or adolescent's MSK pain. As mentioned earlier, some of the patients will develop ongoing symptoms, that can lead to range of negative consequences for the patient. It is therefore important to find a way to solve some of these challenges to optimize the consultation and thereby the prognosis.

During the interviews, the GPs were asked if they had any suggestions for tools that could be a help during consultations with ethnic children and adolescents with MSK pain. When answering this question, I felt a certain helplessness among some of the GPs, because the topic is so multidimensional that it is difficult to come up with one specific solution. One GP mentioned, how he could wish for more time, as it has a major impact on compliance, that everything is explained thoroughly. This relates to the result described above, that some ethnic patients have an inadequate understanding of disease, why the GP needs more time to explain everything properly. If there is also a language barrier, the consultation may be even more time consuming. Three GPs felt a lack of knowledge about this specific patient group, and even more of the GPs mentioned how they miss a better cooperation with e.g. the health providers at school and the different centres for refugees and immigrants. More of the GPs told me that they would not know who to contact, if they needed help. All regions in Denmark are currently working to improve this area with e.g. different courses [14].

Conclusion

This qualitative study investigated the challenges experienced by GPs in the meeting with ethnic children and adolescents with MSK pain. Through interviews with eight GPs with questions aimed at the patients' descriptions of pain, their expectations for the GP, and the possible challenges in the meeting between the GP and these patients, several issues were described. Almost all GPs in the study experience these patients having different expectations for treatment, that can be difficult for the GP to comply. They also often experience these patients having an inadequate understanding of disease, whereby the GP has to explain a given condition, investigation or treatment differently than to Danish patients. This can be difficult and time consuming. Moreover, the inadequate knowledge can result in greater concerns about the pain among these patients. A third topic that appeared in several interviews was family patterns in relation to ethnicity. Most often, ethnic children and adolescents consult the GP together with their parents, which might be taken into account, as the parental acceptance of a given treatment plan has a major impact on compliance. The fourth issue described by more of the GPs was the tendency among ethnic patients to describe their pain in a more dramatic way than similar Danish patients, and the term “ethnic pain” were discussed by some of the GPs. This was a topic that were difficult for some of the GPs to discuss. The last topic arising through the interviews was the linguistic challenges that could be divided into challenges in terms of interpretation, and challenges in relation to cultural differences.

The study provides indication of further research in order to help the GPs solve some of the experienced challenges and to optimize the treatment of and thus the prognosis for ethnic children and adolescents with MSK pain.

Implications

The study demonstrates the potential of further research on ethnic children and adolescents with MSK pain. One way to get closer could be to explore the patients’ experiences of the meeting with the GP, when they consult the GP with MSK pain. This could advantageously be done with qualitative interviews before and after the patient consult the GP in order to investigate what expectations the patient has for the consultation, and afterwards to investigate if these expectations were met during the consultation.

After completion of the study, the results will be passed on to the included GPs.

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Appendix 1

Information om kandidatspeciale til praksis

Projektets titel:
Etniske børn og unge med muskelskeletsmerter – hvilke udfordringer oplever praktiserende læger i mødet med denne patientgruppe?

Jeg er medicinstuderende og i gang med mit sidste år på lægeuddannelsen på Aalborg Universitet. Lige nu arbejder jeg på mit kandidatspeciale, som jeg laver i samarbejde med Forskningsenheden for Almen Praksis i Aalborg. På Forskningsenheden arbejdes der med flere forskellige projekter, der alle tager udgangspunkt i almen praksis. Der forskes blandt andet i muskelskeletsmerter blandt børn og unge, fordi det er et hyppigt problem, der kan få stor betydning for patienterne - også på længere sigt. I mit projekt har jeg fokus på børn og unge med anden etnisk baggrund, som kommer til deres praktiserende læge med muskelskeletsmerter. Jeg laver et kvalitativt studie og er interesseret i disse patienters smerteopfattelse, forventninger og kontakt-mønstre til almen praksis i forbindelse med muskelskeletsmerter. Forhåbentligt kan vi, ved at lære mere om disse patienter, blive bedre til at give en målrettet behandling og dermed forbedre prognosen.

Jeg er godt klar over, at det måske er en meget lille del af de etniske børn og unge, I ser med muskelskeletsmerter, og derfor er det også i orden, hvis I kan sige noget om børn og unge med anden etnisk baggrund og smerter generelt.

Jeg vil derfor rigtig gerne have hjælp fra nogle praktiserende læger eller uddannelseslæger i almen praksis, som har lyst til at deltage i et interviewet omkring denne problemstilling. Interviewet kommer til at vare 15-20 minutter, og jeg er meget fleksibel i forhold til, hvornår det vil passe ind i jeres program. Jeg forestiller mig, at jeg kommer ud i jeres praksis og laver interviewet. Alternativt kan det foregå via Skype eller Facetime.

På forhånd tusind tak for hjælpen!

Venlig hilsen Ditte Borrisholt
Telefonnummer: 31352883
E-mail: dban10@student.aau.dk

Appendix 2

Interviewguide

Briefing

Tak fordi du vil være med i dette interview.

Jeg vil kort starte med at introducere mig selv. Jeg er medicinstuderende og i gang med mit sidste år på lægeuddannelsen på Aalborg Universitet. Lige nu arbejder jeg på mit kandidatspeciale, som jeg laver i samarbejde med Forskningsenheden for Almen Praksis i Aalborg. På Forskningsenheden arbejdes der med flere forskellige projekter, der alle tager udgangspunkt i almen praksis. Der forskes blandt andet i muskelskeletsmerter blandt børn og unge, fordi det er et hyppigt problem, der kan få stor betydning for patienterne - også på længere sigt. I mit projekt har jeg fokus på børn og unge med anden etnisk baggrund, som kommer til deres praktiserende læge med muskelskeletsmerter. Jeg er interesseret i disse patienters smerteopfattelse, forventninger og kontaktmønstre til almen praksis i forbindelse med muskelskeletsmerter.

Interviewet kommer til at tage 15-20 minutter.

Jeg optager interviewet, så jeg kan høre det igen senere, når jeg skal skrive min opgave. Når jeg har færdiggjort min opgave, vil interviewet blive slettet.

Alle data vil blive holdt anonymiserede, så det kun er mig og evt. mine kollegaer, der kan høre interviewet.

Har du nogle spørgsmål, før vi går i gang med interviewet? Du er også velkommen til at spørge undervejs i interviewet, hvis der opstår nogle spørgsmål.

Forskningsspørgsmål	**Interviewspørgsmål**
Er der forskel på danske unge med MSK-smerter og unge med anden etnisk baggrund og MSK-smerter?	- Kan du sige noget generelt om, hvordan etniske børn og unge beskriver deres smerte, når de kommer til læge? - Oplever du, at denne patientgruppe er mere bekymrede for deres prognose end danske børn og unge med MSK-smerter? - Oplever du, at der er tidsmæssig forskel på, hvornår danske og etniske børn og unge kommer til lægen med MSK-smerter? - Hvordan håndterer disse patienter deres smerte? Er der forskel på dette i forhold til danske børn og unge med MSK-smerter?
Er den praktiserende læge klar over, hvilke forventninger den unge med anden etnisk baggrund har til konsultationen?	- Har du en oplevelse af, at denne patientgruppe har andre forventninger til konsultationen end danske børn og unge med MSK-smerter? Hvis ja, hvordan kommer dette til udtryk? - Hvis man tænker på, at forventningerne kan have sammenhæng med den unges familiemæssige baggrund, oplever du så, at der er forskel på danske og etniske børn og unge med MSK-smerter? Hvordan?
Hvilke udfordringer oplever den praktiserende læge i forhold til børn og unge med anden etnisk baggrund og muskelskeletsmerter?	- Hvordan oplever du kommunikationen med de etniske børn og unge, som kommer til dig med smerter? - Hvis barnet/den unge har familiemedlemmer med til konsultationen, hvordan påvirker det så konsultationen? Er der forskel på etniske og danske familier? - Oplever du besværligheder i forhold til at lægge en behandlingsplan? - Hvilke redskaber kunne du forestille dig kunne være brugbare for den praktiserende læge, når denne patientgruppe kommer til læge med MSK-smerter?

Debriefing:

Lægens svar opsummeres/resumeres.

Jeg har ikke flere spørgsmål. Har du mere, du gerne vil sige eller spørge om, før vi afslutter interviewet?

Jeg vil gerne sige mange tak, fordi du ville være med i interviewet.