

# It is time to move beyond 'body region silos' to manage musculoskeletal pain: five actions to change clinical practice

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Current clinical research, education and practice commonly approaches musculoskeletal pain conditions in silos. A focus on body regions such as knee, hip, neck, shoulder and back pain as separate entities is manifest by region-specific clinical guidelines, conferences and working groups. Emerging evidence demonstrates that musculoskeletal pain disorders are frequently comorbid and share common biopsychosocial risk profiles for pain and disability.<sup>1-5</sup> There is broad consensus across clinical guidelines on the recommendations for best practice, irrespective of body region.<sup>3</sup> We contend that a shift to focus on the person is needed. This best practice approach will encourage clinicians to (1) focus on patients' context and modifiable biopsychosocial factors that influence their pain and disability;<sup>3</sup> (2) use education to facilitate active management approaches (targeted exercise therapy, physical activity and healthy lifestyle habits) and reduce reliance on passive interventions; and (3) consider evidence-based surgical procedures only for those

with a clear indication and where guideline-based non-surgical approaches have been rigorously adhered to.

## WE RECOMMEND FIVE ACTIONS TO MANAGE A PERSON WITH MUSCULOSKELETAL PAIN, IRRESPECTIVE OF BODY REGION

To adopt a person-centred active approach to treating musculoskeletal pain and disability, clinicians should:

### 1. Screen for biopsychosocial factors and health comorbidities

Clinicians need to communicate clearly with the patient to identify potential biopsychosocial drivers of pain and disability, which become therapeutic targets for their care.<sup>6-9</sup> These include pain beliefs, emotional and coping responses to pain, social context, physical and lifestyle factors, as well as the presence of comorbidities. Clinicians should incorporate musculoskeletal screening tools, such as the Orebro Musculoskeletal Pain Questionnaire,<sup>10</sup> to identify barriers to recovery and therapeutic targets for examination and care.

### 2. Embrace patient-centred communication

Clinicians should use open and reflective questioning to elicit the patient's understanding of factors, including (1) their pain experience ('Tell me your story'), (2) causation beliefs ('What do you think is the cause of your pain?'), (3) coping ('What do you do when pain increases?'), (4) impact ('Tell me how your symptoms affected your ability to engage with functional and physical activity'), (5) concerns ('Do your symptoms worry you?'), (6) beliefs regarding activity engagement ('Why do you think you shouldn't bend/lift/run?'), (7) social factors ('Tell me about your home/work/social life'), (8) goals ('Tell me about your goals') and (9) expectations

3. What do you think you need to achieve your goals?

This information can then guide an examination that explores the patient's concerns, functional limitations and physical capacity linked to their goals. Communication that privileges the patient's narrative results in patient-centred care and effective shared decision-making about potential risks and benefits of various interventions.<sup>5 6 9</sup>

### 4. Educate beyond words using active learning approaches

Clinicians should embrace education as a central aspect of patient care in order to impart evidence-based information and to facilitate behavioural change. This involves the use of simple and clear language to dispel myths about pain, imaging findings and activity engagement.<sup>7 8 11-13</sup> Education is an active process that is enhanced by writing down key information, using patient stories, web resources and learning aids (see online supplementary appendix). The formats used will vary according to patient's preferences and context. Behavioural learning, such as through exercise therapy, can be used to dispel unhelpful beliefs and build self-efficacy regarding the safety and benefits of movement and activity engagement. To evaluate learning, clinicians may ask patients to report 'take away' messages from each session.

### 5. Coach towards self-management

Clinicians should empower patients to engage in exercise, valued activities and a healthy lifestyle with confidence. Active management relieves pain and improves function across pain conditions and health comorbidities.<sup>14 15</sup> This may involve group-based or individualised models of care. For some, this transition may be easy, while for others, this may reflect a gradual journey over an extended period of time. During this process, care is tailored to patients' individual needs and may include targeting (1) unhelpful cognitions (ie, developing a positive mindset and biopsychosocial understanding of their pain); (2) physical barriers to recovery (ie, load management and a graduated exercise programme of adequate dosage (intensity and frequency) addressing specific physical impairments such as weakness, mobility, movement avoidance and/or protective muscle guarding); and (3) lifestyle factors (ie, sleep, regular physical activity, relaxation, weight control, nutrition and positive social interactions). Clinicians should encourage patients to apply learnt strategies to daily life and

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during periods of symptom exacerbation and distress. Booster sessions may be required during this process. Clinicians should teach patients how to self-monitor and progress their own programme. These strategies can help patients build self-efficacy and develop sustainable self-management strategies that are in line with their context, preferences and goals.

### 6. Address comorbid health factors

Clinicians should refer for co-care in the presence of comorbid mental and physical health complaints such as high levels of emotional distress, eating disorders (overeating and undereating) and type 2 diabetes. We contend that multidisciplinary care needs to be integrated, with consistent messages across the team to prevent care fragmentation and patient distress.

### HEALTH SYSTEMS NEED TO SUPPORT CLINICIANS

Patient-centred care will optimise the value of healthcare provided. Shifting funding to support high-value evidence-based care options and educating society will be critical to enable this transition and will likely be cost-effective. Integrated cross-discipline clinical networks are required for effective co-care. We believe clinicians are ready to change, but they require the support of health systems and payers.

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