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VIEWS & REVIEWS

PERSONAL VIEW

We need to rethink front line care for back pain

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Back pain contributes substantially to workload and healthcare costs in primary care. It is the most common musculoskeletal problem in UK primary care and the second leading symptomatic cause for visits to the doctor in the United States (*BMC Musculoskeletal Disorders* 2010,11:144, doi:10.1186/1471-2474-11-144). In Denmark a family doctor sees on average at least one patient with back pain each working day.

Evidence from clinical trials indicates that treatment in primary care can achieve modest but definite improvement. Encouraging people to stay active and at work, helping patients adjust their beliefs and expectations to realistic but achievable goals, and offering simple analgesia and a range of physical therapies—such as exercise, manual therapy, and acupuncture—and support for rehabilitation to the workplace should result in less suffering, disability, and work loss. However, prevalence of chronic disabling back pain has increased in many countries, sickness absence rates remain high, and many patients seek care from healthcare professionals other than their family doctor.

The first person seen by the patient with back pain is most often the general practitioner. Traditionally, however, GPs receive little training in common musculoskeletal problems in undergraduate medical school, medical internships, and postgraduate education. Surveys and interviews indicate a lack of confidence in examining and treating patients with back pain, and many GPs feel ill equipped, either relying on pharmacological management or subsequently referring patients to doctors with special qualifications or to physiotherapists, chiropractors, or osteopaths (*J Occup Environ Med* 1998;40:958-63; *Eur J Pain* 2007;11:21-9).

Understandably, many patients are concerned that their back pain may signify a serious or progressive disease that, if treated early, can be cured. Research suggests this is rarely the case. The frequency of such diagnoses is very low in patients presenting with back pain in primary care, and the reliability of "red flag" symptoms and signs in identifying them is limited. Evidence suggests that concentration on differential diagnosis and red flags may even divert the GP from evidence based practice and contribute to unnecessary investigations, overmedicalisation, and increased disability and costs (*Arch Intern Med* 2010;170:271-7). This contrasts with GP management of conditions such as angina or diabetes, where toolboxes of diagnostic and practical management skills have been acquired throughout training, and GPs' interventions make a difference.

One solution, first supported in a study in the *BMJ* 20 years ago, is for professionals other than the GP to act as first port of call for musculoskeletal problems (*BMJ* 1987;294:24-6, doi:10.1136/bmj.294.6563.24). Such "primary care musculoskeletal specialists" could provide extended and consistent evidence based management, optimising the opportunity for improvement and prevention of chronic back pain. The minority of patients who need more extensive investigation and patients with complex health problems would be referred to the GP, improving the efficiency of general practice by allowing the GP to focus on patients with multimorbidity, questions of diagnosis, or failure to improve as expected.

This has been well accepted in secondary care. Many back pain services in UK hospitals and interface musculoskeletal clinical assessment and treatment services employ health professionals such as physiotherapists to carry out triage and place the patient in the most appropriate pathway of care. In Sweden many orthopaedic departments now use physiotherapists as front line diagnosticians to triage patients with osteoarthritis. In both countries this has resulted in substantial falls in waiting lists for patients waiting to see surgeons, and many patients are effectively handled without a surgical consultation.

Patient choice suggests this could be achieved in primary care. A third of patients with back pain in Denmark now choose to see a chiropractor as their entry into the healthcare system, and in the US more than half of people who have had back or neck pain during the past year had consulted an alternative health care practitioner, most commonly a chiropractor or massage

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therapist, compared with only one third who had seen a conventional provider (*Spine* 2003;28:292-7).

The question we raise is a practical one—do we continue to organise primary care for musculoskeletal problems around GPs or do we develop the education, practice patterns, licensure, and evidence base of healthcare professions such as physiotherapists, chiropractors, and osteopaths to be the gatekeepers for this condition? The main interests of such professional groups are in musculoskeletal health and back pain, and they drive much research and professional development in these disciplines. Non-medical professions are well accepted as primary care providers of oral and dental health, visual health, and many aspects of mental health, and clinicians such as nurses and pharmacists have been shown to improve quality and cost effectiveness in the management of many conditions. It is time to debate and rethink the way front line back care is delivered in our health services.

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