Who Should Care for Low Back Pain in Israel?

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Neville et al. [1], in this issue of *IMAJ*, address a question that is not frequently asked: For patients in Israel with a new episode of low back pain, how do orthopedic surgeons compare with family physicians as care providers? This type of question will not be asked in many countries around the globe, where it is common practice to visit the general practitioner/family physician (primary care practitioner) as the initial and often only provider of care. In the United States, the only country in the western world without comprehensive health coverage, patients can visit whoever they wish. Studies comparing care by a GP with specialized care abound (for hypertension for example) and frequently claim that domain-specialized care is superior. In most studies comparing usual GP care with allied health personnel interventions (physical therapy, manipulation, exercise), GPs fall behind. It almost begs the question: should physicians be the major source for low back pain management in primary care at all. However, when the argument is limited to what kind of doctor should be at the point of first contact for low back pain in primary care, it is largely accepted that GP gatekeeping is in general the optimal blend of quality and cost containment [2].

Is this true for low back pain care in Israel? Neville and co-authors [1] answer positively for the four variables measured: perceived complaint severity, degree of disturbance to everyday functioning, problem resolution, and health services utilization. This finding is no surprise. The paradigm shift in low back pain care ("the back pain revolution" [3]) is already more than two decades old. Its main thrust is that low back pain is a bio-psycho-social complex and not a spinal disorder, thus lending itself to care by a generalist providing longitudinal care with a comprehensive approach rather than the surgical specialist who provides episodic and intervention-oriented care. The natural history of low back pain in primary care, even when sciatica or disk protrusion is documented, is favorable. The state-of-the-art low back pain management in primary care today stresses:

- that bed rest is not recommended for the treatment of either low back pain or sciatica
- that imaging should be limited to patients with red flags or prolonged symptoms
- that keeping active as much as possible and a rapid return to normal activities is the best course
- the judicious use of simple medications (paracetamol and non-steroidal anti-inflammatory drugs)
- normalization of erroneous beliefs concerning low back pain (for example, that pain is a warning sign and doing any activity while experiencing pain can be disastrous; or that a prolapsed disk is a surgical condition)
- psycho-social support when needed.

It represents a major shift from the earlier paradigm of routine radiography, strict bed rest, wearing a corset, and traction. The present guidelines use a "red flag" warning for the rare serious reasons for low back pain (fewer than 1% of cases), and add "yellow flags" (psycho-social risk, namely, risk conferred by an emotional state such as depression, erroneous beliefs like those mentioned above, life crises, etc,) and "blue flags" (occupational risk), which are the major predictors of chronicity together with a history of back trauma. According to current evidence only the presence of "red flags" is an indication for prompt referral to the back specialist or emergency department. Guidelines for managing low back pain exist in most developed countries, Israel included [4,5]. These guidelines were recently updated locally, based on the European ones [6].

A further explanation for the findings by Neville's group [1] may be the recently published results of a study [7] demonstrating that Israeli orthopedic specialists are less familiar with these guidelines than Israeli GPs. However, since most episodes of low back pain belong in primary care, the more plausible explanation has to do with the appropriate level of care, as highlighted above. When a primary care problem is managed in secondary care, over-treatment and higher resource utilization are the rule.

Explanations aside, it should be stressed that not all is rosy in primary care either. Israeli family physicians, while relatively aware of current guidelines, do not implement them. Dahan et al. [8] have identified that lack of knowledge of LBP guidelines was not the reason for not implementing those guidelines. In a qualitative study, Israeli GPs cite their working conditions as constraints to implementing evidence-

GP = general practitioner

based medicine. This observation was repeated in a recent study of evidence-based medicine education, where despite a positive change in knowledge, skills and attitudes, no change in clinical behavior was noted [9].

Are the study conclusions generalizable? Notwithstanding some methodological and rigor issues (such as not using standard instruments for data collection), the answer is a cautious yes. As the literature lends support to the conclusions, these should be taken seriously by practitioners and decision-makers alike. The study supports the now widespread policy of directing low back pain to primary care (which is the optimal strategy for most new episodes of care other than low back pain, excluding major trauma and the rare sudden onset major health catastrophes). As the studies cited show, this will be best accomplished through attention to the working conditions in Israeli primary care, optimizing the application of the largely existing knowledge, skills and attitudes. When identified, needs-based continuing medical education should address deficiencies, and, coupled with a favorable work environment, adhering to clinical guidelines may become possible.

The message for educators and leaders in orthopedics is that they may need to revise their approach to low back pain care and ensure evidence-based medicine and guidelines proficiency in the orthopedic surgery community. Collaboration of all the disciplines involved in low back pain care, as demonstrated in the current Israeli guidelines, should become the rule (rather than the exception).

The advent of electronic medical records, as well as quality indicators in Israeli primary care, should facilitate further research and monitoring of low back pain care in the country. Although not yet part of current schemes to improve quality indicators, low back pain care is a reasonable marker of the application of evidence-based medicine, resource management and good practice, and should perhaps become part and parcel of the national quality indicator scheme.

Thus, the work by Neville and collaborators [1] can become a catalyst of the multiple levels mentioned for quality improvement, rational practice, and improved outcomes in low back pain care offered by Israeli GPs.

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