LETTER TO THE EDITOR

How effective are guidelines for the management of low back pain?

The National Institute for Clinical Effectiveness (NICE) recently published its first referral practice guide for general practitioners containing inter alia referral advice for acute low back pain. The NICE guidelines are to be evaluated in pilot schemes before being disseminated nationally. Six years have passed since the publication of the Clinical Standards Advisory Group (CSAG) report on back pain and it is four years since the Royal College of General Practitioners (RCGP) issued its own guidelines for the management of acute low back pain. Changes in practice introduced in response to these documents might give an indication of the likely success of the NICE guidelines in altering referral patterns and the clinical management of back pain.

The CSAG report advocated that responsibility for back pain should be transferred from secondary to primary care. If this recommendation has been followed, there should have been a substantial reduction in the number of cases of back pain referred to hospital since 1994. Rheumatology encompasses a wide spectrum of musculoskeletal disorders and back pain accounts for a large proportion of referrals to many rheumatology departments. Amongst its recommendations, CSAG advised that domiciliary visits and hospital bed rest for back pain should be discontinued.

I have audited the numbers, referral patterns, and management of patients with low back pain referred to me following publication of the CSAG and RCGP reports and compared them with previous practice.

There was no overall reduction in the number of back pain cases referred to my main clinic during the period 1987–2000 (fig 1). In the last 5 years back pain has continued to account for an average of 22% of all new referrals, a proportion unchanged from the mean figure for the previous 8 years. The greatest change in practice was observed in the numbers of patients with back pain admitted to hospital for bed rest which fell from 53 in 1994 to 2 in 1997 before rising again to 10 in 1999. Domiciliary visits for back pain (table 1) roughly halved during the same period, but back pain still accounts for almost two thirds of requests for home visits.

The nadir in both domiciliary visit requests and the number of admissions to hospital coincided with the appointment of a specialist back pain physiotherapist who provided an acute referral service in the community as well as conducting a fortnightly clinic in the rheumatology department, seeing patients with back pain who had been referred to the consultant. There was a rebound in the number of back pain admissions when this service suddenly ceased in 1998.

The difference in the responses of secondary and primary care to the recommendations of the CSAG and RCGP reports may simply reflect the easier access to draw a service (inpatient bed rest) than to create a new one (efficient and effective primary care based treatment). The first saves money while the second demands additional resources which are not easily found.

Until the will to demedicalise back pain and manage it in the community is matched by adequate funding, patients will continue to be referred inappropriately to hospitals. When it receives reports of the evaluation of its new guidelines, NICE is likely to be disappointed.

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BOOK REVIEWS


The authors of this book promise much. They rightly identify conflict as being common and frequently corrosive, but they are careful to emphasise that conflict can also be constructive and should not necessarily be feared. The authors describe how pervasive conflict is, and how it protean its manifestations are, but reassure us by emphasising that many of the skills required for the resolution of conflict are possessed by general practitioners and good managers—namely, communication and problem solving skills. The authors have constructed the book with more or less independent chapters, each dealing with a different “conflict zone” ranging from conflict with patients through to conflict with authority. The chapter on “conflict with partners” is probably the most valuable of these. The last three chapters on managing conflict, a series of case studies, and a summary and conclusions are particularly valuable.

Unfortunately, writing the book as a series of independent chapters means that it is repetitive and the truisms that “poor communication feeds conflict” and “prevention is better than cure” are covered in many chapters. It also makes the book’s principal weakness particularly apparent; it is already out of date. Fundholding is no longer an issue whereas current foci of conflict (rheumatology care groups and trusts and the identification of poorly performing practitioners) are not covered. The otherwise useful chapter on “conflict with partners” is diminished by a peculiar table of the “signs” of psychological or mental health which, by and large, are symptoms likely only to be recognised by the unwel person and therefore of scant use for detection by another.

The authors accepted a considerable challenge by writing this book. They have provided some useful advice, some inappropriate advice, and some which is already out of date. This volume would be of most use if used as a focus for critical discussion rather than as a textbook or guideline for practice.

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The contents of this book update and extend the material covered in the authors’ previous and very successful book “Clinical Governance—Making it Happen”. The current book provides a very good review of many of the issues in the area of clinical governance and associated recent Government initiatives. The editors and most of the contributors have a healthy, realistic, and sometimes critical touch on many of the contradictions inherent in trying to modernise and assure quality of all aspects of the NHS, while meeting patient expectation and budgetary constraints.

For those setting up clinical governance arrangements or wishing to check their arrangements against a standard model, chapter 3 on “Organisation and clinical governance” will provide a very useful resource. This chapter contains a clear blueprint for a workable set of arrangements and includes a number of charts and templates for quality reporting documents. This very practical chapter follows a review of the more difficult area of the role of the patient in clinical
governance, in which numerous ways of introducing a broad range of different categories of patients and those outside the healthcare professions into the clinical governance process are discussed. It will be interesting, with time, to see how these different models will work in actual practice.

This contrast between didactic factual chapters and aspirational reviews are a feature of many other parts of the book. There is a very clear and accurate account of the role of the National Institute for Clinical Excellence by its Chief Executive, Andrew Dhillon, and a chapter giving a brief review of the NHS complaints procedure. Some co-authors are clearly more evangelical than others. The chapter on “Nursing and midwifery contribution to clinical governance” was very positive. The review of the controls assurance process was similarly upbeat, very theoretical, and clearly not written by anyone who has had to go through this very complex and detailed bureaucratic process. An interesting way to write about clinical governance is to use case studies. This was exhibited in the chapter by Jenny Simpson, the Chief Executive of the British Association of Medical Managers, in her excellent review of the role of the Medical Director.

My favourite lines in the book come from the chapter on the “Myth of accurate clinical information”: “Usually, there is a failure to understand how difficult it is to collect the even relatively simple data contained in the standard minimum data sets accurately.” The section on “Clinical governance in primary care trusts” attempts to provide some useful guidance on an area very much in its infancy. This section contains the very wise words: “... none of the clinical governance work can proceed without proper resources, protected time and adequate infrastructure”.

My experience of clinical governance is that, if clinicians have data on the clinical quality of their work, they will change behaviour to improve their results. The challenge is to find ways of obtaining and sharing accurate data in a cost effective and non-threatening way.

This book offers a useful guide to many of the dimensions of clinical governance. There are a wealth of references in many of the chapters and a useful resource section at the end. Notable omissions were a section on the Commission for Health Improvement and, in particular, the criteria the Commission will use to evaluate healthcare organisations. The appendix could have provided a guide to the useful Government documentation and guidance available on the world wide web. I hope these will be added in future editions.

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