

Patients' views of low back pain and its management in general practice

A M SKELTON

E A MURPHY

R J L MURPHY

T C O'DOWD

SUMMARY

Background. Low back pain is a common and persistent problem. Research studies seeking to improve the quality of management of this condition have tended to ignore the opinions of patients. There is a growing acceptance of the importance of taking patients' views into account in developing management and educational programmes for a variety of conditions.

Aim. This study set out to elicit the views of patients concerning low back pain and its management in general practice.

Method. Fifty-two in-depth interviews were conducted with patients selected from a broad range of 12 general practices.

Results. Analysis of the interviews identified seven themes relating to: quality of life, prognosis, secondary prevention, help-seeking behaviour, explanation of underlying pathology, satisfaction with general practitioner management, and complementary therapy. Different patient viewpoints or perspectives were expressed within each of these themes. Patients adapted to the progress of their low back pain and were not seeking a 'magical cure' from either conventional or complementary therapies.

Conclusion. Patients' views on low back pain are heterogeneous. The dissatisfaction expressed with medical explanations for the pain may be related to superficial clinical management and the constraints of general practice. Good management of low back pain needs to take patients' complex views of the condition into account.

Keywords: *backache; management of disease; patient health beliefs; patient attitude.*

Introduction

LOW back pain has been identified as a major barrier to improving the health of the nation,¹ with 15-20% of people having such pain at any one time.^{2,3} The impact of the condition is concentrated in the working population⁴ and, in the UK, it results in the loss of 33 million working days each year.⁵ Although most low back pain is self-managed by patients, one in four of the symptomatic population choose to visit their general practitioners,^{6,7} resulting in over two million consultations annually.⁸

Current medical management of the condition focuses upon

A M Skelton, BEd, MPhil, PhD, lecturer, School of Education; E A Murphy, MA, MSc, PhD, lecturer, School of Social Studies; R J L Murphy BSc, PhD, professor, School of Education; and T C O'Dowd, MA, MD, FRCP, senior lecturer, Department of General Practice, University of Nottingham. Submitted: 15 August 1994; accepted: 28 July 1995.

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bed rest, restriction of activity and analgesia.⁹ Such conservative treatment has been criticized not only on the grounds of ineffectiveness¹⁰ but also because it may be harmful^{11,12} and uneconomical.¹³ Research suggests that adapting management programmes to take account of patients' prior understanding, beliefs and experiences may be important across a range of conditions.¹⁴⁻¹⁶ However, few studies of the management of low back pain have focused on the views of patients. Furthermore, apart from notable exceptions,¹⁷ all of those which have done so employed highly structured questionnaires to elicit patient responses to questions which the researchers had identified as important in advance.^{18,19}

Studies of patients' experiences of the management of low back pain in general practice suggest that patients do not accept the general practitioner's bipolar classification of back pain as acute or chronic.¹⁷ Many patients claim that they do not receive an adequate explanation for their problem¹⁸ and are less satisfied with the care that they receive for low back pain than for other conditions.¹⁹ Finally, when compared with patients of chiropractors, general practice patients are less likely to believe that their doctor feels concern for them and is comfortable dealing with the problem.¹⁹

The aim of this study was to explore the views of patients about low back pain and its management in general practice. As part of the same project the views of general practitioners were also studied.²⁰ Both sets of results have been considered in relation to their implications for patient education and counselling.²¹

Method

Data collection

The data were drawn from semi-structured interviews, lasting 60-90 min, with patients presenting with recurrent low back pain in selected general practices in Nottinghamshire, between July 1992 and December 1993. Patients' experiences of low back pain and its management were explored, using an interview guide. The design of this guide drew upon informal interviews with patients, general practitioners and other members of primary care teams, periods of observation in several general practices and in-depth interviews with five sufferers of low back pain.²²

Sample selection

A cohort of adult patients (18-75 years) presenting in 12 general practices who met the following eligibility criteria were invited to take part in the study: more than one recorded general practice consultation for low back pain; no radiation of pain beyond buttock; no evidence of nerve root involvement; no indications of inflammatory disorder; and no history of spinal surgery. These criteria were designed, in consultation with general practitioners and a consultant rheumatologist, to identify a group of patients whose low back pain was reasonably typical of that managed in general practice.²³

The practices from which the patients were drawn were selected to reflect the heterogeneity of general practices in England and Wales.²⁴ Sampling methods which drew upon a detailed study of social areas within Nottinghamshire,²⁵ were used to identify 12 practices. Within each practice, one general practi-

tioner was invited to recruit patients presenting with low back pain. In selecting these general practitioners, attention was again given to achieving diversity in relation to a number of variables including age, sex and length of service.

Each general practitioner was asked to recruit up to seven consecutive eligible patients who presented with low back pain. A maximum of six patients per general practitioner were interviewed. If a patient withdrew from the study before interview, he or she was replaced by the seventh patient recruited, where available. Some general practitioners were unable to identify six patients in a recruitment phase lasting from June 1992 to October 1993.

Data recording and analysis

All interviews were carried out by A S, tape-recorded and the first 15 were fully transcribed. A preliminary analysis of these transcribed interviews suggested nine themes in relation to which experiences and understanding of low back pain appeared to vary. The 15 transcripts were then systematically reviewed and data relevant to each theme were assembled. From these data, the categories describing the range of patient positions in relation to each theme were described.

Data relevant to each of the nine themes were reviewed from the remaining tape-recorded interviews. The extension of the preliminary analysis to the full data set suggested that two of the initial themes were more appropriately viewed as sub-categories of other themes and the number of themes was therefore reduced to seven.

This revised analysis scheme was then applied systematically to the entire data set. Each patient interview was reviewed in relation to each theme, and patients were categorized in relation to that theme. The emergent nature of the analysis means that data were not available for all patients for each theme. In addition, some patient responses could not be categorized in relation to the major categories described in the analysis and thus had to be excluded.

Results

Of the 12 participating general practices five were located in an inner city area, four in a suburban area and three in a rural area. The mean number of partners was four (range one–10) and the mean list size was 2098 (range 1301–3243). Two of the practices were fundholding practices and one was a dispensing practice.

The mean age of the 12 general practitioners who recruited patients to the study was 45 years (range 31–61 years). Nine were men and three were women and their mean length of service was 12 years (range 2–31 years). Three doctors were involved in undergraduate/postgraduate teaching and one had a special interest in back problems.

Of the 61 patients recruited, 52 (85%) were contacted and interviewed (seven refused to be interviewed and two could not be contacted). The mean age of the 52 respondents was 41 years (range 18–66 years) and 26 were men and 26 women. Twenty-one were in social classes 1–3N and the remaining 31 in classes 3M–5.

The remainder of the results detail the seven themes in relation to patients' low back pain which were identified in the analysis: impact of low back pain on quality of life; expectations about prognosis; commitment to secondary prevention; readiness to consult a general practitioner; satisfaction with explanation for their pain; satisfaction with general practitioner management; and willingness to consult complementary therapists.

Impact of low back pain on quality of life

There were considerable differences in patients' reports of the

extent to which low back pain had affected their quality of life. Seven patients claimed to be maintaining the quality of life that they had before the onset of back pain, and reported that pain had made little impact on their activities or behaviour. However, the biggest group response was from 21 patients who said that they had had to adapt their lifestyle since the onset of low back pain. This typically involved reducing the length of time they spent on certain activities (such as gardening) and changing the way in which they performed tasks (for example 'being careful' to sit and lift properly). A further 18 patients claimed that low back pain had led to a major reduction in their quality of life. These patients emphasized 'giving up' or 'refraining from' activities, and had little confidence in the ability of their bodies to withstand any form of physical exercise.

Expectations about prognosis

Patients also varied considerably in their level of optimism or pessimism about their prognosis. Ten patients were optimistic and were excited about returning to 'normal health'. They all maintained that their low back pain was improving and might go away completely in the future. At the other extreme was a group of 11 patients who expressed a much more pessimistic view. They typically maintained that their low back pain was getting worse and feared a loss of mobility and reduced quality of life in the future.

'I know that it sounds stupid, but sometimes I think to myself, "I could end up in a wheelchair"... that's how worried I am sometimes.' (man, aged 34 years)

Between these two extremes were two other groups. Six patients were long-term sufferers who believed that their pain would probably stay with them for the rest of their lives. Mostly, however, they anticipated that the intensity of their pain would remain fairly constant. Twelve further patients were much more unsure about what the future held and they did not really know whether to expect that their pain would get better or worse.

'Is it something that with time can be healed, or is it something that you have to adapt your life around? So I don't understand it enough to know what is going to happen.' (woman, aged 31 years)

Commitment to secondary prevention

Twenty-nine patients claimed to be actively working on their problem and organizing important parts of their lives (for example work, leisure or home life) around their identity as a back pain sufferer. Most of these patients were using more than one preventive strategy including: adopting a particular body posture when bending, sitting and lifting; taking light exercise; rest; and using back and stomach strengthening exercises. For some, managing low back pain had become an occupation in itself:

'But I'm trying this time thinking what I'm doing, the way I sit in the car. When I talk to people, I don't just sort of spin round, you know... So it's like preventive maintenance really. You're thinking about it all the time and preventing it from happening again.' (man, aged 27 years)

In contrast to this very active group a smaller group of 16 patients reported that they adopted a minimalist approach to secondary prevention. These patients employed few or no prevention practices. Those practices that were employed were used inconsistently, usually when the patient's pain was at its worst, during a severe attack. Most of them appeared to have some

knowledge of prevention practices yet continued to engage in inappropriate behaviour such as maintaining poor posture or risking back strain through heavy lifting:

'I should really sit properly which I don't... I shouldn't cross my legs, but I do... and I know I shouldn't but I can't help it.' (woman, aged 24 years)

In between these two extremes was a smaller group of four patients who reported that they were in the process of recognizing that they had a problem and needed to do something about it. These patients appeared to be on the way to realizing that they needed to adopt a management strategy for their back pain, and that they could not carry on ignoring it.

Readiness to consult a general practitioner

Of 44 patients who expressed an unequivocal view, only 15 believed that it was appropriate to visit their general practitioner routinely for episodes of low back pain. Of these 15, four were primarily concerned with sickness certification and the others saw such consultations as an opportunity to challenge misdiagnosis or inappropriate management (six patients) or to explore alternative management strategies with the general practitioner (five).

The remaining 29 patients were reluctant consulters, who visited their general practitioner only during unusually severe episodes of low back pain. Reasons for such reluctance included stoicism and fear of wasting the doctor's time (17 patients), scepticism about the doctor's ability to help (10) and concern about jeopardizing their employment prospects (two).

Satisfaction with explanation for their pain

Only 20 respondents recalled being given a medical explanation for their low back pain by a health professional, with which they were satisfied. Eleven patients had been given a clear explanation, but doubted its validity, either because it conflicted with their own prior understanding, or because they believed that it was based on inadequate investigations. Eight patients believed that their uncertainty reflected genuine professional uncertainty or disagreement among health professionals. Five patients discussed a wider range of tentative explanations, but were unable to choose between them, and three patients claimed to have no understanding of low back pain and said they had never discussed the reason for their pain with a doctor.

Satisfaction with general practitioner management

Twenty-two patients were satisfied with the way their back pain was being managed. The qualities which they valued included the general practitioner's communication skills. In particular patients appreciated being given an opportunity to discuss their problem with a good listener.

'He sits back and he listens to you. You don't feel like you're rushed in and out, like I hear some people say they are at the doctors... Dr Y just listens to you, and then you come out feeling, like he's done something for you.' (women, aged 46 years)

Patients also valued thoroughness in relation to diagnosis. They praised general practitioners who took careful histories, carried out detailed examinations and ordered diagnostic investigations, and they appreciated being offered explanations of the rationale behind such investigations.

Of 21 patients who expressed dissatisfaction, only nine patients blamed the general practitioner for what they saw as the

inadequate management of their problem. Such criticism focused upon the general practitioners inability to explain the condition adequately, the superficiality of examinations or the doctor's lack of interest in the problem and poor communication skills. One patient described a consultation with his general practitioner.

'Painkillers. I'll see you in a fortnight's time and that's it. I mean, she might be a good doctor but... I don't think she's got time for patients, to be honest with you. I mean it's like a cattle market.' (man, aged 45 years)

The other 12 dissatisfied patients were more understanding of the problems faced by their general practitioners. They sympathized with the difficulties general practitioners experience in managing low back pain without an established medical cure, sophisticated diagnostic equipment, facilities, time or ready access to specialists.

Willingness to consult complementary therapists

Only 10 patients had consulted complementary therapists (mainly osteopaths and chiropractors) in relation to their low back pain. Most of these patients presented such consultation as experimental (four) or as a desperate measure when their pain became intolerable and an immediate general practitioner consultation was unavailable or likely to be ineffective (five). Only one patient had elected to use a complementary therapist because she believed that she would receive better quality holistic care.

Of 37 patients who had never used complementary therapy, 13 were largely satisfied with the care they were receiving and had not considered an alternative. Six patients appeared never to have heard of any form of complementary therapy and eight questioned its legitimacy and feared 'being ripped off by quacks' who prolonged care for financial gain. Ten patients felt unable to pursue complementary therapy through lack of information or lack of money.

Discussion

This exploratory study has uncovered a rich heterogeneity in patients' perceptions of low back pain. The use of qualitative methodology has revealed that patients hold complex views on a common problem. Individuals, with what could superficially be regarded as a similar condition, each perceived the problem very differently and also responded in quite dissimilar ways.

Clinically, low back pain does not usually arouse interest or innovation among the medical profession and the growth in complementary therapies is largely welcomed since it offers possibilities for a multiprofessional approach to care.²⁶ However, this study demonstrated suspicion of, and a reluctance to consult, complementary therapists. It also revealed high levels of dissatisfaction with medical explanations, management and treatment. Patients valued good communication together with detailed clinical and radiological tests. Some of the study respondents were sympathetic to the constraints of general practice and their effect on the diagnosis and management of low back pain. In some cases, it seemed clear that depersonalized management and rapid, processed care were at least partly responsible for the patient's response and a different management approach may have led to a more positive doctor-patient relationship.

Most patients in this study were engaged in self help for their backs and did not routinely consult the general practitioner for episodes of low back pain. Patients may change their perspective over time as a response to the condition itself, life events, and/or material circumstances. It appears that patients do not want a 'magical cure' for low back pain when one does not exist, but rather they would like their general practitioners to listen to them

and to offer a comprehensive approach to management.

Low back pain is a common condition in general practice, and therefore general practitioners need help to be more sensitive and positive in their management. This help could come from patients themselves, from educational materials, and from paramedical and complementary therapists. This study has demonstrated patient expectations that it may not be possible to meet in general practice alone. This analysis is offered as a stimulus to further investigations involving larger samples of consulting and non-consulting low back pain sufferers, which would permit generalization to a wider population of sufferers.

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Address for correspondence

Dr A Skelton, Division of Education, University of Sheffield, The Education Building, 388 Glossop Road, Sheffield S10 2JA.

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Evidence-based medicine

You can take a horse to the water but you cannot make him drink.' That ancient English proverb sums up the problem of evidence-based medicine and the implementation of clinical guidelines. This paper from Denmark illustrates just how difficult it is to change clinical practice in the face of almost incontrovertible evidence that can reduce dramatically the incidence of stroke in patients with atrial fibrillation.

The paper quotes five large randomized placebo-controlled studies, all of which revealed a convincing primary preventive effect of anticoagulant therapy with warfarin on the incidence of strokes in patients with non-valvular atrial fibrillation. The number of strokes was reduced by more than two-thirds, even by low-intensity anticoagulant treatment, with an international normalized ratio (INR) in the interval 1.4-2.8, by which serious haemorrhagic episodes could be kept at 1.3% per year compared with 0.9% in the placebo groups. These papers showed that aspirin is less effective than warfarin in reducing the risk of stroke in patients with non-valvular atrial fibrillation.

The purpose of the study was to investigate whether these well-documented scientific findings were sufficient to make doctors accept the proposed criteria for good clinical practice. These Danish investigators distributed an anonymous questionnaire with six standardized case stories to 315 general practitioners and 89 specialists across Denmark. The answers to the questionnaire showed that the Danish doctors recommended anticoagulant therapy only to a low extent (14-57% for general practitioners and 42-89% for the specialists). The best agreement in both groups appeared to be in the classic patient with mitral stenosis.

The reasons for not choosing anticoagulant therapy are given as being lack of knowledge concerning the increased risk of stroke associated with non-valvular atrial fibrillation, worries about the disadvantages, haemorrhagic complications of anticoagulant treatment and lack of knowledge of its benefits. Interestingly, the authors do not comment on the possibility that general practitioners are reluctant to introduce anticoagulant therapy because of the workload imposed by checking the INR at regular intervals for the rest of the patient's life.

This paper confirms experience in the UK where the implementation of clinical guidelines poses immense problems to those who wish to raise the standards of clinical practice in the light of evidence-based medicine.

ALASTAIR G DONALD

Past president, Royal College of General Practitioners

Source: Steffensen FH, Olesen F, Sørensen HT. Implementation of evidence on stroke prevention. *Fam Pract* 1995; **12**: 269-273.

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