

# Annals of the Rheumatic Diseases

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*Leaders*

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## Low back pain: an intermittent and remittent predicament of life

For any of us to live a single year without a backache is abnormal. That is true throughout adult life. And that has, no doubt, always been true.

What is mutable is whether, and how, and how well we cope with another such challenge to our sense of invincibility. Mind you, this insight holds for many morbid events: headache and heart ache and heart burn and more. This is not to belittle the affliction; beyond the pain in the back, the contraction in daily functioning can rival severe heart failure. The difference is that we almost always recover from low back pain and we usually can remember a prior episode.

In the last half of this century, when the incidence of the experience of regional low back pain seems stable,<sup>1</sup> something is happening to our tolerance. The numbers who are turning to others for help and the numbers who now find backache incapacitating have reached epidemic proportions. This trend defies a concerted effort at intervention that has recruited the cutting edge of allopathic medicine and whatever alternatives society can put forward. And this effort at recourse and redress accounts for an astounding transfer of wealth, much of which is brokered by an enormous public/private enterprise charged with indemnification. Whatever the motivation, whatever the ethic,<sup>2</sup> a paradox is painfully clear; the approach to the predicament of regional back pain that has been adopted by the industrialised world this century represents an exercise in social iatrogenesis. Much of this can be explained by the illogic that underlies the effort. We now know that our vaunted ergonomic concept of causation is seriously flawed,<sup>3</sup> our approach to management tragically flawed,<sup>4</sup> and our approach to disability determination fatally flawed.<sup>5</sup> Reform requires more than re-thinking; it requires confronting the entrenched enterprise invested in the status quo.

Practitioners are not faced with social crises in their examining rooms, but with patients one at a time. For these patients, illness is too pressing to wait for societal reforms. The article in this issue by van den Hoogen<sup>6</sup> and colleagues provides important insights for physicians who act as first contact providers for patients with regional low back pain. The insights multiply if the study is contrasted with a similar study we conducted with our colleagues at the University of North Carolina contemporaneously.<sup>7, 8</sup> These two cohort studies are not entirely comparable in design. The

North Carolina study examined only acute back pain patients, the Dutch study admitted both acute and chronic patients. The North Carolina study defined "better" as the ability to perform usual activities for at least a day while the Dutch study used more stringent criteria.

These differences easily explain the slightly more prolonged illness reported in the Dutch series. One need not invoke the fact that practice styles are different in the two settings. For example over half the Dutch patients were referred to physiotherapists at the initial visit; such referrals are less common and occur well into the course of the illness in North Carolina.<sup>9</sup> What is so striking and so surprising is that the outcomes for the patients in North Carolina and Amsterdam are so similar despite the dramatic difference in the sociopolitical constraints on clinical judgment.

Contrasting the North Carolina survey and the survey from the Amsterdam catchment area is a form of small area analysis across two very different social constructs for the management of low back pain. In North Carolina back pain is indemnified by workers' compensation schemes for medical care and wage replacement only if it is viewed as having arisen out of and in the course of employment. Otherwise, the sufferer must take recourse in whatever health insurance is available for medical care, often inadequate, and whatever short-term disability insurance is available, usually none.<sup>10</sup> At the time of the survey in Holland, no such distinction between injury and illness was drawn.<sup>11</sup> At the very least, there was the safety net of the General Disablement Act, which provided clinical care and rehabilitative services for all as well as income substitution near minimum wage for anyone too ill to provide such for themselves. However, if you are employed and unable to perform your job because of any illness, including regional back pain, you were also entitled to wage replacement for up to a year under the Sickness Benefits Act. (This supplemental insurance was not provided without contestation—but that's another topic.) The social contracts for recourse for back pain in North Carolina and Holland early in this decade were as disparate as anywhere in the industrialised world.<sup>12</sup> Yet, the outcomes in the two cohorts are similar.

Even long term disability is similar. Between 5% and 10% of patients in both series do not fully recover over the course of a year or more of follow up. These patients, who

consume the majority of health care costs for low back pain, are not alone in having to cope with back pain beyond the index episode. A substantial number of patients who recover will experience recurrence within the year. In both the North Carolina and Dutch experiences, the recurrence is likely to cause the person to seek care again. It follows that seeking care in the first instance establishes a dynamic that predisposes to seeking care again. In other words, interaction with a physician for one episode transforms a recurrence of the predicament of backache into a relapse of illness. This semiotic may be the most important and inescapable insight forthcoming from the small area comparison provided by contrasting the Amsterdam and North Carolina cohorts. It is an insight relevant to the practitioner in the examining room. We've been missing something in our approach beyond practice style and sociopolitical contract.

You might be tempted to argue that the need to seek care initially, and again for a relapse, and in an on going fashion for chronicity speaks to the magnitude of the pain in the back. You might be tempted to argue that the poultice that waits discovery will be directed toward ablation of the pain at its source. We would urge you to reconsider. Our best information suggests strongly that coping with regional back pain is far more likely to be overwhelmed by psychosocial confounders in daily life inside or outside the workplace, or both, than by the magnitude of the pain itself.<sup>4</sup> The tragedy of the past 50 years of the approach to the management of back pain in advanced countries is that we're treating the wrong illness. We hear the patient complain of back pain when we should be hearing the patient proclaim, "My back hurts, but I'm here because I can't cope with this episode." If we could learn to listen to this

chief complaint, perhaps we can tackle the impairment in coping, which is the illness that renders the predicament of back pain intolerable.<sup>13</sup>

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