1st of September 2023

To: SIRA, NSW

Re: Model of Care for Management of Low Back Pain

Proposed Amendments

I write in response to the proposed changes from SIRA regarding "Model of Care for Management of Low Back Pain". There are a number of issues and deficiencies that are evident with the proposals put forward for public comment.

I am commenting from a position of professional interest with a reasonable depth of knowledge. I do not believe that I have a conflict of interest I actually work within a multidisciplinary team (MDT) of other physical therapy health professionals. I more have a deep interest in advocating for the Physiotherapy profession to ensure best outcome and evidence based management of patients who suffer and present with low back pain (LBP) or more correctly termed low back disorder (LBD). Patient presentation may be acute, subacute or chronic. Many patients present with LBD to Physiotherapists every year. These patients may be private, compensable (CTP or Workers Compensation), referred via the MediCare EPC system, DVA or NDIS related referrals.

I have post graduate training Musculoskeletal physiotherapy and lead a team of 25 physiotherapist within a MDT and also advocate for the profession through my role on the musculoskeletal committee of the APA. Presentations such as LBD common in my professional work. My Physiotherapy colleagues both in Australia and internationally have been at the leading edge of research into LBD including accurate objective assessment, diagnosis and targeted and specific management. The fundamental basis of Physiotherapy assessment and management is the diagnostic triage to correctly allocate LBD as a mechanical disorder, a neuropathic (nerve root) disorder or a presentation with more sinister causes (red flag conditions).

Once a Physiotherapists has made a clinical decision regarding the triage, appropriate and targeted management can then be delivered. Management will be based on clinical experience/expertise, response of the patient after continual reassessment/review and what is deemed clinically necessary. Clinical reasoning is a complex process that allows a suitably qualified professional, ie. a Physiotherapist, to understand and make decisions about assessment and diagnosis in order to implement targeted management and treat the patient in front of them. The essential elements to this process are:

1. Sufficient knowledge of pathology, biology, physiology, anatomy, biomechanics, inflammatory process (injury mechanism, injury healing) and other factors that may influence patient presentation such as medical and general health factors and immune system factors.
2. Sufficient training and understanding of patient psychology (and the many factors that influence psychology … see flag system), patient behaviour, perspectives associated with

pain and pain behaviour including an understanding of patient cognition and understanding of their condition.

3. Sufficient training and understanding of a comprehensive history taking, an objective assessment process including comprehensive history and targeted physical examination. This leads on to implementation of targeted and specific management protocol which may include passive manual therapy (mobilisation, manipulation, stretching), active manual therapy (specific and targeted strengthening and motor control exercises, functional exercises), specific advice and instruction about reasonable activity level, activity modifications, graded return to activity and return to work and advice and instruction on more general and comprehensive exercise regimes.
4. Sufficient training and experience which facilitates the allocation of patients into low, medium and high risk of recovery stratification and stream them into an appropriate pathway of management dependent on their presenting symptoms. There is ample evidence that demonstrates that Physiotherapy lead assessment and physical examination allows the best and most cost effective management of patients presenting with many different types of musculoskeletal problems, LBD being one of them.
5. Sufficient training and expertise to accurately assess and make decisions on neuropathic presentations (nerve root irritation/compression) and what will resolve with targeted conservative management by the Physiotherapist and what may need escalation with referral for imaging or surgical consultation. There is compelling evidence to demonstrate Physiotherapy lead neurosurgical clinics result in a huge reduction of unnecessary referral to see a Neurosurgeon with only the small percentage of patients escalated to this level. The nett result is a large reduction in costs associated with inappropriate and unecessary imaging and consultation with Medical Specialists.
6. Sufficient training and expertise to accurately screen and differentially diagnose other mechanical conditions that may be misinterpreted as LBD. These include SIJ and pelvis problems, hip problems (intraarticular and extraarticular), abdominal problems and problems that may be related to conditions higher up into the thoracic spine.

The Physiotherapist, with their training and background, are the most appropriate professional to make decisions on the best pathway of management for patients presenting with LBD. This may eventually be referral to an EP or similar at some point in the patient rehabilitation. I have worked with EP's for within clinics for greater than 10 years, and the many I have worked with have not displayed the clinical reasoning, screening or risk stratification skills that are to be utilised within this proposed guideline.

There seems to be a pervasive view that Physiotherapists can and do only manage ALBP (however these proposed changes by SIRA seem to put this in doubt too!) and that they have no input or involvement in exercise prescription and exercise regimes. This is just plainly false; Physiotherapists via the very nature of their targeted and specific assessment and physical examination are very specific in their prescription of exercises to allow the patient to progress from ALBP to resolution, including alleviation of leg pain, be it somatic or radicular. This myth that seems to have been created about the expertise (or lack thereof) of Physiotherapists to prescribe, instruct, set up and amend exercise regimes needs is simply incorrect and should be disbanded.

It would be my expectation that 98% of patients that attend a Physiotherapist will have some type of exercise to start with and these exercises will be modified, changed and amended throughout the course of treatment. Physiotherapists will, in general, be looking to move patients from more passive therapy to more active therapy throughout their rehabilitation culminating in self-

management. The only situation that a Physiotherapist may instruct the patient to not perform exercise would be in a very acute stage where rest was deemed useful to facilitate patient recovery. This would be only for a very short period of time and in very specific circumstances.

Exercise Physiologists and other physical therapy professions have their place and have their area of expertise. Assessment, physical examination, decisions on best management and decisions on risk classification and appropriate pathways of care is not their area of expertise. That is the area of Manual Therapists, specifically Physiotherapists. To move away from this management pathway is moving away from evidence based care and poses a risk to patient welfare and appropriate management of patients presenting with LBD.