Low back pain guideline changes response

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With reference to the substitution of physiotherapist / physiotherapy with more generic physical therapies or allied health:

- proposed changes to the guidelines to remove physiotherapy and replace with a generic term of physical providers creates a problem that wasn't there before.
    - It is a guideline and does not prevent NTD's from referring to AHPRA registered allied health professionals such as chiropractors and osteopaths where they provide evidence-based care for low back pain.
    - **Physical therapist** is a protected term. It is easy to confuse this term with therapy / therapies.
        - In my capacity as an SIRA approved Independent Physiotherapy Consultant, I frequently see misuse of 'exercise physiotherapist' / 'exercise physio' in place of exercise physiologist in documentation reflecting confusion of referrers. It is also commonly used by exercise physiologists, which I consider to be deliberately misleading. Any reference to physical therapies should, at a minimum, be changed to **physical modalities** or otherwise kept as physiotherapist / physiotherapy.
    - By changing the terminology to more general providers, opens up referrals to non-evidence-based care and non-registered providers. This would include remedial massage therapists, kinesiologists, myotherapists, strength and conditioning et cetera who could point to these guidelines and claim to be supported providers under the guidelines.
- Rationale for specifically referring to physiotherapists in the guidelines:
    - physiotherapists provide services aligned with the medical framework and diagnostic approach to low back pain. Where there is uncertainty regarding a specific pathoanatomical diagnostic classification, physiotherapists have specifically broadened their diagnostic schema to reflect the impairments and disabilities present in a patient. Therapeutic exercise includes the McKenzie approach, which has good evidence of efficacy in appropriately selected patients.
        - "There is some evidence that exercise can delay recovery when commenced in the early acute phase.35 An exercise program may have value once the patient has recovered from the acute episode, as trials have shown that exercise programs begun at this point can halve the risk of recurrence.36" ACI MOC (2016)
        - How exercise is used in the persistent LBP group is different to that application in the ALBP. Exercise is not necessarily a benign intervention without potential adverse consequences.
    - In the early stages of management of low back pain, it is important to understand expected trajectories and early signs of complications developing. This requires a familiarity with the diagnostic process. NTDs often rely on good two way

communication with physiotherapists and value their musculoskeletal assessment skills.

    - Failing to recognise the clinical expertise of physiotherapists in this process will contribute to missed or delayed diagnoses being established by the NTD or iatrogenic injury where inappropriate interventions and exercises are prescribed by non-skilled practitioners.
    - Exercise physiologists and other non registered providers of physical modalities are unable to contribute to this diagnostic process.
    - Effective reassurance of patients with ALBP requires a patient's confidence in the assessment process and not just on an odds based assessment ("serious back pain is rare"). You cannot provide rational reassurance to patients,if you have not provided a comprehensive clinical examination centred around a clinical model.
    - The absence of a medically aligned examination framework, risks missing relevant clinical markers for changing management or implementing most appropriate evidence based strategies.
  - Physiotherapists have a range of modalities at their disposal and there is good evidence to support the judicious use of manual therapy in the management of acute low back pain as well as appropriate forms of rehabilitation exercise. Some providers such as exercise physiologists are not equipped with the training to provide such appropriate evidence-based care.
  - it is not uncommon for clinical conditions to evolve and an initial diagnosis established by an NTD to change significantly with the development of worsening or red flag symptoms.
- ACI guidelines are not appropriate for the compensation schemes as the audience and population for which they were developed are different. It is typical for most research to specifically exclude compensation scheme patients from research as compensation is considered a confounding variable.

Reference Documents:

ACI Model of Care (30.11.16)

"A key priority for the ACI is identifying unwarranted variation in clinical practice. ACI teams work in partnership with healthcare providers to develop mechanisms aimed at reducing unwarranted variation and improving clinical practice and patient care."

"There is some evidence that exercise can delay recovery when commenced in the early acute phase.35 An exercise program may have value once the patient has recovered from the acute episode, as trials have shown that exercise programs begun at this point can halve the risk of recurrence.36"

ACI Model Of Care - Consultation Draft:

Principle 4: **Active physical therapy encouraged: Physical therapies will primarily be a 'hands off'** approach. The emphasis is on self-management assisting the patient to understand their condition and a staged resumption of normal activities. Consultation with team members may include a physiotherapist or practice nurse.

References cited:

Buchbinder is silent on the use of "hands on / hands off". The **judicious** use of manual therapies can significantly improve "re-activation" strategies and fits within a medical framework for personal injury scheme back pain management.

RACGP Staying active resource is a comparison with no activity and encourages modified levels of activity**. It is silent on "hands on / hands off"**

- Regarding exercise: "All types of exercise help reduce low back pain and improve your ability to do everyday tasks.
    - **Exercises that are mainly strengthening** include core exercises (strengthen muscles that support the spine), Pilates and resistance training (e.g. light weights and resistance bands)
    - **Exercises that are mainly about flexibility and stretching** include yoga and tai chi
    - **Exercises that are mainly about general fitness (aerobic)** include water-based exercises (e.g. swimming and hydrotherapy) and land-based exercises (e.g. walking, running and riding a bike/exercise bike)
- No type of exercise has been shown to be much better for back pain than another type. Choose an exercise that you enjoy and can do regularly."

The above is contradictory and reinforces unhelpful beliefs – such as:

"strength is the reason for back pain; core strength is needed for recovery and weakness is the cause of my pain".

There is poor evidence for any correlation between strength and low back pain. This has led to many fruitless and costly exercise programs based on faulty premises. This is low value care.

Pathway B (red flag) should either be escalated to pathway A as this assessment is a critical way point, or demoted to pathway C, as it is a low frequency pathway.

Pathway C – why are complex pharmacological therapies recommended at only 2 weeks, if the patient with a non-verified radiculopathy is stable. This seemingly contradicts Principle 7.

The draft pathways reflect reviews at 2,6 and 12 weeks. This seems very default practice of post surgical management.

"the primary care team members are considered to include: • the patient and their family1 • the treating general practitioner and practice nurse • treating allied health practitioners. A physical examination and medical history is to be conducted when a person presents to primary care with low back pain. "

This requires an allied health provider to have the appropriate assessment skills.