Part 5

Practitioner’s Role in the Process of Care
Chapter 20

The Physician as Disability Advisor for Back Pain Patients

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20.1 Introduction

It is a proper and likely inescapable function of physicians to sanction disability in the course of treating illness (Sullivan and Loeser 1992). In acute or obvious illness, these dual roles result in little controversy, as recommending a temporary suspension of personal and occupational responsibilities may be beneficial to the process of healing. Moreover, significantly impaired body function often necessitates a period of convalescence—recognized by physicians, patients, and society as reasonable. On the other hand, for the problem of low back pain (LBP), where the pathology is less overt and where symptoms often endure beyond the expected time required for healing, physicians may be faced with a difficult dilemma. What level of disability is appropriate for the pathology, symptoms, and impaired function exhibited by a patient? Here inter-physician variation increases dramatically regarding the degree of work disablement endorsed, or restriction of activity recommended for a given set of complaints. The variability in recommendations may have enormous consequences for patients with LBP, including an impact on the probability of transitioning from acute to chronic disability. It is recognized that inappropriate disability can lead to decreased quality of life due to inactivity, while prolonged absence from normal social roles (including work) is deleterious to physical and mental well-being (Shulman 1994; McGrail et al. 2002). Appropriate and early return to activities and work avoids the consequences of illness reinforcement: assumption of the sick role, deterioration in family dynamics, dependence on drugs, creation of secondary gain, learned disability, as well as other negative impacts (Derebery and Tullis 1983).

Do physicians’ disability recommendations make a difference? For LBP, limited evidence suggests that they do. Several authors have noted that consistent, evidence-based physician recommendations about disability that encourage resumption of activity independent of pain status lead to improved disability outcomes in LBP and other disorders (Indahl et al. 1998; Hagen et al. 2002; Rainville et al. 2002). Of importance, physicians may influence patients’ disability in the opposite direction—advising avoidance of activities to those with back pain. Though the magnitude of this effect on disability is unknown, it is probably of consequence. This is supported by the results from cross-sectional studies of general practitioners (GPs) and their patients with acute LBP and rheumatologist and their patient with subacute LBP. Both studies observed that high ratings of pain beliefs in physicians were associated with a higher rate of pain beliefs of their patients (Poiraudneau et al. 2006; Coudeyre et al. 2007).
Recently, researchers have begun to acknowledge the importance of physicians’ disability recommendations. Not surprisingly, findings have revealed that a complex interaction of physician, patient, social, and political factors influence physician recommendations.

This chapter will explore current knowledge about physician disability recommendations for patients with LBP. It will also review results of attempts to influence these recommendations, and suggest areas where further research may be beneficial.

20.2 Magnitude of the physician role as disability advisor

Nearly all patient–physician encounters for musculoskeletal disorders include recommendations about the appropriate level of activity for the illness under treatment. These generally include advice about use and mobility of the injured body part for personal care, domestic, and recreational activities. Additionally, physicians are often asked or required to make recommendations about the ability of their patients to work. Many jurisdictions in the USA mandate such recommendations, when injury is alleged to result from vocational activities or exposures. In the UK and many other countries, the provision of sickness certification is mandated as part of the contractual services delivered by GPs.

The actual percentage of patient encounters during which physicians are asked to certify disability is substantial. Bollag et al. (2007) reported that 4% and Soler and Okkes (2004) reported that 11% of patient encounters for GPs resulted in the issuance of sickness certificates. Pransky et al. (2002) and Englund et al. (2000a) reported that primary care providers were asked to supply opinions concerning work ability in about 9% of all patient encounters. All studies found that musculoskeletal diagnoses dominated these requests (Englund and Svardsudd 2000). For this reason, practices specializing in musculoskeletal disorders also have a high number of patient encounters where definitions of ‘work capacity’ are required (Arrelov et al. 2007).

20.3 The content of physician recommendations

As activity and work recommendations are an essential part of many patient–physician encounters, it is worthwhile exploring the content of these recommendations. To date, most studies examining physicians’ recommendations have substituted patient histories or vignettes for actual patient encounters, with recognized research limitation (Jones et al. 1990). The results demonstrate a striking lack of consistency in physicians’ assessment of all types of disability. This includes disability assessment of common musculoskeletal disorders (Haldorsen et al. 1996; Patel et al. 2003), social security disability eligibility (Carey et al. 1988), and ill-health retirement determinations (Elder et al. 1994). Not surprisingly, studies limited to LBP-related disability have also demonstrated a lack of consensus among physicians (Chibnall et al. 2000; Rainville et al. 2000).

When explored further however, despite high variability between physicians, individual physicians exhibited consistent patterns in their disability recommendations, ranging from lenient to strict (Getz and Westin 1995; Chibnall et al. 2000; Rainville et al. 2000). The detrimental implications of this inconsistency and inequality are obvious for both patients with LBP and disability systems they access. Clearly, the most negative impact is unnecessary disability with associated overall decline in economic well-being and health (Waddell et al. 2000). Additionally, the inconsistency of disability recommendation encourage ‘doctor shopping’ where patients search for physicians that support their position on disability. Consistent patterns of disability recommendation for individual physicians can establish medical reputations, leading to funnelling of patients to specific medical providers who will either refute or support disability claims. Ultimately, this variance in medical opinions probably consumes countless hours of debate as legal systems try to sort out conflicting physicians’ disability recommendations.
20.4 Physicians' characteristics that influence disability recommendations

There are several possible explanations for the high level of observed variability in activity recommendations for LBP. One source of variability may result from differences in the depth of medical knowledge about LBP. To examine this, Rainville et al. (2000) compared chronic low back pain (CLBP) work and activity recommendations of family physicians and orthopaedic spine surgeons. They noted that orthopaedic spine surgeons were only slightly more permissive than family physicians with work restrictions and very similar with activity restrictions. These findings were corroborated by Englund et al. (2000a). Apparently, the level of expertise as reflected by medical specialty has a limited influence on disability recommendations.

A potential, but unexplored source of variability in physicians’ disability recommendations may be differences in theories about the aetiology of spinal degeneration and CLBP. For decades, medical wisdom supported an injury model of LBP, where exposures of the spine to physical stresses were deemed responsible for spinal degeneration (Nachemson 1975). Indeed, the injury model spawned empirical recommendation about posture, lifting techniques, and back health, and inspired decades of ergonomic research. It is logical for physicians that are strong proponents of this model to advise patients against activities perceived to be harmful to the spine.

The injury model of LBP has been considerably weakened over the last two decades, in part by the failure of ergonomic interventions to reduce back injuries, but mainly from epidemiological, genetic, and neurobiological research that offered alternative explanations for low back disorders (Martimo et al. 2007). A fundamentally different model of spinal degeneration has emerged in which the aetiology of degeneration is explained by genetically encoded, age-activated degenerative processes (Ala-Kokko, 2002) As such, this model undermines the alleged role of physical exposure in spinal degeneration, and weakens the association between persistent pain complaints and ongoing damage or harm. Theoretically, physicians endorsing this model of LBP would more likely recommend that activity avoidance is medically unnecessary.

Another possible source of variation in disability recommendations may be inadequate medical education or poor preparation of physicians for determining disability (Sullivan and Loeser 1992). Indeed, a majority of surveyed physicians indicated that they have learned little about disability programmes from any source (Carey et al. 1987), do not feel confident in their ability to determine patient disability (Zinn and Furutani 1996), and felt burdened by participation in this task (Zinn and Furutani 1996). Furthermore, many physicians feel inadequately educated about work capabilities and risk for injury from occupation exposures (Pransky et al. 2002). Despite concerns about their role as disability advisors, the degree of physicians’ dislike of this role or their feelings of inadequacy towards this process are not reflected in the duration of sickness certification for patients under their care (Tellness et al. 1990).

A related area of importance is the physician’s ability to identify the small number of cases at high risk for progression from acute, self-limited injury to a chronically disabled state. These cases may benefit the most from interventions designed to avoid prolonged disability at an early stage. Unfortunately, physicians have little training in risk prediction for low back injury and are often unaware of specific advice or intervention that can alter the progression to disablement (W.S. Shaw et al. 2001; Haldorsen et al. 2002).

Perhaps reflecting these problems, patients did not view the physician as an active facilitator of return to work and activity in one study (Roberts-Yates 2003). These patients cited the physician’s lack of experience, dissociation from the workplace, disinterest in workplace issues and needs, and failure to devote the necessary time as evidence of their ineffective role in this issue.
One could easily theorize that inherent beliefs, fears, and concerns that healthcare providers hold about pain and function should be strong determinants of their recommendations for activity and work after an injury. This association is supported by several studies. Utilizing the Healthcare Providers’ Pain and Impairment Relationship Scale (Rainville et al. 1995), Rainville et al. (2000) discovered that pain attitudes and beliefs of physicians were the strongest predictor of their work/activity recommendations. Similarly, Houben et al. (2004) noted that physical therapists’ work/activity recommendations were strongly predicted by the strength of their pain attitudes and beliefs as well. Poiraudeau et al. (2006) noted that rheumatologists with strong fear-avoidance pain beliefs were less likely to follow guidelines on prescribing physical and occupational activities for LBP. Linton et al. (2002) reported that physicians’ recommendations for sick leave were strongly dependent on their own fear-avoidance beliefs with regard to back pain.

20.5 Physician–patient relationship factors

Despite this evidence of a connection between providers’ beliefs and work recommendations, some studies suggest that other characteristics of physicians may override their personal beliefs. Gulbrandsen et al. (2007) grouped physicians into four groups based on combinations of characteristics including their perceived burden of sickness certification, doubt, permissiveness, personality, degree of paternalism, job satisfaction, opinion of sickness certification as medical task, and sociopolitical attitudes. Despite prominent differences between groups, no association was found between group-level differences of physician traits and rates of sickness certification. Watson et al. (2008) found no relationship between physicians’ pain attitudes and the frequency of issued illness certificate for non-specific LBP. Instead, they noted that sickness absences certification for LBP was predicted by the physicians’ sickness certification behaviours for all medical illnesses in general.

The above findings suggest that there are other characteristics—besides physicians’ pain attitudes and beliefs—that determine physicians’ disability recommendation. Mounting evidence suggests that the physician recommendations may be largely determined by a seldom-studied factor—the physician–patient relationship.

Discordance is common between physicians and patients concerning the issue of LBP and work (Lofgren et al. 2007; von Knorring et al. 2008). Physicians and patients often differ in terms of expectation of the length of disability for LBP (Kapoor et al. 2006), especially as symptoms become more chronic (Reiso et al. 2004). Physicians tend to rely more heavily on clinical findings, whereas patients tend to assess job related factors such as stress and the physical strenuous nature of work (Reiso et al. 2004).

When differences of opinion occur, it seems that patients’ opinions often win. Pransky et al. (2002) noted that primary care providers relied mainly on patient input for disability assessment. Englund and Svardsudd (2000) observed that in cases where primary care physicians could not medically justify ‘sick-listing’ certification, a certificate was issued anyway in 87% of cases. In a separate study, Englund and Dahlgren (2002) noted that the most important factor affecting ‘sick-listing’ was the patient’s attitude to ‘sick-listing’, as those wishing ‘sick-listing’ were ‘sick-listed’ to a greater degree than those who were reluctant. Mayhew and Nordlund (1998) found that 41% of family physicians reported feeling pressured to write unwarranted work excuses and had a sense of being manipulated by their patients. Brook (1996) reported that hostile, demanding, threatening and malingering patients, frequently influenced physicians’ completion of disability requests. Zinn and Furutani (1996) found that 40% of physicians reported a willingness to exaggerate clinical data for patients they felt deserving of disability.

The observations described above document that significant discordance exists between patients and physicians about the degree to which illness justifies limitation on activity and work.
For some physicians, the discordance may be trivial—they feel unable to judge the appropriateness of disability more accurately than their patients, and therefore rely upon their patient’s ‘better judgment’. It is also possible that in order to avoid this discordance, many physicians adapt rather neutral attitudes about pain and function (Rainville et al. 1995). These neutral attitudes may serve the physician well, as it allows the physician to easily acquiesce to the disability position adapted by their patients, and thus avoid conflict.

For many other physicians, this discordance is troubling. However, they still may acquiesce to the patient’s requests. One important reason for this is suggested in the study by Zinn and Furutani (1996), where over 80% of physicians felt that refusing to fill out disability forms could adversely affect the doctor–patient relationship, and 62% felt that it reflected a conflict of interest. These findings suggest that most primary care physicians see their role as gatekeepers for compensation systems as subservient to their role as patient advocate, especially when their relationship is long term and includes care for all medical problems (Hussey et al. 2004). From a practical point of view, it may be much less time-consuming for physicians to simply acquiesce to patients’ demands and avoid conflict.

It appears that the interaction of patients’ beliefs, behaviours, and demands, with internal physician characteristics of professionalism, social desirability, and negotiation strategies can profoundly influence disability recommendations (Monday et al. 1988). Research is needed on how physicians cope with their conflicting roles as patient advocate and gatekeeper to disability benefits, with the goal of identifying potential interventions that would improve their performance as disability advisors.

20.6 Patients’ perceptions of disability

This discordance may in part result from patients perceiving the disabling effect of their problem differently than physicians do. For many chronic musculoskeletal disorders, physical factors actually play a relatively minor role in influencing disability outcomes. Indeed, it appears that patients with chronic musculoskeletal symptoms who continue to seek medical care may possess attitudes and beliefs about pain and function that are more restrictive and potential disability levels that are significantly higher than others in the general population with a similar malady (Szpalski et al. 1995; Waxman et al. 1998). Past research suggests that much of the observed variance in self-reported disability results from factors that are independent of the physical aspects of the musculoskeletal afflictions. Influential factors include coping abilities (Turner et al. 2000), affect and personality (Gatchel et al. 1993; Maxwell et al. 1998), fear-avoidance beliefs (Swinkels-Meewisse et al. 2006), educational level (Roth and Geisser 2002), work issues (Bigos et al. 1991), and concerns about benefit loss and secondary gain (Rainville et al. 1997; Klekamp et al. 1998). Though frank malingering is probably quite rare, somatization, distortion, and some exaggeration may be common (Ensalada 2000). These areas of non-medical distress can strongly influence patients’ behaviours and magnify their perception of disability, especially as it relates to work.

Patients relating back pain to exposure to physical activities, fear of re-injury, and the belief that pain indicates harm are likely important factors influencing disability (Rainville et al. 1993; Waddell et al. 1993; Jensen et al. 1994; Symonds et al. 1996). People with a history of back pain, and those with blue-collar occupations more often attribute back pain to external factors such as physical activities and the work environment, though misconceptions about back pain are widespread, even in the group reporting no back pain (Linton and Wang 1993; Goubert et al. 2004). Patients may be reluctant to continue activities that are believed to have precipitated their back pain. With this in mind, a recommendation to remain active and return to work may be ineffective unless it’s accompanied by information that resolves or addresses fears of re-injury. Physician-presented patient education, such as that reported by Indahl et al. (1998), that attempts to displace...
the injury model of spinal degeneration with a more benign hypothesis, and dissociates pain and function, may offer some encouraging results. This approach is clearly in need of further study.

20.7 Factors external to the physician–patient relationship that influence disability

Employers can also have an influence on physician behaviour regarding disability by engaging more cooperative physicians, communicating their return to work expectations and providing alternative duty (Habeck et al. 1991; Pransky et al. 2002; L. Shaw et al. 2002; W.S. Shaw 2003; van Duijn et al. 2004). Baril and Nordqvist (Baril et al. 2003; Nordqvist et al. 2003) conducted qualitative studies of return-to-work programmes, contrasting the perceptions of workers, employers, physicians, and others involved in the process. Although physicians focused on individual factors as the most important determinants of return-to-work outcome, workers and health and safety managers readily identified workplace-specific factors as the most important determinants for returning to work.

Yet another influence may be the healthcare system itself, including level of reimbursement for services related to caring for disabled workers, local market effects, and provider-induced utilization in work-related musculoskeletal disorders. Johnson et al. (1999) demonstrated that healthcare providers incur a benefit in the form of healthcare utilization in disabling work-related musculoskeletal disorders. For some providers who offer costly diagnostic and therapeutic procedures, a disincentive may exist to return patients quickly. The burden of salary replacement benefits may motivate some insurers to authorize expensive medical services, especially when the medical provider insists that return-to-work recommendations are contingent on performing a procedure or test. Even for clinics specializing in work-related musculoskeletal disorders that are established specifically to improve care, incentives to increase utilization can lead to a net increase in disability, as aptly demonstrated in a series of Ontario clinics by Sinclair et al. (1997).

Legal jurisdictional influences on physician behaviour in relation to disability are highly significant. This is a key factor in the profound differences across jurisdictions in mean lengths of disability for equivalent conditions—despite absence of differences in the nature and the severity of injury, and the availability return to work opportunities (Johnson et al. 1996).

In summary, the recommendations for work/activities made by physicians to patients with musculoskeletal complaints are the product of the complex interaction of many factors. In addition to the obvious factors of the medical condition itself, as well as idiosyncratic characteristics of the physician and patient, factors external to the physician–patient encounter also influence physicians’ recommendations. These include the work place, medical systems, and legislation.

20.8 Efforts to influence physician recommendations

Interventions have attempted to improve the quality of physician recommendations about work resumption after injury, with varying degrees of success.

20.8.1 Medical educational efforts

Efforts to improve physicians’ education about the impact of activity recommendations on disability have been sparse, and the results are unimpressive. Lie (2003) reported on an educational effort in Norway to decrease the length of sick leaves by augmenting the knowledge base of GPs. Participating physicians received education about common musculoskeletal disorders and financial compensation for spending extra time with patients with extended sick leaves. Unfortunately, no impact on sick listing practices or disability outcomes were noted.
Perhaps it is not the direct knowledge about musculoskeletal disorders that is most important, but instead the pain attitudes and beliefs of the practitioners that are most critical in disability recommendations. If so, efforts to directly alter these may be of some benefit. This issue has also received limited study. Latimer et al. (2004) reported on an educational project designed to change the attitudes and beliefs about pain and function of physical therapy students. Results indicated that substantial changes in favour of endorsing function occurred following the teaching module and these changes were maintained 1 year out.

From another perspective, training for physicians should focus on skills that directly address the findings that it is psychosocial and not medical issues that are the primary determinants of disability. This implies developing an ability to elicit and address the factors that may inhibit successful return to work and knowledge of how to effectively address these factors (L. Shaw et al. 2002). Related skills such as prognostic screening and selective referral to resources based on the specific barriers to return to work, may also be directly related to producing evidence-based return-to-work recommendations, inasmuch as these interventions are necessary to insure a high likelihood of compliance and success (W.S. Shaw et al. 2001; Haldorsen et al. 2002).

20.8.2 Guidelines

In the mid 1990s, leading researchers developed medical guidelines to address disability issues in musculoskeletal disorders, especially LBP, urging physicians to facilitate return to work (Frank et al. 1996; Canadian Medical Association 1997). The premise was that evidence-based guidelines, norms, and other ‘scientific’ knowledge would lead to practice change once physicians were informed about them (Verbeek et al. 2002). In isolation, educational efforts appear to have minimal impact, especially in low back pain (Rao et al. 2002; Verbeek et al. 2002).

Direct efforts to mandate that physicians’ work recommendations be based on clinical and not subjective criteria have shown some promise. In a case-controlled study, Hall et al. (1994) examined the impact of a mandate that all low back injured workers be released to unrestricted (versus restricted) work, unless objective medical contraindications were present. This mandate resulted in twice the number of patients returning to unrestricted work, without an adverse effect on the probability of successful return to those work activities. Similar finding were noted by Hiebert et al. (2003). Both studies were undertaken in private business settings where physicians were employees and modest control over physicians’ actions could be elicited. As such the applicability of these findings to more traditional medical practice settings is questionable. This is demonstrated by a study in a less controlled setting by Scheel et al. (2002) which demonstrated that simply providing physicians with a mechanism to return patients to work sooner was insufficient, even though most physicians readily acknowledged the importance of improved return to work outcomes. In part, these results may reflect the highly skewed distribution of length of disability amongst a minority of patients, the inherent difficulty in engaging physicians, as well as the multitude of factors besides physician recommendations that shape outcomes (Scheel et al. 2002).

20.8.3 Systems efforts

Realizing the limitation of interventions that are aimed at medical providers alone, several recent projects have taken a broad-based, systemic approach, thereby acknowledging that physician behaviour occurs in a larger context that includes patient knowledge, expectations, and behaviours. As observed by Grimshaw, Deyo, and others, most successful approaches: (1) include some form of medical educational outreach with use of academic detailing by recognized leaders; (2) include changes in the processes that direct physicians to the desired behaviour; (3) include
simultaneous education of patients; (4) include a high and sustained level of administrative and financial support; and (5) acknowledge that one technique may not be suitable for all (Oxman et al. 1995; Deyo et al. 2000; Grimshaw et al. 2001).

Community-wide interventions have been attempted in several countries. These interventions theorized that by simultaneously supplying both the public and medical providers with similar information about the benefits of activity and work, the discordance between physicians and patients could be lessened. One could argue that as the community is brought along, physician-patient dialogue might change and achieve concordance at a point consistent with evidence-based guidelines.

Buchbinder et al. (2001a, 2001b) initiated this type of intervention in Australia. The intervention used a multimedia campaign to disseminate information about the benefits of staying active with back pain, including work. The result was a large, significant improvement in back pain beliefs and less fear-avoidance regarding physical activity. This was paralleled by improvements in beliefs and practice intentions of physicians. Of equal importance, the researchers noted a clear decline in the number of claims for back pain, days of compensation and medical cost for claims during the campaign.

A similar system wide approach was taken for a public health initiative entitled ‘Working Backs Scotland’ (Waddell et al. 2007). The initiative utilized a combination of radio and a website to disseminate information targeting both people with back pain and employers. Concurrently, information supplied to medical providers advised against recommending bed rest, activity restrictions and issuing sickness certification for back pain. This initiative also demonstrated a shift in public beliefs away from rest to staying active, and a comparable shift in professional advice. However, no changes in work or compensation outcomes were noted. These results exposed a flaw in the ‘Working Back Scotland’ intervention—it avoided direct discussions of work. The lack of changes in work-related factors suggests that work expectations during a back pain episode must be addressed directly for these interventions to be successful.

Smaller and more focused systemic changes can also impact physicians’ behaviours and responses. Bernacki and Tsai (2003) described a successful workers’ compensation management system at an employer-level that decreased lost time by 73% and the number of medical claims by 61% over a 10-year period. In this system, physicians’ expectations for advising light duty and return to work are unambiguous; there are appreciable rewards for providers to work within the system, and employers will accommodate a returning injured worker. Similar programmes have reported comparable results (Green-McKenzie et al. 2002; McGrail et al. 2002). Eccleston and Yeager (1998) concluded that these types of programme generated savings of 9–54%, not by reducing medical costs, but by providing earlier and more effective return-to-work recommendations from treating physicians.

Some innovative approaches recognize that physicians are trained to perform within a medical model; to the extent that determinants of disability are primarily psychosocial, not medical, their training and orientation are poorly suited to effectively address issues of return to work (Hunt et al. 2002). Based on this presumption, one successful approach places physicians as a contributing member of a team that provides specific recommendations about return to work and facilitates the return to work process (Durand and Loisel 2001; Edlund and Dahlgren 2002). Another approach trains physicians to become more effective communicators about LBP, its prognosis, and the optimal approach for management (McGrail et al. 2002).

20.8.4 Legislative efforts
Clearly social systems that compensate individuals for illness and disability have a profound potential to influence human behaviours. As such, changes in these systems, especially changes
That affect eligibility, should have the ability to change societal expectations and the financial burden of disability. The positive effects of altering eligibility criteria for financial compensation are demonstrated in studies by Cassidy et al. (2000) and Claussen (1998).

Even though changes in the public support of disability can be legislated, these may have limited impact on physicians’ disability recommendation. Englund et al. (2000b) noted no change in the ‘sick listing’ practices of physicians collected before and after a legislative reform, other than they completed the forms more thoroughly after the reform. Legislative changes instituted in Sweden in 1995 aimed at reducing costs of sickness absence by mandating that physicians exclude non-medical criteria for sick-listing, recommend more part-time sick-listing, and pursue faster rehabilitation did not meet any of their goals. Indeed, a survey of physicians by Getz and Westin (1993) reported that a majority of physicians believed that legislation resulting in a higher percentage of refusals for disability applications would not bring many applicants back to employment, but would instead transfer the financial burden of disability to other public sources of support. Apparently, physicians’ attitudes towards disability and their behaviours with patients requesting disability certification are not easily impacted by legislative efforts, most likely because they do not lessen the demands of patients for disability certification.

20.9 Summary and conclusions

When attending to patients with musculoskeletal complaints, physicians are required to give advice about the appropriate level of activities and work for the condition under treatment. Evidence suggests that this advice varies greatly between physicians. This variation results from multiple factors. From the perspective of physicians, differences in medical knowledge, attitudes and beliefs, negotiation abilities, and professionalism surrounding the doctor–patient relationship can all influence their recommendation. Patient, employer, and societal factors may also influence these recommendations.

Prolonged work avoidance has no identified therapeutic benefit and significant adverse effects on social well-being. Although some physicians recognize the impact of poor recommendations, most efforts to persuade physicians to discourage patients from sustained work absence have been unsuccessful. This may be in part due to an incomplete understanding by physicians of the processes whereby back pain-related disability becomes chronic (Guzman et al. 2002). Regardless, efforts to harmonize physicians’ recommendations to promote full return to activity or work despite chronic musculoskeletal pain seem warranted. One-dimensional interventions such as physician education or implementation of evidence-based guidelines have had limited effect on disability recommendations. Based on the available evidence, significant changes in physician recommendations will require educating both physicians and patients, along with altering societal expectations about back pain and work (Aylward and Waddell 2002). Successful multidimensional efforts have included educational material to enhance physicians’ knowledge combined with effective community-based efforts to influence patients’ functional expectations before they enter the physicians’ office. During the medical encounter, physicians should be motivated to address the issues where there is disagreement about disability, consistent with the standards of high quality doctor-patient communication. Accepting the input, and understanding the needs of employers and governmental organizations can aid the physician in providing appropriate medical input for these entities.

Thus, future research should concentrate on interventions that can change the attitudes and actions of key players in the disablement process, within the context of a particular sociopolitical environment. Even in the setting of expectations for prolonged disability, interventions that address all of the most significant factors underlying extended LBP-related work absence could be
successful (Loisel et al. 2003). Our future challenge will be to generalize these findings in a way that will enable physicians, patients and employers to accept early, rapid, and safe return to activity and/or work as an expected outcome.

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References


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FROM ACUTE TO CHRONIC BACK PAIN


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