
Practice and ideals in neck and back pain management

INVITERT KOMMENTAR

STEFÁN HJÖRLEIFSSON

stefan.hjorleifsson@uib.no

Stefán Hjörleifsson, specialist in general practice, associate professor at the Department of Global Public Health and Primary Care, University of Bergen, and general practitioner at Alrek Medical Centre.

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Effective collaboration across specialties is crucial when patients with neck and back pain need follow-up care in the specialist health service.

Norway's national clinical guidelines for neck and back pain recommend that patients be referred to interdisciplinary rehabilitation if they have not returned to work within 6–8 weeks after pain onset [\(1\)](#). However, more than nine out of ten patients referred to neck and back outpatient clinics at Norwegian hospitals reported having experienced pain for over three months, and more than four out of ten had been in pain for over two years [\(2\)](#).

General practitioners (GPs) write the vast majority of referrals to the specialist health service for neck and back pain, and they appear to wait longer than recommended in the guidelines. However, when deciding how quickly a patient should be referred, consideration must also be given to capacity and sustainability in the health service. The number of patients experiencing functional loss for more than 6–8 weeks is probably so high that the specialist health service would be overwhelmed if they were all referred at that stage. Unrealistic guidelines are not helpful.

A study by Bjørneboe et al., published in this edition of the Journal of the Norwegian Medical Association, sheds light on an important part of the collaboration between primary and specialist care intended to help these patient groups [\(3\)](#). The authors analysed the quality of 632 referrals to the neck and back outpatient clinic at Oslo University Hospital. They found that only 57 % of the referrals included information about the patient's clinical examination, and just 69 % mentioned the patient's

employment status. This missing data had direct consequences, as details of the clinical examination and employment status, together with medical history, were the strongest predictors of whether a referral was accepted.

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The national clinical guidelines do not recommend routine MRI for the investigation of neck and back pain. Nevertheless, in the study by Bjørneboe et al., 91 % of the referrals included information about MRI scans. Positive, objective findings hold a high status in the medical knowledge hierarchy, and supplementary tests are often given more weight than clinical assessments based on patient history and ordinary clinical examinations. MRI scans of the back and neck are rarely 100 % negative, and findings that are not the cause of the patient's (current) pain are often given too much weight. 'My back is ruined', says the patient who has little hope of improvement. 'I've been suffering horribly due to a herniated disc I've had since 1999, and another herniated disc found on the scans in 2020. I have a CD with the MRI images that I can bring to the next consultation' (fictional patient story). An unfortunate consequence of the high rate of outpatient MRI scans in Norway (one of the highest in the world) is that many patients may have incidental findings that make them appear sicker than they actually are (4).

«The high rate of outpatient MRI scans in Norway (one of the highest in the world) can sometimes make it appear that patients are sicker than they actually are»

In 2008, Ringberg documented major differences in referral rates to the specialist health service and imaging examinations among GPs in Northern Norway (5). GPs who frequently issued referrals also reported more often than other GPs that they expected little or no benefit for the patient. It would also be useful to know whether some GPs are more likely to submit incomplete referrals to neck and back outpatient clinics than others, and if so, in what other ways these GPs differ.

Recognising variations in practice allows for valuable – albeit sometimes uncomfortable – professional self-reflection. The Norwegian Institute of Public Health recently published a report indicating that self-employed GPs, and particularly those with a large number of patients, are less restrictive gatekeepers than salaried GPs (6). Although GPs have protested against the notion that financial incentives can cloud their clinical judgement, we must acknowledge the need to investigate the reasons for variations in practice.

GP referrals are sometimes incomplete, too many scans are probably performed, and the guidelines for neck and back pain may be unrealistic in some respects. The Norwegian colleges of paediatrics and general practice recently began working together to harmonise the management of the most common paediatric conditions (7). Perhaps the time is ripe for a similar cooperation between the fields of physical medicine and general practice.

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