

**Sorry but did I miss something?
Daring to treat musculoskeletal pain differently**

The heresy of one age becomes the orthodoxy of the next.
Helen Keller

A 45 yr old woman visits her GP with pain in her shoulder. She has had it on and off for 3 months with no response from simple analgesics. The practitioner has an interest in musculoskeletal pain but can find no clear-cut abnormality. He suggests some local physiotherapy and refers her onward into the orthopaedic department. Two years later she is still struggling with pain, depression and incapacity.

Did he miss something?

Like what?

What about that she is a veiled Somali immigrant of 4 years who speaks little English living in appalling accommodation in a rough Estate in Hammersmith? Or that she is an ex-publican who is still drinking too much having just escaped from her second abusive marriage with a history of sexual abuse and a cot death? Or that the pain started in a minor accident at work and she has ongoing litigation and a grievance against her employer with a history of dysmenorrhoea, migraines and back pain?

Oh that sort of thing you mean...

Let me stick my neck out. Musculoskeletal pain (that amorphous blot of disquiet that accounts for nearly half of all incapacity for work) is only problematic when it is perceived to be intolerable. Such a perception comes from three main causes: someone else is to blame, various unique psychological vulnerabilities cause neurophysiological changes to pain perception, or the social milieu confers advantages to the pain complainant. Illich was right: culture predicates necessity. Most people can cope with most musculoskeletal pain.

What does their doctor do when they don't or can't?

They search for a biological explanation for the distress and disability. Usually this involves delving ever deeper into an investigative rucksack by ordering at least an X ray or MRI scan, or seeking a second or third opinion. The problem is that the distress and incapacity, which is driving the consultation process in the first place, are not predicted by biological markers (which often remain immeasurable in any event), but by a range of psychosocial variable, collectively termed 'yellow flags'. Thus factors such as past sickness absence leave for similar problems, a tendency to negative or catastrophic thinking, a view that pain signifies damage and requires rest, avoidance of activity, a conviction of a medical solution thus provoking a passive role, and the seeking of compensation, are all predictors of a worse outcome following an episode of musculoskeletal pain. Whilst ineffective coping can certainly be solved by curative treatment that abolishes pain generation (frequently seen in hip replacement surgery), when such curative treatment is lacking half a pain turns out to be a big a problem as a whole pain.

There are three major problems with the current mindset. Firstly the 'fear of negligence' poison taints the well. The pursuit of useless investigation on the basis of 'we might be missing something' is a process of not just neutral but negative effect. Secondly for those vaguely aware of the need to broaden the assessment there are

few readily available tools and these are time consuming and seldom available. Lastly even if one were to follow the Clinical Standards advisory group recommendations of an interdisciplinary assessment by a third party provider, where would one find it?

The recently published musculoskeletal service framework is subtitled 'A joint responsibility: doing it differently' and promotes some good ideas but does it get to the nub? Is it going to alter the process at primary care level such that the person walking through the door has a yellow flags assessment carried out along side a biological evaluation? (As is often pointed out the term biopsychosocial includes biology). I remain unconvinced. Organisation change will not alter mindsets unless it is monumental or draconian.

Alongside better care pathways we need altered mindsets that tunes the primary care system into a different way of thinking. For example on the first day of consultation a person with back pain has a 1- 5 % chance of long term incapacity with its attendant miseries to individual and family. In other words a single figure percentage of something awful happening. The 'something' we might be missing is seldom worse or at a higher risk of occurrence than this.

Doing it differently means really doing it differently. For example

- Measurement of yellow flags should be routine within 4 weeks of onset of a complaint
- With back and some joint pain self management should be start point with group based education packages and ongoing exercise programmes.
- The GP surgery should not be first port of call for back pain
- Access to more intensive treatments (acupuncture, chiropractic) should be contingent upon attending information session.
- Persistent problems should be treated on interdisciplinary cognitive behavioural condition management programmes
- No patient should contemplate spinal fusion until they have engaged in a functional restoration programme

This will entail community based care pathways with open doors and easy access. It is achievable and affordable but only on the basis that cumbersome obsolete hierarchies and systems have to be dismantled to make way for new ideas. There is now a growing movement to make the change. Not only do I think it can happen, I think it will happen.