

**THE MANAGEMENT OF BACK PAIN AND
THE AVOIDANCE OF DISABILITY**

**GETTING THE EPIDEMIC OF BAD BACKS UNDER
CONTROL WITHOUT EXPENDITURE AND WITH HUGE
SAVINGS IN THE FINANCIAL AND HUMAN COST**

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Introduction

When someone complains of a bad back they mean a persistent problem and a degree of disability. Most people will experience a back pain episode at some time in their life. Back pain episodes are self-limiting and isolated episodes imply nothing sinister. Of far greater concern is the slide into disability.

The cause of the common back complaint is unmasked by rudimentary observation and simple experimentation. It is a mechanical issue as distinct from a medical condition and the remedy is simple. Even patients with long histories can make a prompt and lasting recovery. In most cases, no treatment is required. Popular treatments are part of the problem, not part of the solution. It is mismanagement of the complaint that is fuelling the epidemic of bad backs. Detailed patient histories indicate that the slide into disability is primarily attributable to the influence and practice of alternative medicine. With a change of management, disability is resolved¹.

While the true cost of chronic back pain must be measured both in financial and human terms, in the UK the scale of the problem is reflected in the cost to industry, the expenditure on incapacity benefit and the cost to our National Health Service (NHS). Being both the largest employer and the healthcare provider, it is an appalling drain on the NHS at a time of impending austerity. Industry is struggling and the expenditure on incapacity benefit is running at twice the cost of funding the NHS. It is intolerable that, in the 21st Century, mismanagement of a rudimentary complaint is allowed to consume billions and ruin lives.

The explanation that follows is designed to be accessible to laymen as well as physicians. Concerned parties include government, employers, journalists and the general public. Most particularly, the public must understand the road to disability if they are to avoid it.

The starting point

Back pain is a symptom not a disorder. It may be caused by injuries of force and speed such as broken bones and torn tissue or it may be caused by an organic disorder such as an inflammatory condition. However, in the vast majority of cases there is no evidence of either. The common complaint has been termed idiopathic; meaning cause unknown. It is commonly referred to as mechanical back pain but there has been no coherent explanation of the nature of the mechanical problem, its cause or remedy.

A phenomenon on the scale of the common back complaint has to have a rational explanation. Medical science is very good at the study and treatment of organic disorders; as evidenced by the helter-skelter pace of medical advance. Had the cause been some common organic disorder (disease) then it would have been found long ago.

It follows that the cause must be a functional disorder; something people are doing to cause the problem. It must be a very common habit and we have our first clue. In the advanced stages of the complaint we find evidence of excessive wear and tear in the joints of the low back and at the base of the neck. We are looking for a common habit that can, over time, cause excessive wear and tear in these joints.

Another important clue is to be found in the examination of the supple elasticity of spines. We may invite a healthy teenager to lie face-down on an examination table and press down on the spine and observe that the spine is yielding; demonstrating that the spine is supple. We may observe that when the pressure is released the spine rebounds; demonstrating elasticity. Contrast the spines of middle-aged men. The spine is relatively stiff and unyielding. In patients presenting with severe and intractable back pain, the spine typically feels set like cement.

To function correctly, the spine should be supple and elastic like the spine of a healthy teenager. As the spine stiffens the joints at and around the lumbar-sacral junction (low back) and the thoracic-cervical junction (base of the neck) become increasingly overworked and overstressed. Excessive wear and tear and referred pain are natural consequences of the overwork and overstraining of these joints.

However, while the supple elasticity of youth does fade with time and age this does not explain the common back complaint. There are two reasons for this. Firstly, many relatively young people are affected while many people much older are not. Secondly, we can test the supple elasticity of the spine as described above. In the early stages of the complaint, there is no evidence of a common and significant loss of mobility. In other words, in the early stages of the complaint, the spine is not stiff enough to account for the complaint.

We are still looking for a functional disorder. More specifically, we are looking for a common habit which causes the joints of the low back and the base of the neck to be habitually overworked and overstressed. The answer is dynamic fixation. Dynamic fixation causes a supple spine to function as a stiff spine.

Dynamic fixation

Adopt the 'light on your feet' stance of an athlete; weight balanced over the balls of the feet. Note the supple, fluid and free movements associated with this stance. Importantly, note the lack of strain on the low back when bending and twisting and the lack of strain at the base of the neck when turning the head.

Now transfer your weight from the balls of your feet to your heels. Note that, when your weight is on your heels, the spine is effectively fixed and fluidity of movement is lost. Importantly, feel the strain on the low back when bending and twisting and the strain at the base of the neck when turning the head.

We find evidence of true fixation in the later stages of the complaint because joints must be exercised if they are to remain mobile. Habitual dynamic fixation leads to true fixation.

The important point is that a subtle shift in balance produces a profound change of body mechanics. Precisely how this biomechanical issue causes the symptoms of the common back complaint is explained in the section entitled ‘connecting the dots’ which follows description of tests and observations that are crucial to understanding the complaint. However, in short, learn the shift in balance that produces a profound change in body mechanics and even patients with a long history of debilitating back pain can make a prompt and lasting recovery¹. Getting it wrong causes dynamic fixation. Dynamic fixation causes the joints of the low back and the base of the neck to be habitually overworked and overstressed. The symptoms of the common back complaint stem from that. To be light on your feet and active is both the prevention and the cure.

The term ‘sprightly’ is used to describe older people who are light on their feet and active. They move well and do not have a back problem. However, this biomechanical issue is not age related. A distressing number of teenagers habitually shuffle along with the weight on their heels. Shoes with raised heels exacerbate the problem.

Dynamic fixation is not to be confused with the old chestnut about bad posture. The issue is about the mechanics of movement, not posture while standing or sitting; and it is about the habitual overwork and overstressing of particular joints, not muscles.

Back pain sufferers do tend to have poor posture but this is a consequence of getting it wrong, not the cause of the problem. This can be demonstrated by simple experimentation. With the weight on the heels, it takes a conscious effort to fight ‘the slouch’. The fight is exhausting and the conscious effort is lost to the demands of a busy day. Now adopt a shift of weight from over the heels to over the balls of the feet and discover that posture improves automatically and it is effortless. To be light on your feet, one must be relaxed.

The BOF technique

Traditional advice on posture is wrong and does not work. Advise a patient to improve their posture and they draw themselves up. Even if they were to maintain this, there would be little biomechanical benefit because they hold themselves rigid with their weight on their heels. In practice, the effort of drawing themselves up is abandoned in minutes.

Attempts to simply explain the problem and the remedy tend to fail. The expectation of treatment is deeply ingrained in our culture and the profound change of body mechanics associated with a subtle shift in balance is not immediately obvious. More often than not, the patient walks away thinking that they have been fobbed off with words when what they really needed was treatment. They then turn to alternative medicine and the mismanagement of the complaint begins.

A lot of experimentation has gone into developing a technique that does work. With the weight on their heels, the patient is encouraged to feel the restricted movement and strain on the low back when bending and twisting and the strain on the base of the neck when turning the head. The patient now understands the cause of their problem because they can feel it.

The patient is now taught the shift in balance and shown how to be light on their feet. They can immediately feel the freedom of movement and the lack of strain on the low back and the base of the neck during activity. The patient now understands the remedy.

In most cases, practical instruction is necessary. Simply tell patients to get the weight off their heels and on to the balls of the feet and many look puzzled and stand stiff legged on tippy-toe. Tell patients to walk with the weight on the balls of the feet and they try to walk on tippy-toe with the gait of a duck. There is a knack to learning to be light on your feet. However, the 'balls of the feet' or BOF technique is so simple that a practice nurse in a GP surgery can teach a patient in a matter of minutes.

Compliance is excellent if patients are encouraged to contrast the feel of 'light on their feet' with the feel of an exaggerated slouch with the weight on the heels. Slouched with the weight on the heels, the patient can feel the sensation of age and, with the aid of a mirror, they can see the posture and body language of the old. It feels depressing. Going light on the feet makes the patient look and feel younger and it is effortless. Getting the right habit is about feeling good, not about guilt and effort. When they get the knack, it feels so natural and right that the patient cannot imagine why they have not always done it. If it is well taught, the patient should be excited by the discovery and impatient to get on and enjoy the benefit.

The vast majority consult their GP on the occasion of their first back pain episode and the complaint is best addressed promptly within the GP practice. The sooner patients get on the balls of the feet and get moving the shorter the episode. The more active they are the better the prognosis. The practice nurse is the ideal candidate to provide the appropriate instruction and it takes about 10 minutes.

As the symptoms subside, old habits may reassert themselves. In which case, the symptoms are liable to recur. If they do then the patient will remember the remedy. The patient is in control. Given the nature of the complaint, the patient is the only person who can provide the remedy.

Treatment is not appropriate where there is no treatable condition and slouching with the weight on the heels is not a treatable condition. Palliative treatments have the unfortunate effect of causing the patient to believe that they do have a treatable condition. The patient then expects treatment to provide the remedy. It cannot.

While the cause of the common back complaint and the remedy are matters of body mechanics, the disability issue goes deeper. The biomechanical cause of the complaint is not to be confused with the cause of the slide into disability. It is the mismanagement of this rudimentary complaint that draws people into disability and ruins lives.

Acquired disability

It is helpful to bear in mind that all back pain complaints start out as acute cases. The complaint is defined as chronic if it persists for 12 weeks or more.

A recent and rigorous trial on the management of acute cases² found that the outcome was the same with or without treatment and that, at 12 weeks, almost 99% had recovered. It follows that back pain episodes account for the vast majority of back pain complaints. Back pain episodes are, by definition, self-limiting.

Remain active and episodes typically self limit in a couple of weeks. With benefit of the BOF technique, recovery is faster. However, while an isolated episode implies nothing sinister, the study of episodes tells us nothing about the long-term prognosis. The real issue is acquired disability.

The consequences of slouching with the weight on the heels may amount to little more than the odd episode, a bit of backache and morning stiffness and generally becoming old before your time. However, in far too many cases it leads to costly tragedy.

When the back fails the patient can no longer hold down their job. They cannot stand for long, sit for long or sleep at night and living with persistent debilitating pain leads to depression; not a lot of fun to live with. All too often this leads to divorce. They have now lost their job and their home life is in ruins. The depression deepens. Depressed and with no money, their friends soon tire of them. The social life of this once competent person now revolves around visiting their doctor and the pain clinic. Pain clinics and rehabilitation clinics are full of tragic examples.

The explanation for the dramatically different outcomes is to be found in patient histories. Those that have fared best resolved to get on with life and remained active. Those that fared worse believed that they were suffering from an affliction and nursed their back. Adopting the role of the back pain sufferer is a self-fulfilling prophesy.

One of the strengths of the BOF technique is that it causes the patient to feel and discover the cause of the problem and experience the remedy. Failing that, GP advice on the importance of remaining active carries little weight. Louder voices cause patients to

believe that they are the hapless victims of an affliction. Chiropractors, osteopaths and physiotherapists in private practice vie to treat the affliction. Other voices join the chorus. “Protect your fragile back with our specially designed office chair”. “Care for your back with our orthopaedic bed”. “Sit back and let your personal injury lawyer take the strain”. These siren voices draw people into disability.

To make the explanation easier to follow we have gone straight to the nub of the problem. In doing so we bypassed a number of big questions. For example, what triggers a back pain episode and why are these episodes self-limiting? Why do back pain sufferers experience good periods and bad periods? At what point and why do these on/off symptoms become persistent debilitating pain? We must now answer these questions and make sense of the symptoms so that the road to disability can be fully understood. We can then see what must be done to halt the slide into disability. In the interests of brevity, we can focus on the low back.

The key to the puzzle

The key to the puzzle is a phenomenon called sciatic scoliosis. It is an involuntary protective postural response that is known to occur when a prolapsed intervertebral disc is impinging on a spinal nerve in the low back. This involuntary response is also observed at the onset of a back pain episode but, in the early stages of the complaint, the disc is sound and the protective response diminishes over a matter of days.

Figure 1 illustrates a pair of vertebrae with the disc in between and a spinal nerve that passes through the joint. A disc is not something that can slip about. Discs are primarily composed of concentric rings of tough fibres firmly bonded to the vertebrae. At the centre of the disc is a ball of jelly which is surrounded by this tough fibrous jacket. The disc forms a cushion between the bony vertebrae.

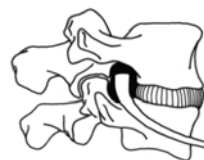


Figure 1.



Figure 2.



Figure 3.

Figure 2 illustrates the excessive wear and tear that can develop over time. At some point in this degenerative process, the fibres become rotten and the disc bursts; a prolapsed intervertebral disc. It is generally symptomless. The patient is not aware that anything has happened. However, if the burst presses on the spinal nerve, it generates debilitating pain of rapid onset and the protective postural response illustrated in Figure 3.

The irritation of the spinal nerve activates a nervous loop that produces an involuntary muscle contraction. When it is severe, this involuntary contraction is experienced as muscle spasm. In the case of sciatic scoliosis, involuntary muscle contraction produces a sideways curvature of the lower back convex towards the site of nerve root irritation. This protective response acts to increase the space around the affected nerve root and relieves the pressure on the nerve.

At the onset of a severe back pain episode we observe the same debilitating pain of rapid onset and the same protective response. The essential difference is that there is no evidence of a prolapsed intervertebral disc and the protective response diminishes in a matter of days.

From patient histories we know that back pain episodes are typically triggered by an awkward movement such as bending and twisting to pick up the soap in the shower. The debilitating pain of rapid onset and the accompanying protective response are consistent with a spinal nerve having been momentarily pinched in the joint during this awkward movement. However, at this stage of the complaint, there is no evidence of a common and significant degree of joint degeneration to account for this vulnerability to momentary nerve root compression.

We may reason that the habitual overwork and overstressing of a spinal joint (dynamic fixation) will lead to stretched ligaments and growing instability. We may reason that, in an unstable joint, the nerve root may be vulnerable to momentary compression during activity such as an awkward movement. Indeed, there is no other rational explanation. However, the explanation must be tested. This can be done with posture tests.

Posture tests

It would be difficult if not impossible to observe momentary compression of a spinal nerve during activity. However, the moment of compression can be extended indefinitely by inviting a patient to maintain a particular posture. If the posture causes a spinal nerve root to be gently compressed, the patient experiences a symptom called neurapraxia. Neurapraxia is a tingling and loss of sensation associated with a temporary loss of nerve function. Because the tingling and loss of sensation is confined to a specific area the affected nerve can be identified. With a change of posture, nerve function is restored.

In patients vulnerable to back pain episodes, the symptoms of nerve root compression can be switched on and off with change of posture. Given that these gentle and cautiously

conducted tests demonstrate nerve root compression, it follows that the patient will be vulnerable to fierce compression during an awkward movement. Thus, vulnerability to back pain episodes is linked to vulnerability to momentary nerve root compression during activity.

We may reason that, when the habitual overwork and overstressing of the affected joints is halted (BOF technique) ligaments will tighten and stability will be restored. If the posture tests are now repeated, the vulnerability to nerve root compression is seen to have been resolved. Thus, vulnerability to back pain episodes is linked to the habitual overwork and overstressing of the affected joints (dynamic fixation). Confirmation of the link comes from the systematic resolution of cases of debilitating back pain that have persisted for many years¹.

Postural measurements

Postural measurements provide the final piece of the puzzle. Back pain and sciatic scoliosis are symptoms of the same nerve root irritation and are in proportion. The severity of sciatic scoliosis can be measured. This measurement provides an objective means of observing the severity and duration of the symptoms. Patients cannot disguise, mimic or exaggerate this involuntary response.

The involuntary muscle contraction that produces sciatic scoliosis produces a shift in the sacro-iliac joints which, in turn, produce an apparent difference in leg length and pelvic tilt illustrated in Figure 3. Consequently, the response can be measured by contrasting the height of the iliac crests i.e. by measuring the pelvic tilt.

The shift in the sacro-iliac joints that produces the apparent difference in leg length cannot be achieved voluntarily. To voluntarily produce a pelvic tilt, it is necessary to shorten one leg by bending a knee. When measuring sciatic scoliosis, it is a simple matter to ensure that neither knee is bent. Given that sciatic scoliosis and back pain are symptoms of the same nerve root irritation; these measurements are an objective means of observing the severity and duration of low back pain. Armed with the results of posture tests and postural measurements, we can connect the dots and make sense of the symptoms.

Connecting the dots

Stage 1. The habitual overwork and overstressing of a joint leads to growing instability. When the instability has reached the point where a spinal nerve may be pinched in the joint during an awkward movement, the patient is vulnerable to a back pain episode. At this stage, nothing shows on X-ray.

An episode is characterized by debilitating pain of rapid onset and an accompanying protective postural response e.g. sciatic scoliosis. The protective postural response guards against further nerve root irritation and the pain subsides quite rapidly. In the event of an episode, the pain phase typically lasts for between 6 and 48 hours. Thereafter, the patient experiences backache attributable to the muscular effort involved in maintaining the protective response.

Back pain is a debilitating pain that arises from irritation of a spinal nerve. Backache arises from muscular effort. Backache and morning stiffness may be a consequence of an unaccustomed spell of gardening or a consequence of the sustained muscular effort involved in maintaining a protective response. Muddle backache with back pain and you have a recipe for confusion, as evidenced by the literature.

In the early stages of the complaint, sciatic scoliosis and the associated backache diminishes over a matter of days. As a rule of thumb, if the backache is slow to diminish or if the patient still complains of some residual backache at twelve weeks then the patient is paying scant regard to GP advice on the importance of remaining active.

Stage 2. If the overwork and overstressing of the affected joints continues, joint degeneration is inevitable. We now see narrowing of the disc space and the beginning of the tooth-like bony growths illustrated in Figure 2. We also observe a mild but persistent protective response. Consequently, in place of major episodes set months apart, we tend to see frequent minor episodes set against a background of persistent backache and morning stiffness.

While joint degeneration is irreversible, this degree of wear and tear is not significant. If these patients get light on their feet and active, they can make a prompt and lasting recovery. If they expect treatment to provide the remedy, adopt the persona of the back pain sufferer and avoid activity the prognosis is poor.

Stage 3. If the overwork and overstressing of the joints of the low back continues unabated, further joint degeneration is inevitable. The patient suffers persistent debilitating pain when the protective postural response can no longer deliver relief.

There is no direct correlation between the degree of joint degeneration and the point where the protective response can no longer deliver relief. Sciatic scoliosis involves a shift in the sacro-iliac joints that produces an apparent difference in leg length and the pelvic tilt. If the sacro-iliac is very stiff, it takes more muscular effort to achieve the response and the patient experiences a correspondingly greater degree of backache and morning stiffness. If the sacro-iliac is too fixed to permit an effective response, the patient experiences persistent debilitating pain at an earlier stage. However, if they get light on their feet and active, these patients can still make a lasting recovery.

Stage 4. Habitual dynamic fixation plus the avoidance of activity have combined to produce a significant degree of true fixation. In the presence of true fixation, activity exacerbates the overwork and overstressing of degenerated joints. The patient is now

beyond simple remedy. The term ‘failed back’ is commonly employed to mean failed spinal surgery. In this context, the term is employed to mean persistent debilitating pain and a degree of true fixation that puts the case beyond simple remedy.

Beyond simple remedy does not mean that all is lost. Evidence of the systematic resolution of such cases is attached or otherwise referenced¹. As dry reports do not tell the human story, an example of what is possible may be helpful.

Patient A’s back problem began in 1982. He tried physiotherapy, osteopathy, chiropractic, pain management and underwent two spinal surgeries but things just went from bad to worse. Having been severely disabled for two decades, he attended the Springback clinic in 2006. He has subsequently been exploring France with his bicycle and at the age of 67 is completing cycle rides in hilly and mountainous areas that many young men would find daunting.

The management of these cases is the opposite of the revolving door of treatment dependency that leads to disability. The procedure does not treat joint degeneration and it does not treat pain. It merely restores the supple elasticity of the spine to the point where the patient can get light on their feet and active without exacerbating the overwork and overstressing of degenerated joints. It is learning the subtle shift of balance that produces a profound change of body mechanics and getting active that delivers the lasting benefit. If supple elasticity is restored but the patient fails to get light on their feet and active, the benefits are minimal and temporary.

Fuelling the epidemic

Having made sense of the symptoms and having traced the development of the complaint, we can take a closer look at how mismanagement is fuelling the epidemic of bad backs. Where patients have a long history, the taking of the history may take several hours and require some patience. This is because people modify their history to take account of what they have been caused to believe about their condition and have reinforced these modifications by repeated telling to family, friends and the man in the pub. Busy physicians cannot spend hours taking a history but researchers can and detailed histories are very revealing.

For example, a patient may recall that it all started when they ‘put their back out’. They went to a chiropractor. He fixed it but it came back and since then it has just gone on getting worse. This is a very common account. However, when a detailed history is taken, a different story emerges.

Typically, the onset was such debilitating pain that they could barely crawl. The patient believed that they had ‘put their back out’ and made an appointment with a chiropractor. The first available appointment was three days later. On day three, the patient got up, showered, dressed and went down to breakfast. Thereafter, they drove to town, walked

from the public car park and mounted the stairs to the clinic. Clearly, the debilitating pain phase had passed and the patient was already on a diminishing scale of backache by the time they saw the chiropractor. If this patient had put their back out, whatever that is supposed to mean, then they must, by some mysterious means, have put it back again before attending the clinic.

It is a simple matter to examine the supple elasticity of spines. Combine these observations with detailed histories and a very clear and remarkably consistent pattern emerges. Firstly, while habitual dynamic fixation will lead to true fixation, of itself it may take years, if ever, before the back fails. However, this period can be perilously short if the patient adopts the role of the back pain sufferer and avoids activity.

Secondly, it is commonly assumed that the avoidance of activity relates to the avoidance of pain. This is not so. In case after case, the altered perception and modified behaviour is traced to the first back pain episode. The debilitating pain soon passed but the altered perception and modified behaviour persisted. Neither does the modified behaviour stem from fear of pain.

In case after case after case, modified perception and the avoidance of activity is traced to the fear that their back will 'let go'. Debilitating pain of rapid onset is very alarming. In the first few hours they were helpless and could barely crawl. They got away with it this time but if their back were to 'let go' they would be unable to hold down their job, support their family and pay the mortgage. Instead of a tower of strength, they would become a useless burden to their family. Unaware of the cause of their complaint, they continue to slouch with the weight on their heels and so the complaint rumbles on and this acts as a constant reminder of their fear. Naturally, the patient becomes cautious and avoids activity that might cause their back to 'let go'. Ironically, this provokes the disability they fear.

Dig a little deeper and you discover that their fear was rational insofar as it stemmed from deeply ingrained belief. 'I put my back out' and 'his back let go' are the vernacular of this belief. Ask the patient what they understand by these terms and they typically reply 'slipped discs'. Everyone knows someone who went to a chiropractor who put back a slipped disc. Patients imagine a disc to be something like a shiny piece of cartilage. Show them what a disc is and that it is not something that can slip about and they are astonished.

A prolapsed intervertebral disc is the structural equivalent of dropping a rotten tomato on a hard floor. Needless to say, there is no magic manipulation that can turn a rotten and burst disc back into a healthy disc. If this is explained to the patient, they become very thoughtful.

Patients in the failed back category have typically undergone many months or years of chiropractic and other treatments. Ask the patient "If chiropractors can fix these problems then why did they not fix it in your case?" and they become very thoughtful indeed. It

would be cruel to explain that, at the outset, they will have been suffering from nothing more than a bad habit.

The patient's deeply ingrained beliefs are no accident. They are the product of generations of sustained effort by schools of alternative medicine. They have been very successful. Even respectable newspapers carry articles such as '*osteopath put back my slipped disc*' all in the guise of public information. Through persistent effort, spurious belief has achieved the status of common knowledge.

The most striking feature of detailed histories is the correlation between the rapidity and severity of the slide into disability and the early start and intensity of mismanagement. Typically, these patients describe having turned to alternative medicine on the occasion of their first back pain episode and then being caught in a revolving door of alternative therapies.

Mismanaging the complaint

Osteopaths, chiropractors and physiotherapists in private practice derive the bulk of their income from the treatment of the common back complaint. Their industry relies on persuading people that it is a treatable condition.

These practitioners know that back pain episodes account for the vast majority of back pain complaints and they know that these episodes are self-limiting but their patients do not. Consequently, a practitioner can perform a magic manipulation or wave an ultrasound wand over the painful area and, when the episode subsides, claim it as a triumph for their treatment. It is a recipe for an easy living and a staple income.

It is a good trick and self-perpetuating. When the episode subsides, the patient is impressed and imagines that the practitioner has done something clever like put back a slipped disc. This perpetuates the belief system that makes the trick work.

The detailed histories of patients in the failed back category suggest that the contribution of alternative medicine goes beyond causing patients to believe that they are the victims of an affliction. The chiropractic history of many of these patients is a case in point.

For example, the patient thought they had 'put their back out' and went to a chiropractor. The chiropractor styled himself 'doctor'. Introduced to a doctor in a clinic, the patient assumed the title to mean the same as the title applied to their GP or a hospital doctor. Patients are conditioned to trust the doctor.

The chiropractor now assessed the patient's condition. This assessment is a long and elaborate procedure. This elaborate assessment plays a vital role in the slick presentation of chiropractic. Then comes the diagnosis.

Back pain episodes account for the vast majority of back pain complaints and GPs have no difficulty in recognising a back pain episode when presented with one. However, back pain episode is not a diagnosis employed by chiropractors. On completion of the assessment, the chiropractor informs the patient that there is something wrong with their spine; something that requires a course of chiropractic treatment. Chiropractors employ forceful manoeuvres and high-velocity thrusts to ‘adjust’ the spine.

In the early stages of the complaint there is no evidence of joint degeneration and, in any event, joint degeneration is not something that can be reversed by spinal manipulation. Orthopaedic specialists and spinal surgeons equipped with the most advanced scanning equipment cannot observe this ‘something wrong with the spine’ or even imagine what it might be. This is why the common back complaint came to be termed idiopathic; meaning cause unknown. Chiropractors cannot even agree among themselves what this ‘something wrong with the spine’ is or how spinal manipulation is supposed to fix it. However, the patient knows nothing of this and begins a course of treatment.

Typically, by the time the patient attended the chiropractor, the debilitating pain phase had passed and the patient was on a diminishing scale of backache; as evidenced by the fact that the patient was able to get up, shower, dress, go down to breakfast and travel to the clinic. This is a classic back pain episode that would ordinarily be expected to self-limit. However, in spite of or because of the forceful manoeuvres and high-velocity thrusts of spinal manipulation the episode did not self-limit in the normal way.

The patient was advised that they needed regular treatment to keep their condition under control. The forceful manoeuvres and high-velocity thrusts continued and the patient’s condition deteriorated. When the symptoms became severe enough, the patient was advised that their condition was now becoming serious and that they required more regular treatment; as often as three times a week towards the end. Their condition deteriorated further and this is when the patient turned to the surgeon and expected miracles to be performed. It is an appalling outcome for something that starts out as nothing more than a bad habit.

There is no reliable evidence linking spinal manipulation to prognosis and the characterisation of chiropractic reflects the writer’s opinion. However, if repeated spinal manipulation is not injurious then the onus of proof is on the chiropractic profession. In the absence of such proof, we should be very concerned.

The notion that the millions who have ‘a bit of a back’ and everyone who suffers a back pain episode have all got something wrong with their spine is absurd. It is particularly absurd given that orthopaedic specialists, spinal surgeons and skilled radiographers can find no evidence to support the notion. If it is not absurd then the onus of proof is on the chiropractic profession.

Moreover, if patients do not understand what is alleged to be wrong with their spine and how spinal manipulation is supposed to fix it then they cannot consent to treatment. Consent implies informed consent.

The principle is irrefutable. Given that chiropractic diagnoses and spinal manipulation are practiced on the public, it is incumbent on the chiropractic profession to produce credible evidence of this something that must be corrected by manipulation and subject the evidence to scrutiny. Failing that, if an acute case becomes chronic or the patient's condition deteriorates and they become disabled, chiropractors have a case to answer. A test case would be very revealing. The same arguments apply to osteopathy and the rest.

In the absence of such evidence, the following advice is proffered. Learn the subtle shift of balance that produces a profound change of body mechanics and get light on your feet and active and the problem will go away. If you continue to slouch with the weight on your heels, the complaint will rumble on and you risk becoming old before your time. Believe that you are suffering from an affliction, not diagnosed by an orthopaedic specialist or rheumatologist, and get trapped in the revolving door of alternative therapies and you risk acquired disability and a ruined life.

People who suffer back pain sue their employers. And yet, the common back complaint is not an accidental injury and has nothing whatever to do with employment. This is true even where there is evidence of a prolapsed intervertebral disc. Healthy discs do not prolapse during extreme sport. Degenerated discs can and do when coughing or turning over in bed. A prolapsed intervertebral disc is evidence of joint degeneration, not accident. It is the mismanagement of the complaint, not employment, that is fuelling the epidemic of bad backs.

Getting the epidemic under control

Until such time as medical science is satisfied with the conclusions, every statement must be treated as a question. However, every GP is familiar with the marked sciatic scoliosis that is observed at the onset of a severe back pain episode and how it diminishes in a matter of days. Question this observation and it is a small step to posture tests and postural measurements. A mass of familiar observations then fall into place and the complaint ceases to be enigmatic. Identify the cause and the remedy presents itself.

This rudimentary complaint would surely have been understood long ago but for the fact that, while physicians and scientists tackled a host of complex organic disorders, primary back care has been the fiefdom of osteopaths, chiropractors and therapists. Influenced by their claims of knowledge and expertise, what has passed for back pain research has largely consisted of testing various treatments: based on the assumption that the common complaint is a treatable condition.

Such studies as have been conducted are fundamentally flawed insofar as they fail to distinguish between backache and back pain. In a randomized study, the vast majority will present with mild to moderate back pain episodes. By the time they enter a study, the pain phase has passed and they are already on a diminishing scale of backache. This diminishing scale is monitored by self-assessment of the type...how is your pain today on a scale of 1-10? These scores better reflect the patient's mood and circumstances than their condition. Typically, a self-employed mason will be back at work in two or three days while clerical staff in secure employment will be incapacitated for some time. This unreliable data is then subjected to statistical analysis designed to contrast shades of grey. Now add interpretation to taste and present as science.

Ideally, there will be a controlled trial of the BOF technique based on GP practices. Instead of starting down the road of prescription drugs and referrals, acute cases would be taught the BOF technique. Long-term back pain sufferers would be encouraged to participate in a change of management and their progress monitored. However, great care must be taken with the design, controls and interpretation of the study.

The significance of the systematic resolution of cases of debilitating back pain that have persisted for years¹ is obvious because, in this category of patient, there is no pattern of spontaneous recovery and the magnitude and lasting nature of the benefit render placebo effects irrelevant. However, early stage and mild cases are more difficult to observe because the issue is behavioural. *As the symptoms subside, old habits may reassert themselves. In which case, the symptoms are liable to recur. If they do then the patient will remember the remedy. The patient is in control. Given the nature of the complaint, the patient is the only person who can provide the remedy.* The design of a meaningful study of early stage and mild cases is a challenge for experts.

Nevertheless, the remedy is proven by simple experiment. Learn the subtle shift in balance that produces a profound change of body mechanics and back pain sufferers soon discover the benefit. If old habits do not reassert themselves, the benefits are lasting. Even severe cases of long-term disability can be resolved; subject to the patient being motivated to learn and get active¹. Given that the complaint is rudimentary and the remedy simple, getting the epidemic of bad backs under control should be a simple matter. GPs manage conditions that are far more complex and public education should do the rest. However, the work may have to be completed in another country.

In the UK, we have a system of state medicine. It is not the state funding of medicine that is the problem; it is the micro-management of medicine by politicians. Physicians are employed by the state and are not free to exercise their knowledge and intellect. The state prescribes policy, the procedures it funds and the targets it sets. This has some bizarre consequences but few as bizarre as the management of back pain.

Politicians have draped the institutions of osteopathy and chiropractic in the robes of state; granted them statutory powers and public money. The state has taken money from frontline medical services to fund alternative medicine. Physicians specialising in pain

management, for example, may not exercise their judgement on the use of steroid injections to keep their patients mobile. Instead, patients shall be referred to a chiropractor or for acupuncture. The fate of back pain sufferers shall be entrusted to alternative medicine. It is like pouring oil on a fire. If there is no change of policy, billions will continue to be wasted; lives will be needlessly ruined and quacks will continue to prosper while their victims sue their employers.

Robert Taylor

References

1. CLINICAL AUDIT CARRIED OUT AT THE SPRING-BACK CLINIC 2008

By Dr N C G Richards MBBS DIH DRCOG MRCGP MFOM:

To see the report click <http://development2.gloversure.co.uk/springback/pdf/CA.pdf>

- 2.** The clinical trial referred to above (Evidenced-based Management of Acute Low Back Pain...Bart W Koes...The Lancet – Vol. 370, Issue 9599, 10 November 2007, Pages 1595-1596) can be viewed online on payment of a fee to the publishers. The trial appears to be exceptionally well designed and compares the outcomes when patients are treated with NSAIDs, manual therapy and placebo. The outcomes were the same in all groups and at 12 weeks almost 99% had recovered. Before paying the fee, it is worth bearing in mind that observing the progress of patients for 12 weeks after the onset of an episode sheds little light on the cause and nature of the complaint. Moreover, the 'Acute Low Back Pain' title is misleading. By the time these patients entered the study, the pain phase will have passed. This sort of study is actually observing a diminishing scale of backache.