Author's response to reviews

Title: Staying at work with back pain: patients' experiences of work-related help received from GPs and other clinicians. A qualitative study.

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RESPONSE TO REVIEWERS

Thank you for your invitation to submit a revised manuscript. We are grateful for the reviewers’ comments and address their concerns point-by-point below. All changes have been highlighted in the manuscript. In addition, all changes have been highlighted in the manuscript and cross-referenced with comment insertions.

Reviewer 1:  Sarah Dean

NB: The report states that it is a ‘re-review’ of the paper, rather than a first review. This is perhaps a typing error.

Major compulsory revisions

Please include gender as one of the variables reported when describing the participants.

Gender has now been included as a variable in the description of the study sample in the Results section (Comment: Reviewer 1.1) and for each participant quoted in the results.

Please clarify what is meant by ‘large’ employers when describing the workplace of participants. Although these two points are covered in the earlier paper it would help to have at least these details repeated here to allow this paper to stand alone in terms of describing its participants.

The description ‘Large’ employers has now been clarified as those with >250 employees in the Results section (Comment: Reviewer 1.2).

Please include (PT) in the first quote on page 8 to identify who ‘he’ is (first line of quote). In same way that the second quote has (GP) inserted to clarify who is saying what.

The term ‘he’ in the third quotation in the third theme has been clarified by inserting the word ‘physiotherapist’ in brackets (Comment: Reviewer 1.3).

Please clarify (if need be by inserting a comment in brackets) what ‘paper’ means in the first quote, top of page 10. I presume it means certificate?

The term ‘paper’ included in the last quotation in the fourth theme has been clarified by inserting the term ‘sickness certificate’ in brackets (Comment: Reviewer 1.4).

Please expand on the comment made in first line of the ‘strengths and limitations’ section. In what way were early interviews constrained?

This comment was made to reflect the fact that the interview guide was revised as the interviews progressed in order to explore some of the topics in greater depth. However, this explanation has now been included in the section (Comment: Reviewer 1.5).

Minor essential revisions

Insert ‘at work’ at end of sentence, line 5, page 13.
The words ‘at work’ have now been inserted at the end of the sentence in the Discussion (Comment: Reviewer 1.6)

Insert apostrophe for ‘patients’ feel’ on line 6, page 13.
An apostrophe has been inserted in ‘patients’ feel’ in the Discussion (Comment: Reviewer 1.7)

Discretionary revisions

Consider inserting a table to show number or proportion of participants who contributed to each theme

We do not feel that a table detailing this information is required.

Consider including standard deviation of participant age, or perhaps range of ages.
We have inserted the age range in brackets following the mean age in the Results section (Comment: Reviewer 1.8).

Referee 2: Padraig MacNeela

Major revisions

The question defined by the authors is not well defined, at the end of introduction the aim is to explore ‘the experiences of employed people with back pain and identifies factors that are important to them in continuing to work’ -- that is quite a broad question and may be appropriate, but does not tally with the introduction, which focuses on GPs, and the analysis, which focuses on perceptions of GPs and other clinicians.

We agree that the research question could be more clearly defined. The sentence at the end of the Introduction now reads (Comment: Reviewer 2.1):

‘In contrast, few studies have examined this area from the perspective of the client. This study explores the experiences of employed people with back pain regarding the help they have received from GPs and other clinicians regarding work.'

The study is framed for the most part in terms of GPs and their role, yet several references are made to what other clinicians such as physiotherapists do, and the aim refers to patients and factors that might influence their continuance at work (including presumably factors we don’t
know about from this study, such as attitudes to work, family support, relationship with partner, and so on); can the study focus be resolved one way or the other?

The study aimed to explore the help received from healthcare providers regarding the management of their back pain at work. All the participants would have contacted their GP at some stage and we have stated that GPs are intimately associated with decisions to remain in or be absent from work, hence the emphasis on the GP role. However many participants had also consulted with other clinicians, mainly manual therapists, through the NHS and/or the private sector. We therefore felt that these experiences also needed to be explored and presented. We have added further detail to the Introduction to clarify the main focus of the research (Comment: Reviewer 2.2a):

‘Compared with most other countries within the European Union and North America there is little occupational health provision in the UK, and for the majority of the UK population the general practitioner (GP) remains the main source of advice on work-related health and sickness certification. In addition, other clinicians, particularly physiotherapists, chiropractors and osteopaths, are commonly accessed by those seeking help with with back pain [5,6]. Practice guidelines recommend that all healthcare providers reassure patients with low back pain, allay fears and encourage the maintenance of, or return to, normal activity including work’.

And also in the Introduction (Comment: Reviewer 2.2b):

‘Other studies have demonstrated that the attitudes and beliefs of physical therapists and GPs, including their own anxieties about pain causation influence the advice and help they give patients about work [9-11]’.

And further detail in the Discussion section (Comment: Reviewer 2.2c):

‘Alternatively they may consult other healthcare professions instead, particularly manual therapy which is recommended as a core intervention for non-specific low back pain [17]. A recent study by Pincus et al [18] suggests that low back pain comprises 70% of the caseload of private musculoskeletal practitioners, and that these tend to be patients with long term recurrent symptoms rather than acute episodes. A study by Foster et al [5] concluded that low back pain accounted for at least 50% of physiotherapists’ workload; this proportion may increase further as the government intends to increase the provision of self-referral to NHS physiotherapy [19].’

And also (Comment: Reviewer 2.2d):

‘UK healthcare professional bodies have signed a Consensus Statement, pledging to ‘do all we can to help people enter, stay in or return to work’ [30], but as yet, with no clear lines of responsibility or pathways of communication, patients seem to be left to rely on their own resources’.

And the following paragraph in the ‘strengths and limitations’ section of the Discussion to recognise that this study did not aim to address all necessary factors (Comment: Reviewer 2.2e):

‘Other factors are essential to consider in the overall study of work retention and with low back pain such as the context of the workplace and home situation, but these were not the aim of this piece of research. However, our study does highlight the issues and challenges specific to the context of healthcare’.
The methods are not sufficiently well defined at present -- 'recruited by clinicians at routine back clinic assessment' (not clear how they ended up in the back pain clinic), numbers as to particular type of work, more information on demographics (breakdown of gender, age). What was involved in the group rehabilitation they were eligible for, e.g. was it minimal or an extensive commitment?

The Methods section details that ‘the participants were recruited by clinicians during routine back clinic assessment following referral by their GP or other healthcare professional’. We have also now described this in more detail in the introduction to the Results section [Comment: Reviewer 2.3a]:

‘Most, but not all of the participants had been referred to rehabilitation by their GP. In some cases this was as a result of by seeing a different GP at the practice than usual, or had arisen during a consultation about another condition. A small number had been referred from secondary care, e.g. Rheumatology or Pain Clinic.’

We have also included more detailed information on demographics in the Results section [Comment: Reviewer 2.3b]:

‘Twenty-five patients participated in the study, representing private and public sector workers; professional, skilled, semi-skilled and unskilled work; manual and non-manual occupations. Twenty worked for large employers (>250 employees). Six had never taken sick leave for back pain. Six were off sick due to back pain at the time of the interview, two for more than six months. The mean age of the participants was 44.7 years (range 22-58yrs), with a mean back pain history of 6.8 years. Twelve were male, thirteen female. Further demographic details have been published previously [13].’

We have described the intensity of the group rehabilitation in the Methods section [Comment: Reviewer 2.3c]:

‘a seven-week community-based group rehabilitation programme (21 hours in total)

The discussion and conclusion would benefit in being more balanced, which could be achieved by taking a view on GP attitudes, as in my view the contention that GPs simply need more training is not getting at the underlying issue, in fact it is important to understand the attitudes GPs have toward patients with back pain, they may be resistant to changing their views so I doubt it is a straightforward issue of not having been exposed to the right training to date.

We agree that the discussion and conclusion need to address the fact that training alone may insufficient in changing GP management of patients’ work problems and have reflected this in the Discussion section [Comment: Reviewer 2.4]:

‘Early return to work with a musculoskeletal disorder has been associated with GPs providing advice on managing a recurrence and contact with the workplace [25] but these are not requirements of the fit note. The ‘work-focused’ advice and support provided by healthcare providers will be dependent on their knowledge, skills, attitudes and beliefs. Further training may help to address educational needs, but may be insufficient alone in addressing attitudes; having an interest in back pain does not necessarily improve occupational management [22] and a recent systematic review has concluded that there is inconsistent evidence that educating doctors in evidence-based guidelines has a positive effect on their management of low back pain[27].'

The limitations should talk about the diversity of the sample -- while a strength of the research is that a broad understanding of the phenomenon is achieved, a weakness is that the diversity
of the sample limits the potential to build up a highly focused understanding e.g. in terms of understanding people in manual work and their position with relation to work, or a perspective that takes gender into account, and so on.

We agree that the diversity of the sample should be addressed in the limitations section of the Discussion and have inserted the following sentence [Comment: Reviewer 2.5]:

‘A strength of the research is that it provides a broad understanding of the issues involved, although the diversity of the sample also limits the potential to understand in depth the experiences of different sub-groups in terms of for example age, gender, occupation’.

Minor Essential Revisions

The introduction would benefit from a better introduction to perceptions that GPs have of back pain patients, and on the relationship between the GP and the patient, as these factors bring about a problematic context, according to past research.

We agree that the relationship between the GP and the patient is important and have inserted the following sentence in the Introduction [Comment: Reviewer 2.6]:

‘However, previous studies have identified the problems that GPs have in managing consultations and sickness certification for back pain, including for example the balance of maintaining the doctor-patient relationship whilst challenging patients’ expectations and perceptions of the consultation [7,8].’

First paragraph of results: some detail on participants is given which is better placed in the methods in describing the sample.

We accept that some qualitative studies may describe the participants in the Methods section, however we feel that this information is more appropriately placed in the Results section.

At the beginning of findings I would find it helpful to see some characterisation of the GP care the patients received in general, e.g. was the performance in relation to work an exception to what was otherwise a satisfactory relationship or did reflect a perceived disengagement overall? How frequently did these patients attend the GP?

We agree that this point would be of interest. We did not systematically address the care that participants had received in general from their GP although it did emerge during the interviews that the relationship with the GPs was varied and that in some cases this had affected the decision to consult. The following sentence has therefore been inserted at the end of the first theme [Comment: Reviewer 2.7]:

‘Participants varied in their relationship with their GP. The frequency with which patients had consulted their GP is not known. Some had rarely needed to consult their GP or had chosen not to as a result of previous experiences. Some reported a very good relationship, others less so. Several reported different experiences within the same practice or by changing practices.‘

Reference is made to a low level of consultation but presumably the doctor referred the patients to the back rehab programme?
Most, but not all participants were referred by their GP. Some could potentially have been referred earlier but had either not consulted as they did not perceive that the GP had much to offer, or did not get on with their GP, or their GP had referred them elsewhere initially. We have now addressed this concern as per the paragraph inserted in the Results section in response to item 3a above (Comment: Reviewer 2.8):

‘Most, but not all of the participants had been referred to rehabilitation by their GP. In some cases this was as a result of by seeing a different GP at the practice than usual, or had arisen during a consultation about another condition. A few had been referred from secondary care, e.g. Rheumatology or Pain Clinic.’

Under the second theme the first quote presents a very negative impression, is this indicative of other quotes or an extreme example?

This is an extreme example when the views of the GP as to his role was made explicit. However, other studies have demonstrated that GPs do feel that occupational health should play a greater role (refs 23,24). We have clarified that experiences varied, and that the quotation was from one participant by the following alteration to the wording (Comment: Reviewer 2.9):

‘When they had consulted their GP, many participants reported that they had not received any advice or support in relation to work that they had found effective. It seemed that some GPs were more inclined to offer help than others. One participant who worked for a large public employer described how her GP had not considered it to be his role’:

The third quote under the second theme -- should we take it that a doctor would say 'nothing, have a paracetamol' and in effect make a diagnosis over the phone?

This may be unlikely, but we are reporting the experience and perception of one participant. This participant had reported that he avoided consulting his GP because he was upset at the way he had been managed, and contacted NHS Direct instead who directed him to A & E. They advised him to see his GP but he again decided against this. Six months later he saw the practice nurse about another health condition who suggested he saw another GP in the practice who referred him to Rheumatology, We are unable to verify what actually took place during the phone conversation, but his perception was that the GP had been unsympathetic and unhelpful, and his response to this was to avoid further consultations with the GP.

We have inserted the following sentence (Comment: Reviewer 2.10):

‘As a result, this participant reported that he then delayed consulting his GP further because he was upset at the GP’s response’.

Theme 3 -- first paragraph, 'implying that work was connected with their symptoms' -- isn't this a reasonable assumption to make?

We agree that this wording is unclear. We have replaced this sentence with the following (Comment: Reviewer 2.11):

‘Several participants described how GPs and other clinicians advised avoidance of work or particular tasks, implying that work would exacerbate their condition or could place them at risk, rather than form an essential part of their recovery’.
The introduction of chiropractors in theme 3 makes me wonder about the purpose -- isn't it now moving from a broad sample to now introducing another professional group (soon to be joined by physiotherapists) so in turn do we not lose focus on the phenomenon?

As stated earlier, manual therapists are commonly consulted by patients with back pain as well as GPs and therefore we feel it important to include the participants’ experiences of those consultations which were raised by them.

The last text paragraph between theme 4 introduces the idea of patients being told not to do anything, to restrict activity, yet earlier we heard about doctors encouraging patients to remain active; is there a dual attitude here to be explored, is there a difference in attitudes between professional groups, or how can this issue be resolved?

Both approaches reflect the need to tailor advice to the workplace – simply advising a patient to stay at work, although adhering more closely to the guidelines, may be insufficient. We have made this more explicit in the Discussion (Comment: Reviewer 2.12):

’Simplify advising a patient to stay at work, although reflecting clinical guidelines to remain active, is of little practical help and may be misconstrued as ignorance’

The last quote of theme 3 gives an important insight on the patient’s attitude to work; I find in this article a lot of responsibility is being attributed to the doctor, but equally it is important to understand context given by the patient’s expectations for medical care (how much should we rely on doctors to help us get back to work) and their work attitudes (here the patient says 'if I wanted a job doing lighter work I would have found one a long time ago').

Theme 4 -- the second quote cited for theme 4 also gives an important context of self management -- 'I just deal with it at the weekends', so I think there is an interaction of doctor and patient that we need to know about to understand attitudes to work continuance, but we don’t get that interaction at present.

We have linked these comments together as they raise similar points. We agree that the context of the patient’s expectations of medical care and their attitudes to work are important. This aspect is partially addressed this in the discussion but we have now increased the emphasis given as follows in the Discussion (Comment: Reviewer 2.13a):

Laypersons/patients on the other hand, may see themselves as responsible for managing musculoskeletal disorders [29] and/or have varied expectations of the help that GPs and clinicians can provide.

And in the Conclusion as follows (Comment: Reviewer 2.13b):

‘Patients’ expectations of healthcare regarding work support and advice may need to be challenged.’
The following paragraph --- ‘the only example of a GP using the 'remarks' section’--what is the basis for this contention, were you reviewing sick cert documentation as well?

We asked participants what their GP had written on the sickness certificates and other participants reported that this had been limited to ‘back pain’. We did not formally review sickness certificate documentation.

In the paragraph following this, we see the context provided by the employer ‘they’ll be alright with that’ -- so the employer is kind of invisible as an influencing factor

We agree that the influence of the employer is key factor, but this was not a focus of this study.

Terminology -- ‘signed off’ -- maybe in other cultures there will be limited understanding of specific terminology such as this

We agree that the terminology needs clarification, and have inserted the term ‘sickness certificate’ where appropriate.

Theme 5 -- was the low evidence of dialogue reflective of the relationship between doctor and patient overall? This is important as later the contention is made that more training is needed, yet if there is a problematic relationship overall I don’t think it will be as simple as that.

We agree that this is an important factor, however we did not collect data about this. However, we have argued that the relationship may affect participants’ decision as to whether to consult the GP.

Theme 3 and Theme 5 include a lot of references to other professions, but I find the introduction and discussion are oriented toward understanding GP care, so I would recommend the perspective is broadened, or else more focus placed on data about GPs

The introduction and discussion have now been broadened to include other professions.

We get a largely rationalistic discourse from patients in the quotes, I don’t hear the frustration and emotional turmoil that is also associated with back pain. Was there any evidence or discussion of informal coaching, reassurance etc. that often happens as the emotional component of GP care?

As stated, most participants reported having a satisfactory relationship with their GP. It could therefore be assumed that informal coaching, reassurance etc. did take place during the consultation, but these factors were not raised by the participants. We feel that a number of the contributions made by the participants do reflect the frustration associated with back pain, e.g. the quotations in the second theme (pages 5 and 6, the last quotation in the third theme (page 7), the first quotation in the fourth theme (page 8).

Overall, the theme titles could be looked at to characterise them better in humanistic language, they are phrased in rather technical terms, which does not seem very consistent with the approach to thematic analysis outlined.
These were the titles that most accurately seemed to reflect the themes.

In the conclusions, the point is made that patients' expectations may need to be challenged, while this is interesting I don't see any discussion of this up to this point in the article.

This concern relates to point which has now been addressed (Comment: Reviewer 2.13a/2.13b).

SUMMARY

In summary, we have actioned all of the compulsory and essential revisions requested by the first reviewer. We have actioned all of the major revisions requested by the second reviewer, and the majority of the minor essential revisions. Where we have held a differing viewpoint from the reviewer we have given justification for our decisions.

In order to address the concerns of the reviewers we have added six references [5, 6, 10, 17, 27, 30] and deleted previous reference 14 (Campbell and Cramb) which we felt that this was of less relevance to the paper than those added. We have made some minor clarifications to the text as shown by the insertions.