Education can 'change the world': Can clinical education change the trajectory of individuals with back pain?

Mary O'Keeffe,^{• 1} Peter B O'Sullivan,² Kieran O'Sullivan^{• 3}

This fourth and final *BJSM* editorial spotlighting *Lancet*'s 2018 low back pain (LBP) series^{1 2} focuses on four ways clinicians can provide patients with an invaluable treatment—education. This editorial excludes public education via mass media as that has been covered previously.³

Nelson Mandela asserted that 'Education is the most powerful weapon you can use to change the world' and education is recognised as the first line treatment for individuals with LBP.^{1 2} Education is a low-risk, low-cost intervention—the foundation for managing LBP. At the same time education's modest effect size means it is not a panacea for the condition. In this editorial we aim to provide BJSM readers with a four-step accelerated and concise summary of how to use the education evidence to treat individuals with back pain.

LISTEN AND CONNECT

Traditional clinical training prepares us to ask people with LBP a series of questions to help pinpoint the pain 'source' to guide management. However, we are usually unable to identify any one source or pain generator, and instead LBP involves a complex interplay of multiple factors.⁴ Therefore, gathering wider information about the person's unique pain experience may provide better insights.⁴ Providing each person with the space to disclose their pain story in detail may facilitate education in a more personally relevant manner.⁵ Educational strategies which merely 'tell' people what to do have failed to change behaviour.

In fact, listening and data gathering has been shown to be as effective as an information giving intervention for acute LBP, or recurrence of episodes of LBP.⁶

Correspondence to Dr Mary O'Keeffe, School of Public Health, Faculty of Medicine and Health, University of Sydney, Sydney NSW 2050, Australia; mary.okeeffe@sydney.edu.au

REASSURE

While there is debate regarding what constitutes effective solutions to LBP, there is more certainty around the nature of pain, its natural history, recurrence and drivers of disability. Cognitive reassurance (eg, information, education) appears to reduce fears and concerns about LBP more than affective reassurance (eg, empathy) in the long term.⁷ It is important to emphasise the non-life-threatening nature of most LBP, and the importance of safely engaging in work and physical activity.

Education about the positive natural history and benign nature of LBP can provide long term reassurance, reduce pain-related distress and reduce health-care utilisation in patients with acute and subacute LBP.⁸ Our skills in clinical examination and treatment can also be used to reassure people with LBP regarding any personal fears (eg, engaging in valued activities). It is worth noting that reassuring educational interventions as short as 5 minutes can benefit people for up to 12 months.⁸



Figure 1 Four pillars of education for individuals with low back pain.





1

¹School of Public Health, Faculty of Medicine and Health, University of Sydney, Sydney, New South Wales, Australia

 ²School of Physiotherapy and Exercise Science, Curtin University, Perth, Western Australia, Australia
³Sports Spine Centre, Aspetar Qatar Orthopaedic and Sports Medicine Hospital, Doha, Qatar

DEBUNK MYTHS

Unhelpful myths regarding LBP persist in clinical practice.³ A key role for education is to dispel these myths where present, as they may act as barriers to self-management. These include the presumption that imaging is vital and imaging findings always relate to LBP; that pain is an accurate indicator of tissue damage; that pain-provoking activities should be avoided, and that the spine is vulnerable and must be 'protected' during daily tasks.³ Providing links to publicly available resources on these discussions.⁴

EXPLORE MOVEMENT AND LIFE

When we think of education, we often think of the verbal explanations we deliver. However, healthcare professionals can also facilitate powerful learning by leveraging our expertise in human movement. Obstacles to physical activity and hobbies include low self-efficacy and fear avoidance. Therefore, behavioural experimentation may be a powerful way of demonstrating to people with LBP that movement and activities can be safe.⁴ This can involve safely returning people to personally relevant activities that they fear, avoid, or find painful.

THE END-GAME: PUTTING THE PERSON WITH PAIN IN THE DRIVING SEAT!

While there is a lack of robust evidence in this area, we contend a 'successful' educational intervention for LBP is likely to be one which gives people the information and understanding to self-manage their LBP.

We believe more research is needed to disentangle exactly how education should be delivered, in what format, when and what the content should be. We require more qualitative studies focusing on perceived needs, barriers, preferences and expectations among both people with pain and clinicians, as well as clinical trials where we test different approaches to education.

However, using these four aspects (listening and connecting; reassuring; dispelling myths; exploring valued activities) (figure 1) can enable the positive health approach to LBP that is envisioned by the *Lancet* series; the ability to adapt and to self-manage in the face of social, physical and emotional challenges.^{2 3}

Acknowledgements We thank Kevin Wernli for creating the infographic that accompanies this editorial. Kevin is a physiotherapist and is currently doing his PhD in Curtin University in Perth, under the supervision of Professor Peter O'Sullivan.

Contributors MOK was primarily responsible for study conception and design. MOK drafted the first version of this manuscript. All authors (POS and KOS) provided critical evaluation and revision of the manuscript and have given final approval of the manuscript accepting responsibility for all aspects. Kevin Wernli created the infographic for the editorial.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests KOS serves in a voluntary capacity as Senior Associate Editor of BJSM. All three authors conduct research on a behavioural intervention called cognitive functional therapy (CFT) which places a strong focus on patient education. All authors have received payments for clinical workshops on CFT.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

© Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.



To cite O'Keeffe M, O'Sullivan PB, O'Sullivan K. *Br J Sports Med* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/bjsports-2018-100190

Accepted 14 January 2019

Br J Sports Med 2019;**0**:1–2. doi:10.1136/bjsports-2018-100190

REFERENCES

- 1 Buchbinder R, van Tulder M, Öberg B, *et al*. Low back pain: a call for action. *Lancet* 2018;391:2384–8.
- 2 Foster NE, Anema JR, Cherkin D, et al. Prevention and treatment of low back pain: evidence, challenges, and promising directions. *Lancet* 2018;391:2368–83.
- 3 O'Keeffe M, Maher CG, Stanton TR, et al. Mass media campaigns are needed to counter misconceptions about back pain and promote higher value care. Br J Sports Med 2018:bjsports-2018-099691.
- 4 O'Sullivan PB, Caneiro JP, O'Keeffe M, *et al*. Cognitive functional therapy: an integrated behavioral approach for the targeted management of disabling low back pain. *Phys Ther* 2018;98:408–23.
- 5 O'Keeffe M, Cullinane P, Hurley J, et al. What influences patient-therapist interactions in musculoskeletal physical therapy? Qualitative systematic review and meta-synthesis. *Phys Ther* 2016;96:609–22.
- 6 Traeger AC, Lee H, Hübscher M, et al. Effect of intensive patient education vs placebo patient education on outcomes in patients with acute low back pain: a randomized clinical trial. JAMA Neurol 2018.
- 7 Pincus T, Holt N, Vogel S, et al. Cognitive and affective reassurance and patient outcomes in primary care: a systematic review. *Pain* 2013;154:2407–16.
- 8 Traeger AC, Hübscher M, Henschke N, et al. Effect of primary care-based education on reassurance in patients with acute low back pain: systematic review and meta-analysis. JAMA Intern Med 2015;175:733–43.