The perspectives and experiences of physiotherapists and general practitioners in the use of the STarT Back Tool: A review and meta-synthesis.

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Abstract

Background: Chronic low back pain is associated with disability and work absence. Stratified primary care management of acute low back pain using a prognostic screening tool (STarT Back) allows triage of those at risk of chronicity. Primary health practitioners can use this method of stratification to assess patients with low back pain then allocate them to matched treatment groups. STarT Back was designed for use in the health service in the United Kingdom (UK) where stratification using STarT Back has been shown to improve clinical outcomes, patient satisfaction, and reduce treatment costs and time off work. Implementation of STarT Back in health care systems outside of the UK is in an early stage and its success is dependent on the health practitioners using it and the healthcare system in which they work. Gaining health practitioners' perspectives on STarT Back is an important step in effective implementation. This will help contextualise the tool to each healthcare environment, making it easier and more meaningful for intended users.

Methods: A computerised search of qualitative literature was conducted across seven databases in August 2020 using keywords to identify studies that investigate the perspectives of physiotherapists and general practitioners on the use of STarT Back in primary health care. Study quality was assessed using the CASP tool. Data were analysed using reflexive thematic analysis.

Results: Eight articles met the inclusion criteria where qualitative data was retrievable and included the views of general practitioners and physiotherapists from primary health care settings from four countries. Participants' perspectives varied across the data, and three key themes were created from these findings: 'making it work', 'will I do it?', and 'it's all about the patient'.

Conclusions: Physiotherapists and general practitioners found using STarT Back frequently enhanced their practice. General practitioners did express concerns about time constraints and the potential for STarT Back to undermine their clinical experience. Findings from this study will inform adaptations of STarT Back to ensure successful implementation into different health contexts.

Background

Low back pain (LBP) is a significant problem worldwide; prevention and management strategies have not reduced escalating prevalence rates (1–8). Studies of the trajectory of LBP indicate a natural course that will include some or all the following: recurrent and persistent, mild, recovering, severe, chronic or fluctuating symptoms. A high proportion of those with LBP have episodes that recur over a lifetime (9–13). The varied presentation of LBP makes it difficult to manage, as the point of transition from acute to recurrent and later to chronic LBP is indistinct. It is estimated that approximately 10% of people with acute LBP go on to develop chronic LBP which often results in disability and work absence (4, 11, 14, 15). Globally the impact on society is significant, in the personal cost of pain and suffering and the financial cost of treatment and work absence. (6, 16–18)

Low back pain affects all age groups and is influenced by biological, social and psychological factors (9, 13, 19–22). Traditionally a biomedical approach has been used to manage LBP (23). However there is compelling evidence of an association between the presence of psychosocial factors and the propensity for acute LBP to become chronic (15, 18, 24–26). This has led to the development of management strategies which consider psychosocial factors.

Low back pain is a condition which is appropriate for stratification due to the heterogeneity of the population, the diverse treatment options available and the variable prognosis (27). Several screening tools have been developed for the management of LBP; the *STarT Back Screening Tool* (SBT) (28)(<http://www.keele.ac.uk/sbst/startbacktool/>) was designed, developed and tested in the United Kingdom to support primary health care practitioners such as physiotherapists (PTs) and general practitioners (GPs). The evidence-based recommendation is for STarT Back to be

used at the first contact for each new LBP episode (National Institute for Health and Care Excellence [NICE], 2016). STarT Back is a 9-item questionnaire prognostic screening tool. It identifies psychosocial risk factors for developing chronic LBP (29). Patients are stratified to receive targeted treatment, matched to their level of risk (30): Low risk patients require one treatment session which includes assessment and evidence based education on self-management; medium risk patients also receive education on self-management and an additional six sessions of evidence based physiotherapy; high risk patients receive the same as for medium risk and psychologically informed physiotherapy (15, 31–33). This strategy of screening and matched care, supports health practitioners in clinical decision-making, enhancing efficiency of healthcare. (27, 34, 35). STarT Back has been shown to reduce health care costs, individual suffering and productivity loss in the UK (4, 15, 33, 36).

STarT Back was initially validated for use in the National Health Service in the UK (31) and has since been used in a number of countries. However, the introduction of a stratification tool into a primary care setting is dependent on those who will administer it and the constraints imposed on them by the health care system in which they work (32). Consequently understanding practitioners perspectives of STarT Back and the environment they work in, will help address barriers to successful implementation (32, 37). This study is a systematic review of studies investigating the perspectives of physiotherapists and GPs on the use of STarT Back in clinical practice.

Methods

The review was conducted using Preferred Reporting Items for Review and Meta-Analysis guidelines (PRISMA; (38)). Search terms were developed to identify studies relating to the perspectives on the use of STarT Back and were adapted for different databases (see Table 1). Key terms included low back pain, stratified care (STarT Back), the health care practitioners (physiotherapists and general practitioners), and beliefs, experiences and perspectives of those administering the tool. Databases searched were CINAHL, MEDLINE, Sport Discus, Scopus, Web of Science, Cochrane Review Database, and Cochrane Central Register of Controlled Trials from 2008 (STarT Back inception) to August 2020 and were imported into bibliographic management software (Endnote X8). Duplicates were identified and removed. Title and abstracts of articles were reviewed against inclusion and exclusion criteria to identify relevant articles by two reviewers (FT and JH). Full texts were then reviewed using the same eligibility criteria by FT. JH independently reviewed the identified eligible full articles for inclusion.

Reference lists of all included articles were searched for additional relevant articles and two authors (Hill, JC and Caeiro, C) were contacted and invited to view the final article list to ensure all relevant literature had been included.

Table 1
Search terms used

Criteria	Search terms used
Health care practitioners: Physiotherapist General practitioners (GP)	"health* practitioner*" OR "health care pract*" OR "health* professional*" OR "health person*" OR physiotherap* OR "physical therap*" OR "primary care*" OR "general pract*" OR gp OR doctor* OR physician* OR nurse* OR pt
Stratified Care	Stratified OR stratification OR stratifying OR (target* treatment*) start-back" OR "start back
Low back pain (LBP)	"low* back" OR "lumbar spine" OR "lumbar pain" OR lbp OR "non specific back pain" OR "non-specific back pain"
Perspectives (beliefs and experiences)	opinion* OR thought* OR perspective* OR experience* OR impression* OR view* OR training OR support* OR administer* OR implement* OR attitude*

Quality Assessment

The Critical Appraisals Skills Programme (CASP; Critical Appraisal Skills Programme, 2018) tool was applied independently by two reviewers (F.T. and G.A.) to assess the quality of included articles. The Cochrane Collaboration recommend this tool to assess confidence in quality of reviews (40). Any discrepancies of opinion were resolved using an additional reviewer (JH).

Inclusion Criteria

Articles were included if they were of qualitative design or included qualitative data reported separately from quantitative data. Participants in the study were general practitioners or physiotherapists working in clinical practice in primary care and had experience of STarT Back. Studies needed to be published in English, and available in full text.

Data Extraction

The following data were extracted from the included articles: study design, participants, country, and method of data collection. Two reviewers (F.T. and G.A.) extracted data independently from the results section of each paper in the form of direct quotes and summaries of participant interviews.

Data Analysis

Reflexive thematic analysis with an experiential orientation was used to gather findings and generate themes (41). This method captured the experience of the participants by focussing on the language used (42). Two reviewers (F.T. and G.A.) familiarised themselves with the data, which were then extracted and coded. Four reviewers (F.T., G.A., J. H. & N.S.) constructed candidate themes inductively using the codes and data. Themes were finalised following multiple reviews of candidate themes and subsequently defined and named. Representative quotes were selected to support the themes.

Results

Literature Search

The process for study selection can be found in Fig. 1.

Six hundred and three journal articles were identified, 300 remained after removal of duplicates. Results from eight studies undertaken between 2011 and 2020 were included in the final review and meta-synthesis. Authors were contacted to request full publications of two abstracts that appeared relevant to this review; one was not published (43) and one author contacted twice did not reply (44). In the eight articles retrieved, 76 physiotherapists and 65 GPs were interviewed or surveyed about their perspectives on the use of STarT Back.

Figure 1 here

Study Characteristics

A summary of the articles included in this review can be found in Table 2. Studies were completed in four countries: four in the UK, two in Germany and one each in the USA and Portugal between 2011 and 2020. Four studies interviewed participants following exposure and use of STarT Back for several months (36, 45–47). The remaining four studies reported on interviewed participants who had completed workshops where potential STarT Back use was discussed (4, 44, 48, 49).

Quality of Articles

All studies met at least seven of the ten criteria in the CASP tool, with the relationship between the researcher and included participants most frequently not addressed. (see Table 3).

Table 2

Summary of included articles (n = 8)

Author	Year	Country	Design	Data Source	Currently using STarT Back	Participants	Participants for interview (n)
Hsu et al.	2019	USA	Qualitative / Observational	Interview	Y	PT	7
Karstens et al.	2015	Germany	Qualitative	Think tank workshop	N	GP	19
Karstens et al.	2018	Germany	Qualitative	Think tank workshop	N	PT	19
Sanders et al.	2011	UK	Qualitative / Observational	Interview	Y	GP	9
Caeiro et al.	2019	Portugal	Qualitative	Focus group	N	GPs and PTs	GP: 6 PT: 6
Bamford et al.	2017	UK	Qualitative / Observational	Audit data extraction	Y	PT	18
Sanders et al.	2014	UK	Qualitative	Interviews; face to face and telephone	Y	PT	26
Saunders et al.	2016	UK	Qualitative	Focus groups and telephone interviews	N	GP	23
PT = physiotherapist, SBT = STarT Back Tool, GP = general practitioner, Y = yes, N = no							

Table 3

Quality assessment (CASP tool) results

Study	Bamford et al., 2017	Caeiro et al., 2019	Hsu et al., 2019	Karstens et al., 2015	Karstens et al., 2018	Sanders et al., 2011	Sanders et al., 2014	Saunders et al., 2016
Clear statement of aims	Y	Y	Y	Y	Y	Y	Y	Y
Appropriate methodology	Y	Y	Y	Y	Y	Y	Y	Y
Appropriate research design	Y	Y	Y	Y	Y	Y	Y	Y
Appropriate recruitment strategy	Y	Y	N	N	Y	Y	Y	Y
Data collected appropriately to address research issue	Y	Y	Y	Y	Y	Y	Y	Y
Relationship between research and participants considered and participants considered	N	N	N	N	N	Y	N	Y
Ethical consideration	Y	Y	Y	Y	Y	Y	Y	Y
Rigorous data analysis	Y	Y	Y	N	Y	Y	Y	Y
Clear statement findings	Y	Y	Y	Y	Y	Y	Y	Y
Value of research	Y	Y	Y	Y	Y	Y	Y	Y
TOTAL (yes/10)	9	9	8	7	9	10	9	10
Y = Yes; N = No								

Principle findings

Three main themes were generated from the data:

1. Making it work, 2. Will I do it? and, 3. It's all about the patient.

1. Making it work

This theme identifies factors that may influence implementation and continued use of STarT Back in clinical practice. It has four subthemes: *help me*, *changing my practice*, *interprofessional relationships* and *system policies*.

Help me refers to the support and skills participants felt they required to implement STarT Back. Physiotherapists voiced their need for support, specifically supervision (4, 45).

But it's definitely true that it's something that not everybody can do [skilled communication] and it's hard to learn it on a theoretical basis. I think you'll need supervision on top. (Physiotherapist; Karstens et al., 2018)

Additionally, physiotherapists identified specific areas of education they needed to manage psychosocial factors. They reported feeling under prepared by their tertiary education to undertake cognitive behavioural therapy, exercise prescription and the level of skilled communication required (4, 44).

I need to learn more about patient education, mainly how to use strategies from the cognitive-behavioural model in order to carry out education about the neurophysiology of pain. (Physiotherapist; Caeiro et al., 2019)

Changing my practice relates to how STarT Back affected the way participants practised. Both professions felt it improved quality of care and reinforced or, in some instances, introduced evidence-based practice (4, 44).

[...] so, this may help moving physiotherapists from practices that are not evidence-based towards new and more effective treatments. (Physiotherapist; Caeiro et al., 2019)

Participants agreed that STarT Back would help provide guidance for clinical reasoning and stratification of patients (4, 45, 46, 48, 49).

I'd be happy with it saying, 'This is the most appropriate treatment,' because that's where you want to go. And more often than not you'll think, 'Yeah, that's more or less what I had in mind anyway.'... Or you'll go, 'Oh, that's a good idea. That wasn't quite what I was going to do but it might make sense'[...] (GP; Saunders et al., 2016)

Both professions also agreed it facilitated difficult conversations regarding psychosocial factors (36, 45, 46, 49).

Overall, the most helpful thing is it's really kind of given a framework to approach patients with... low back pain. Whereas in the past it's... not an easy clinic visit to lead [...] but now we have a bit of a framework to work in [...] (GP; Hsu et al., 2019)

Interprofessional relationships illustrates the relationships between GPs and physiotherapists in the implementation of STarT Back. Three research groups identified that GPs were largely unaware of the physiotherapists' role in the use of STarT Back (46–48).

Well, that would be desirable, if you knew what the physiotherapist really does in this case. (GP; Karstens et al., 2015)

Some physiotherapists hoped that STarT Back would increase the trust GPs had in physiotherapists' ability to manage patients with LBP (4).

[...] our everyday reality is that there is little confidence in our capabilities [...] this approach enhances our own confidence as well as the physicians' trust in us, that the patients receive appropriate physiotherapy treatment. (Physiotherapist; Karstens et al., 2018)

Through STarT Back training, GPs became more aware of physiotherapists' role in LBP treatment. This appeared to have a positive effect on interprofessional management, and to improve consistency between professions (4, 44–46).

[...] the GP is the first person the patient sees, if they could be better educated with regards to back pain and then that filtered down and everyone trying to do a fairly similar thing, not similar for every single problem but approaching problems in similar ways. (Physiotherapist; Sanders et al., 2014)

System policies refers to how specific health system policies affected the motivation of participants to use STarT Back appropriately. GPs reported a fear of being penalised by insurance companies for overloading services, reduced their motivation to refer patients to physiotherapists (47, 48).

[...] I wasn't going to get my wrists slapped, because you do sometimes get your wrists slapped [...] we get messages saying what the wait is for physio and you know, please don't overload us and we're often being told that so I try and manage. (GP; Sanders et al., 2011)

Physiotherapists also expressed concerns about restrictions placed on them from insurance companies. These included lack of freedom in decision making, prespecified time for consultations, and a restriction in the number of follow-up appointments. These restrictions could limit the appropriate use of STarT Back (4). Physiotherapists reported that closer working relationships with GPs reduced waiting times (44) and the change in frequency and duration of consultations resulted in a reduced case load (46).

We may be seeing them over a longer period of time, but we're not seeing them as often. So that's working better for us from a case load point-of-view. (Physiotherapist; Sanders et al., 2014)

2. Will I do it?

This theme emphasised factors affecting participant motivation to implement STarT Back. It highlighted the feasibility of implementing STarT Back, captured participants' conflicting perceptions of whether it was worth undertaking, and potential consequences of adopting it. There were five subthemes: 'is there time?', 'ability to change', 'recognise me', 'I know better', and 'changing me as a health professional'.

Is there time? examines whether there was time available in participants' sessions to administer STarT Back. Most GPs indicated that they lacked time to administer STarT Back assessment and treatment recommendations (44, 47–49), with some GPs having as few as nine minutes per consultation (48). Some physiotherapists agreed that STarT Back was time consuming for GPs and both professions suggested ways to reduce the time taken. For example, education being delivered remotely via media instead of face-to-face (4, 45, 46, 48).

[...] the problem is the time. It's definitely playing a major [part] on the issues you know. You're doing something a bit extra on top of what you normally do on a daily basis [...] (GP; Sanders et al., 2011)

In contrast, most physiotherapists found the tool quick and easy to use as it helped to speed up their clinical decision making (4, 44).

This tool is feasible in our context, because it includes only nine questions, which are easy to answer [...]. The outcome helps us on stratifying the patient and identifying treatment priorities. (Physiotherapist; Caeiro et al., 2019)

Ability to change, considers the factors affecting GP's and physiotherapist's ability to make the change required to implement STarT Back. A factor that was pertinent to the success of STarT Back implementation was ensuring the local availability of recommended referral services (49).

Whatever decision you come out with, the care option that it's recommending must be embedded within the healthcare system that you're working in. So there's no point of having these treatment options in a tool if it's not going to be available in your practice area. (Physiotherapist; Saunders et al., 2016)

Another influencing factor was the reported stress associated with a change to routine care practises. Some participants forgot to use the tool in consults (44, 45, 47).

My major difficulty was remembering to ask the questions because my practice is to enter my notes after the patient has left [...] and you think oh I've forgot to ask them. (GP; Sanders et al., 2011)

Recognise me refers to the factors that affected physiotherapists' motivation to upskill and treat more challenging patients. Due to the significant role they would play in the management of LBP patients using STarT Back, physiotherapists advocated for increased recognition from health industry colleagues (4, 46).

[...] that would indeed be a first flagship. Meaning, that in medicine or even politics they would say: 'look how important physiotherapy is!' (Physiotherapist; Karstens et al., 2018)

The reduction in the number of treatment sessions required for low-risk patients, with the consequent reduction in income was of concern to physiotherapists (4). This concern, combined with an increase in complexity of treatment required for high-risk patients, meant physiotherapists expressed a desire for remuneration to reflect the change (4).

I think reimbursement is rather cause of frustration for all of us therapists [laughter], we are convinced that we don't get paid to an extent we think we are qualified [...]. With these tasks [described for the STarT-Approach], with these additional qualifications, physiotherapy is gaining more, dramatically more importance and thus deserves a higher reimbursement. (Physiotherapist; Karstens et al., 2018)

I know better refers to the incongruency between participants' professional training and clinical reasoning versus STarT Back recommendations. Both professions questioned whether STarT Back could stratify patients correctly or whether stratification could be adjusted if necessary (36, 47). Specifically, physiotherapists found that a patient's category might change during treatment. In addition, some GPs and physiotherapists identified STarT Back as redundant as it did not provide additional information (36, 45, 49).

I'm not using the tool at all... The tool wasn't really showing me something I didn't already know from my interview and exam. (GP; Hsu et al., 2019)

A few GPs confessed they were not using STarT Back, not only because LBP was not a priority for them, but that it was a clinically uninteresting condition that often did not require a GP visit (45, 47). Others felt conditions such as heart disease and diabetes took precedence over LBP (47). Physiotherapists also noticed when they referred patients back to GPs due to unsuccessful treatment, GPs were reluctant to engage with patients (46).

Yeah, the sort of patients who don't seem to respond to what I do [...] the GPs never want to really see them they just sign them off with sick notes and give them anti-depressants and things like that... (Physiotherapist; Sanders et al., 2014)

Changing me as a health professional, illustrates how STarT Back affected the professional attributes of GPs and physiotherapists. Both professions expressed that STarT Back improved their confidence when dealing with the psychosocial factors that often accompany chronic LBP (45–47).

And I think now I've got more confidence in how to deal with some of the things they're saying to me. Before if I'd done that and I wasn't confident I think I would've reverted back. (Physiotherapist; Sanders et al., 2014)

Physiotherapists found STarT Back training was useful as it helped them reflect on their current practice and gave a fresh perspective on the treatment for LBP. Additionally, they reported a shift in focus from a biomedical approach to a biopsychosocial one (45, 46).

It made me reflect on things and it's helped me see, identify some habits that I probably have got into over the years that I need to look at changing. (Physiotherapist; Sanders et al., 2014)

Some physiotherapists experienced increased engagement and motivation in their new role and found that dealing with the psychosocial aspects of LBP was more rewarding and intellectually stimulating (4, 44, 46).

[...] the social side of it, of people's lives and their problems and things like that and seeing if you can problem solve with that ... I find that more interesting than dishing out a sheet of exercises. (Physiotherapist; Sanders et al., 2014)

Conversely, a prominent concern of GPs was that using STarT Back would reduce clinical autonomy and would undermine GPs' professional identity (49). Physiotherapists were also fearful that addressing more psychosocial aspects and using fewer traditional hands-on treatments could decrease patient respect (4, 46). Karstens and colleagues (4) also reported that some physiotherapists were afraid that selected areas of traditional treatment would become obsolete.

[...] the more you as a physiotherapist address these psycho-social aspects of medicine, don't you risk rationalising yourself out of the picture? (Physiotherapist; Karstens et al., 2018)

3. It's all about the patient

The theme 'it's all about the patient' emphasised how STarT Back may affect patients and their potential reactions to risk stratification and matched treatments. Both professions identified three areas to be considered prior to implementation: patient individuality, the influence of patient demand on decision making, and a patient's motivation to improve. Participants felt they were pigeonholing patients by stratifying them into one of only three groups which they felt fails to consider patient individuality (4, 47).

[...] I'm one of these that thinks that there's an art to general practice and it's more a sort of conversation and a feeling between two people. Now, you can't put feelings into a questionnaire [reference to the tool] so what's right for one, is completely wrong for another and unless you had a questionnaire that was a thousand questions long, you're just not going to capture that, are you? (GP; Sanders et al., 2011)

Both professions agreed that patient demand could significantly influence decision-making surrounding referrals (36, 46, 47). These participants recognised that patients have rights to request specific treatment and therefore they felt the need to consider the requests to keep generating business.

Whereas, with a patient it's more of, I don't know how to put it really, it's not like a bartering but it is a bit like that you know. They want physio, [...] and you're thinking well you know, should they have it or not and they may only score one but if they really want physio, they going to get physio because we're here to meet the patient expectations and demand... (GP; Sanders et al., 2011)

On the other hand, certain GPs did not want to take away patient choice, fearing that it would impede rapport and the therapeutic relationship.

So my worry about it is that it sort of dupes the patient decision... it's like a trump card, almost. [...] (GP; Saunders et al., 2016)

Participants mentioned that some patients prefer passive treatments and lack motivation to recover (4, 46, 47).

If he is really motivated and wants to recover quickly, then things will go faster [...], for those people who enjoy being given a sick note and spending a week or two at home ... (Physiotherapist; Karstens et al., 2018)

On the other hand, some physiotherapists anticipated that this method of treatment may be embraced by patients due to previous unsuccessful treatment. Karstens and colleagues (4) reported that patients who received a preliminary education session prior to physiotherapy presented with an improved attitude towards treatment. Additionally, physiotherapists found STarT Back encouraged patient engagement in treatment (46).

[...] it means you've got a totally different starting point with the patient, [...] the patient is pro-active, and we can get away from never-ending treatment sessions. (Physiotherapist; Karstens et al., 2018)

When considering patient-clinician interactions and how patient-centred care was affected, both professions highlighted that STarT Back enhanced communication by enabling conversations with patients regarding different aspects of their LBP (36, 45, 46).

What was really useful to me was the discussions with the [trainer]... That really changed my focus when talking with patients about back pain, really letting them know that no harm will come to them from being active and how to prepare them appropriately for what physical therapy could offer. (GP; Hsu et al., 2019)

Discussion

Implementation of a tool to help manage a clinical problem is dependent on the willingness of health practitioners to accept new knowledge and utilise new concepts to drive a change in behaviour. The tool needs to make sense and have meaning to intended users to increase the likelihood of positive impact and successful implementation (46). This review captures the perspectives on the use of the STarT Back tool and how health practitioners feel it may influence their practice.

Summary of Results

The main themes identified health practitioner perspectives that influenced the use of STarT Back. Participants felt STarT Back enhanced their practice though many found it constrained the use of their diagnostic skills. Time constraints were of concern, but many felt that if they put time in to making it habitual practice, using STarT Back could become efficient. Involving patients in decision making on their treatment was thought to be one of the benefits of using STarT Back, though some GPs felt it had the potential to limit treatment options.

Physiotherapists and GPs felt the psychosocial education during STarT Back training added to their skills and ability to treat more complex patients. Many would have valued additional support with this after they'd had a chance to use it in practice.

The wide range of pathologies GPs encounter meant they often placed LBP as a low priority meaning they discharged patients with chronic LBP sooner than physiotherapists believed was optimal. However, using STarT Back gave physiotherapists and GPs a better understanding of each other's management of LBP resulting in an improved interprofessional relationship.

Physiotherapists had concerns about the financial implications of using STarT Back and the ability to translate it into their specific healthcare system. Many felt that once proficient in the use of STarT Back, their skills should be recognised financially.

Findings in relation to existing literature and guidance

STarT Back stratifies patients with LBP to receive appropriate matched treatment at an optimal time point (32). Most participants felt that STarT Back served its purpose as a stratification tool and enhanced their practice. However, a contrasting view from some physiotherapists and GPs was that STarT Back prevented them from exercising autonomy. Additionally, the inclusion of STarT Back in some clinical guidelines gives the impression of compulsion for some participants, preventing the use of the diagnostic skills they have developed through clinical experience. The ability to diagnose often involves pattern recognition, which many GPs view as a component of 'the art of practice' (50). However reliance on pattern recognition can result in a longer pathway to effective treatment and using STarT Back has been

shown to enhance rather than detract from effective practice (15). The training focuses on the key messages, that STarT Back is designed to: aid, not take over clinical decision making; improve the efficiency of LBP management; and help manage high and challenging caseloads (34, 51).

A finding from this review was that some GPs perceived LBP to be a low priority, a finding corroborated by Poitras and colleagues (52) who reported on barriers to the use of LBP management guidelines by health practitioners. Physiotherapists reported that patients with chronic LBP were discharged from their GP prematurely, with GPs expressing that their clinical expertise was better spent on major chronic conditions. GPs reported that guidelines were of low impact and that LBP represented a limited, clinically uninteresting portion of their caseload. This perception may stem from their requirement to manage a wide range of health conditions; in Australia, LBP only accounts for 1.8% of GPs caseload despite being the eighth most common condition they manage (51). Many GPs also express a lack of confidence and understanding of chronic LBP, with authors reporting that the more complex a patient is, the less willing GPs are to address the problem in its entirety (53, 54). The belief that LBP is not a serious condition may explain why some patients are dismissed as malingerers. Frequently such patients have underlying psychosocial factors inhibiting their recovery and if not addressed early, there is an increased risk they will experience fear-avoidance behaviour (55) and may enter a cycle of pain, suffering and disability.

A promising finding from the current review was that physiotherapists and GPs expressed increased engagement in their role following STarT Back training, due to increased confidence in addressing psychosocial factors (52, 56, 57). This facilitated a shift from a biomedical to a biopsychosocial approach (20), adding a new dimension to routine care. Synnott and colleagues (57), reported on physiotherapy perspectives of managing psychosocial dimensions of LBP after intensive training. Participants described increased confidence and an improved level of skill in the management of patients with chronic LBP.

Some participants in this review believed that allowing patients a choice of treatment options made them the centre of decision-making. GPs expressed concern that stratified care could limit options and result in a loss of patient choice and independence. Loss of patient autonomy has been shown to negatively affect patient biopsychosocial wellbeing (58–60). However, it is a matter of debate how much clinicians should allow patients to dictate their treatment. Health practitioners often deal with the internal conflict between a paternalistic approach of doing what is best for the patient and cultivating patient autonomy (58, 60). An example of this is whether imaging should be undertaken for LBP in the absence of red flags (61). In some cases imaging may reassure the patient that there are no abnormal findings, but early imaging for acute LBP has been correlated with increased sick leave and likelihood of surgery, and an overall poorer prognosis (62). Consequently, when patients express a strong treatment preference, GPs and physiotherapists can choose to grant patient requests, to maintain therapeutic relationships or deny requests with the intention of doing what is best for the patient (60, 63).

Strengths and limitations of the study

Strengths of this study include the use of PRISMA guidelines and the CASP tool. The data analysis was subjected to a rigorous peer-review process; FT and GA presented their initial coding to NS and JH and there was discussion and re-coding to ensure that each code reflected the participant data accurately. The process of writing the results yielded several iterations and refinements to the themes which were agreed upon by all authors. Studies were included from four countries, and participants had a range of experience in their professions. There was a dearth of studies undertaken outside the UK, despite undertaking a sensitive search of seven data bases and contacting key authors in the area. This may be due to the relatively recent implementation of STarT Back in countries other than the UK. One limitation was that only four studies had participants who had used STarT Back (36, 45–47), the remainder had been educated and were contemplating its use (4, 44, 48, 49). Although this pre implementation data is of interest, it is not experiential.

Clinical and research implications

In the United Kingdom (UK) healthcare is primarily publicly funded by the National Health Service (NHS) (64). STarT Back was developed in the UK and hence was specifically designed to fit their funding model. Research in other countries is needed to gain an understanding of how STarT Back can be translated and adapted to fit health practitioners working in other health funding models. Consultation and collaboration with health practitioners and other stakeholders is required to facilitate development and effective translation of STarT Back into their environment. Understanding how different healthcare systems implement stratified care will help to develop an effective system for managing people with LBP. Furthermore, whilst evidence-based practice has a significant role in the translation and implementation of STarT Back, patient expectation and satisfaction are equally important for successful implementation. Further research needs to focus on patient self-reported clinical outcomes using the STarT Back approach and their satisfaction with the care they received.

Conclusion

This review highlights perspectives of GPs and physiotherapists in the use of STarT Back. Clinicians are open to the possibility of using STarT Back and can see some positives for practice despite some misgivings. It may improve interprofessional understanding and help provide more cohesive management of LBP patients. Widespread implementation of STarT Back presents significant challenges for some health practitioners in loss of revenue and a perceived loss of autonomy.

The translation of a clinical tool designed for a specific health system to a different context necessitates consideration of many factors and consultation with stakeholders. This will facilitate adaptation of the STarT Back approach for each country's healthcare system.

Abbreviations

LBP
Low back pain
CASP
Critical Appraisal Skills Programme

Declarations

The perspectives and experiences of physiotherapists and general practitioners in the use of the STarT Back Tool: A review and meta-synthesis.

Consent for publication – Not applicable

Availability of data and materials – Not applicable

Competing interests - "The authors declare that they have no competing interests"

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Authors' contributions

JH designed the study, assessed identified literature for eligibility, confirmed accurate, consistent data extraction and quality assessment. NS designed the study. FT carried out the literature search, quality assessment and data extraction. GA and FT analysed the findings. All authors contributed to identification of the themes and analysis of the themes and drafted the manuscript.

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Availability of Data and Materials:

This was a qualitative systematic review of studies investigating perspectives of health practitioners. As such the data used and themes generated were from existing studies and hence the data sets are not supplied.

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Figures

Figure 1

The process for study selection

Figure 1

The process for study selection