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Governing healthcare: Finding meaning in a clinical practice guideline for the management of non-specific low back pain

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ABSTRACT

Clinical practice guidelines produced by NICE – the National Institute for Health and Care Excellence – are seen as key mechanisms to regulate and standardise UK healthcare practice, but their development is known to be problematic, and their adoption and uptake variable. Examining *what* a guideline or health policy means to different audiences, and *how* it means something to those communities, provides new insight about interpretive discourses. In this paper we present a micro-analysis of the response of healthcare professionals to publication of a single NICE guideline in 2009 which proposed a reorganisation of professional services for chronic non-specific low back pain. Adopting an interpretive approach, we seek to understand both the meaning of the guideline and the socio-political events associated with it. Drawing on archived policy documents related to the development and publication of the guideline, texts published in professional journals and on web-sites, and semi-structured interview data from professionals associated with the debate, we identify a key discourse that positions the management of chronic non-specific low back pain within physician jurisdiction. We examine the emergence of this discourse through policy-related symbolic artifacts taking the form of specific languages, objects and acts. This discourse effectively resisted and displaced the service reorganisation proposed by the guideline and, in so doing, ensured medical hegemony within practice and professional organisations concerned with the management of non-specific low back pain.

Introduction

In the United Kingdom (UK), healthcare governance is enacted via a multiplicity of means, including national health policy and guidance, clinical protocols and through the actions of professional groups and non-government institutions (Armstrong, 2002; Nettleton, Burrows, & Watt, 2008). A key governance role is provided by the National Institute for Health and Care Excellence (NICE). Set up in 1999, NICE provides national healthcare guidance aimed at improving care and, ultimately, reducing healthcare inequalities and costs (Rawlins, 1999), however, the implementation and uptake of NICE guidance has been shown to be highly variable (Sheldon et al., 2004).

Clinical guidelines constitute one type of NICE guidance, offering evidence-based recommendations for the care and treatment of specific conditions. Processes of guidelines seek to configure work and workers, standardise healthcare and thus render it comparable across settings and systems (Timmermans & Berg, 2003; Timmermans & Epstein, 2010). There is substantial literature which shows that guideline generation (McDonald & Harrison, 2004; Moreira, 2005) and implementation (Mickan, Burls, & Glasziou, 2011; Spyridonidis & Calnan, 2011) are highly problematic and deeply politicised (this is especially well described by Timmermans & Berg, 2003).

In this paper we focus on a debate surrounding a single NICE guideline (CG88), published in 2009, which made recommendations for the care of individuals with persistent non-specific low back pain. We present a case study, looking in detail at the responses of healthcare professionals and the socio-political events that accompanied this guidance. Our interest in this particular guideline stems in part from the professional experiences of the lead author, a physiotherapist involved with managing patients presenting with back pain.

Background

In November 2005, the UK Department of Health asked NICE to produce a clinical guideline for the early management of patients with chronic (defined as lasting more than 6 weeks) low back pain (NICE, 2006). Low back pain is a major cause of work absenteeism and considerable healthcare spending (Bevan et al., 2009; Hong,

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Reed, Novick, & Happich, 2013). Approximately one third of individuals affected by an episode of low back pain will not have recovered after one year (Henschke et al., 2008) and, for the majority, a specific cause of their back pain is never identified and is therefore classified as non-specific low back pain (Airaksinen et al., 2006; Deyo & Weinstein, 2001). In addition, there exist a myriad of treatments for back pain, though research evidence suggests that most of those currently available have only modest effects (Balagué, Mannion, Pellisé, & Cedraschi, 2012). Diagnostic uncertainty, combined with this treatment diversity and outcome variability, has led to a lack of clarity about which healthcare practitioners should manage low back pain, such that general practitioners, physiotherapists, osteopaths, chiropractors, spinal surgeons and pain specialists all have some role in the treatment of this condition (Prior, 2003).

The guideline developed over a two year period, culminating in publication as CG88 in May 2009. It affirmed the non-specific nature of most low back pain and recommended that spinal imaging (X-ray and Magnetic Resonance Imaging {MRI}) should not be performed unless on grounds of suspected serious medical pathology (cancer, infection, fracture, inflammatory disorders) or where a surgical opinion was to be sought (Savigny et al., 2009). Though MRI enables the identification of spinal anomalies which are not visible externally (May, Doyle, & Chew-Graham, 1999), spinal anomalies have been demonstrated in a large number of individuals without symptoms (Jarvik, Hollingworth, Heagerty, Haynor, & Deyo, 2001), thereby reducing the diagnostic value of this procedure (Rhodes, McPhillips-Tangum, Markham, & Klenk, 1999). The significance of a spinal anomaly and its correlation with pain can be explored, for example, by injecting the spine with therapeutic substances, but secure diagnosis resulting from these procedures has not been demonstrated (Manchikanti et al., 2009). Given the lack of evidence to support the use of these injections, this practise too was not recommended.[1] Elsewhere the guideline recommended increased provision of exercise, manual therapy and acupuncture as first line interventions - treatments typically offered by physiotherapists, chiropractors, osteopaths and acupuncturists – some of whom historically work outside the NHS in the private healthcare sector. For those resistant to initial treatments and presenting with high disability and/or psychological distress, a combined physical and psychological treatment programme (termed CPP) was to be offered, whilst for the small group unresponsive to all conservative treatments, and willing to consider surgery, an opinion on spinal fusion was recommended (Savigny et al., 2009).

Reactions to the guideline were mixed; some healthcare organisations welcomed it (British Acupuncture Council, 2009; British Osteopathic Association, 2009; Chartered Society of Physiotherapy, 2009; General Chiropractic Council, 2009), while others openly contested the recommendations (Hester, 2009; Royal College of Anaesthetists, 2011). The guideline appeared to challenge common practices and professional boundaries and threatened to redistribute work amongst healthcare professionals. A heated discussion about the guideline took place in professional journals and other fora, such as blogs. This debate questioned the guideline recommendations and the processes of guideline development.

Key UK professional organisations, including the British Pain Society and the Faculty of Pain Medicine of the Royal College of Anaesthetists, called for the guideline to be withdrawn (Hester, 2009; Royal College of Anaesthetists, 2011). Following this, in July 2009, the British Pain Society held an extraordinary general meeting during which the President of the Society signalled his resignation following a vote of no confidence. The President (a consultant physiotherapist) had worked on the development of the guideline having been appointed clinical advisor to the guideline development group in 2007. In Spring 2009, he was elected President of the British Pain Society, the first non-medical healthcare professional to hold this role. The events within the Society fuelled further correspondence, and much of the debate surrounding the unseating of the President centred on the question of whether his role in the development of, and support for, the guideline was in direct conflict with his role within the Society.

Our approach

Clinical guidelines are procedural standards (Timmermans & Berg, 2003) which, through their development and implementation, transform the social world. In line with other types of standards, they have potential to 'change positions of actors', alter 'relations of accountability' and emphasise or de-emphasise 'pre-existing hierarchies' (Timmermans & Berg, 2003, p. 22). Moreover, standards can both shape and constitute our understanding of things (Pickersgill, 2012), and their effects warrant 'careful empirical analysis' (Timmermans & Epstein, 2010, p. 69). Our study sought to investigate these transformations and, in particular, to examine how these were accomplished via the discourses and actions of health professionals.

We were interested to explore the guideline debate in relation to ideas about professional boundaries and boundary-work. In part, we were inspired by classic sociological analyses of professional segmentation (Bucher & Strauss, 1961) and demarcation (Gieryn, 1983), but also more recent contributions including Mizrachi and Shuval's study (2005) of the symbolic boundaries between alternative and biomedical practitioners in hospital and ambulatory settings, Burri's work about how imaging technologies are used to configure professional authority in radiology (2008), and Pickard's analysis (2009) of power struggles involving general practitioners with special interests. To our knowledge, the role that clinical guidelines play in boundary-work and relations between the physiotherapy and medical professions has not previously been examined, and we therefore hoped to augment the literature by providing empirical analysis of debate surrounding guidelines and possible shifts in lines of demarcation between healthcare professions.

We employed a Foucauldian-informed discursive interpretive approach to make sense of the socio-political events associated with the CG88 guideline. Interpretive approaches to policy analysis allow us to focus on meaning – for example, the meaning of policy for those formulating and implementing it (Yanow, 2000) – and consider how meaning shapes actions, practices and institutions (Bevir & Rhodes, 2004, p. 130) and how meaning itself is shaped by context (Schwartz-Shea & Yanow, 2012). This interpretivism contrasts with more 'naïve rationalist' models of policy-making, which Russell, Greenhalgh, Byrne, and McDonnell (2008, p. 40) describe as 'decision science', seeing policy as a linear and logical process.

Wagenaar (2011) and Schwartz-Shea and Yanow (2012) note that meaning is neither directly accessible nor appreciable at the surface of human existence. Yanow's work (Yanow, 2000, 2006), however, provides examples of how meaning can be identified through a focus on policy-related artifacts. She argues that symbolic artifacts, in the form of *languages*, *objects* and *acts*, are the concrete symbols of human meaning – infused with the beliefs, values and feelings of those generating, enacting and interpreting policy and policy-related events. Thus, they express the meanings embedded within a particular policy process (Wagenaar, 2011;

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[1] The guideline recommended research into the effectiveness and cost effectiveness of facet joint injections and radiofrequency lesioning for people with persistent non-specific low back pain.