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Sincerely,

Eric J. Rubin, MD, PhD

Evaluating the Cultural Environment and Organizational Support in Physician Opportunities

Physicians should proceed from the premise that their questions are expected—and, ideally, welcomed

By Bonnie Darves

The pandemic has had far-reaching effects in many areas of physician practice—namely added stress, job-security concerns, and emotional and psychological challenges for physicians at the front lines of care. This sustained disruption in the practice environment has also prompted many physicians to take a deep look into what matters most to them. That, in turn, has impelled some to reevaluate—even reorder—the priorities for the jobs they're in or the new opportunities they're considering.

While a good cultural fit and practice support structure have always been important, those two considerations, along with work-life balance, have begun to eclipse compensation on the wish-list scale, recruiters are reporting. “Of course, what constitutes a good fit is personal and individual for each physician, and what's important for residents coming out might differ from priorities for career physicians. But what we're seeing, since the pandemic, is that physicians are placing a higher priority on work-life balance and family concerns in opportunities they're considering than they might have before,” said Emerson Moses, MBA, regional director for Clinical Talent Acquisition in Optum Health's Northeast, North Central, and Tri-State regions. “Many physicians are deciding, based on what they've experienced and witnessed in the past 18 months, that it's very important to live near family.”

Physicians who are seeking a first or subsequent practice opportunity should have more than a vague idea of what they desire in setting, culture, and practice support, before they start actively interviewing, according to Kelley Hekowczyk, director of Physician Recruitment and Credentialing for UCHealth Medical Group in Loveland, Colorado. “Employers assume that if you reach out, you know what you're looking for in the culture and what you want your practice to look like. Ideally, you'll have a pretty good idea of that when you come to the recruitment process, so that you can match up the qualities you're looking for,” said Ms. Hekowczyk.

Sincerely,

Eric J. Rubin, MD, PhD

June 30, 2022
Recruiters can be essential in both helping physicians focus their preliminary, “pre-interview” questions around factors that help reveal the culture of an organization — and in answering those queries early in the process, Ms. Hekowczyk reminds physicians. “The list of information that we as recruiters try to provide candidates is constantly evolving, but we do provide details on things like schedules, coverage, call backup, and mentoring. However, assessing the family [flexibility] issue can be a tough one,” she said, that’s best addressed in site interviews and open discussions with prospective colleagues.

**Do ask all the questions on your mind**

Even though it’s hard to assess culture and physician support from afar — especially when onsite interviews and those all-important dinners with prospective colleagues haven’t been possible — there are ways to get a sense of the practice environment, Ms. Hekowczyk maintained. She urges job-seeking physicians to review the organization’s website thoroughly for evidence of cultural characteristics and then set one-on-one conversations with prospective physician partners. This can help physicians determine, she said, “whether the practice environment is one that they’ll likely thrive in.” In her organization, Ms. Hekowczyk noted, there’s a strong emphasis on ensuring that candidates have ample opportunities to ask questions of their prospective colleagues — and all questions are fair game if they’re important to the physician.

One of those culture questions has taken on new importance of late, Ms. Moses reports, and it’s one that she thinks young physicians should ensure they ask: What is your strategy around physician well-being? “To some extent, it’s a generational thing. Seasoned physicians may be willing to work themselves to the bone to make good money, but that’s not core to this newer generation — the Generation Y and millennial physicians,” she said. “They’re hard workers, but they’re also committed to having work-life balance.”

Ms. Moses cautions that if an employing entity’s interviewers appear reluctant to answer the “physician well-being” question, or if the question is received negatively, that might be a sign that the organization isn’t focused on physician well-being. “Don’t be afraid to ask all your important questions about culture — those questions are very important to finding a good fit,” she said.

Lynne Peterson, president of the Association for Advancing Physician and Provider Recruitment and a 30-year veteran of physician recruiting, believes that cultural fit is too important a consideration for it to be short-changed in the job-search process. “Physicians really need to look at both practice and organizational culture,” said Ms. Peterson, senior director and ambassador of Provider Recruitment and Retention for Bluestone Physician Services in Stillwater, Minnesota. “At the practice level, that culture encompasses things like whether you like and trust prospective colleagues, and if you can be assured that they’ll take care of your patients when you’re not around.”

**Organizational culture is important for a different reason, Ms. Peterson explained.** “You want to make sure that the organization truly supports the practice, that when executives talk to physicians, the physicians’ voices are truly heard.” Further, she said, physicians should try to find out, from prospective colleagues, whether “what the C-suite people say about doctors is borne out by physicians.”

**Assessing collegial environment and practice support**

For invasive cardiologist Eks Wye Pollock IV, MD, at UCHealth in Fort Collins, Colorado, assurance of a culture of collegiality and having a good team were key considerations, along with a family-supportive environment, as he began looking for his first practice position. “That question was answered for me at each interview,” he said of his experience at UCHealth, his first choice because of the university’s standing and the practice’s proximity to his extended family. “It was clear that the practice was collegial, and that the organization valued physician lifestyle and non-work time,” he said. “I’ve since learned that other people I trained with aren’t necessarily finding that in their jobs.”

The team support in place became evident soon after Dr. Pollock started his job in 2019. Just a few months into the position, there was a death in his family. He emailed his colleagues, worried about getting his duties and patients covered while he was away. “Almost immediately, I received several emails from my team, and it was clear that everything would be taken care of,” he said. “I was told when I joined that ‘we’re all here to help each other,’ and I certainly experienced that.”
In posing key questions, be candid but cordial

In terms of how to phrase probing questions, Tom Farrington, MS, Director of Physician and Provider Services for Franciscan Physician Network in suburban Chicago and Indiana, offers some observations and guidance. First, he says, physicians should know that questions about work-life balance are common — and expected — these days. Likewise for detailed questions about training support and orientation, and the administrative support available. “I also believe that physicians want to know that demands on them to do burdensome administrative tasks are going to be minimal,” he said.

Mr. Farrington suggests posing such questions in a diplomatic manner. “Questions phrased as ‘help me understand the practice schedule, how call works, and the frequency of calls during coverage’ are all fair questions that provide physicians information without them making overt demands,” he said. On the other side of the spectrum, if physicians are asked to describe their ideal practice setting, they should supply a thoughtful, candid response. “That question is surely an opening for physicians,” he said, to talk openly and honestly about what’s important to them.

When internist Luis Gerald Lora Garcia, MD, was seeking his first post-residency practice position, he had specific needs and he made those known early in his search process. First, because he is on a J-1 Visa, he wanted to ensure that any practice he joined would be amenable and prepared to process his immigration. He also wanted to be close to a big city and to ensure that there would be some schedule flexibility and support from colleagues who were seeking a structure that enabled time for family and lifestyle pursuits.

In the end, Dr. Garcia found both at Franciscan Health’s Valparaiso, Indiana, primary care clinic, the Franciscan Physician Network Health Center. He practices four 10-hour days, and he has enjoyed his proximity to Chicago and his ability to travel around the region and explore — activities he didn’t have time for in residency. He admits that he has also found both a supportive culture and a collegial environment, and the ability to pursue his preferred clinical interests of cardiovascular-disease reduction and diabetes management. “It has worked out well so far, and I’m glad I was able to find an opportunity that meets my needs,” he said.

When physicians do ask about what the clinical and administrative support they’ll receive, they should expect detailed answers, according to Tammy Hager, MBA, Executive Director of Physician Recruitment and Privileging for Surgical Affiliates Management Group, Inc., in Sacramento, California. “When you’re asking about staffing, you really should expect and be given some numbers behind that,” she said, not just blanket statements suggesting that support will be adequate.

Mary Ebbets, MS, a senior physician and Advanced Practice Provider (AAP) Recruiter at Cooley Dickinson Hospital, in Springfield, Massachusetts, echoes what Ms. Peterson says about teasing out the culture through pointed questions. But Ms. Ebbets also advises physicians leaving residency to ask about the overall practice-support environment, which can be key to ensuring both a good fit and longevity in the position. Some new residency graduates are reluctant to do that for fear that they’ll be seen as self-serving or demanding, recruiters report, but that’s generally not the case. Ms. Ebbets suggested the following as good starting questions for gauging practice support:

• Will I have “mentor-type” access to senior physician colleagues?
• What kind of nursing and administrative support will I have in my daily practice life — is there a dedicated medical assistant and do we have APP support?
• What is the group’s or hospital’s policy regarding schedule flexibility for addressing family-life needs or requests?

“Remember that interviewing is like dating, so physicians should vet the organization just as much as the organization vets them — which means that physicians should ask all of the above questions,” Ms. Ebbets said. “The only types of questions that cause my organization pause are questions or requests around patient volumes that are below the industry standard — such as physicians saying that they only want to see 10 patients a day.”

Ms. Ebbets added that perhaps the most important question physicians should ask in assessing culture is: Why is this position available? If it’s a “replacement” position, she said, physicians should be prepared to ask why the previous physician left and should expect a candid answer. If it’s a new position based on growth, Ms. Ebbets added, the organization should be able and willing to supply market data to support the addition of another physician.

In posing key questions, be candid but cordial

In terms of how to phrase probing questions, Tom Farrington, MS, Director of Physician and Provider Services for Franciscan Physician Network in suburban Chicago and Indiana, offers some observations and guidance. First, he says, physicians should know that questions about work-life balance are common — and expected — these days. Likewise for detailed
On the topic of collegiality, physicians should ask questions in a manner that calls for somewhat specific answers. Ms. Hager suggests inquiring about outside-work activities that physicians engage in, such as group dinners, boating excursions, or family get-togethers, for example.

For physicians who are trying to figure out whether they’ll be a good fit within the existing group, it’s not out of order to ask questions that will give the candidate a sense of the physician partners’ diversity, backgrounds, and families. “If ethnic diversity is important to you, you might ask the recruiter where the other physicians live and where their children go to school. I think it’s possible to do that without coming across as racially biased,” she said. She notes that the Association of American Medical Colleges (AAMC) maintains and publishes data on race, ethnicity, and gender patterns in U.S. medical education and the practice patterns of the physician workforce in its Diversity in Medicine: Facts and Figures reports.

Finally, all interviewees agreed that while assessing culture and practice support are hugely important, physicians should ensure that the organization they’re considering joining has the financial viability to keep them gainfully employed for the long term. That’s become especially important in the wake of the pandemic’s initial impact on health care organizations of all sizes. “More experienced physicians ask about things like whether there’s a planned merger or acquisition that might affect their job, and whether there was an issue with layoffs or furloughs during the pandemic,” Ms. Hekowczyk said. “But the younger ones don’t tend to ask questions about the organization’s financial position, but they should.”

Ms. Moses urges physicians to do some research on the financial and market position—hospitals and health systems compile and publish data on their operating ratios, revenues, and cash reserves, for example—of any organization they’re evaluating. Ideally, candidates will conduct their research before the interviews begin. Annual reports and other public published data are a good start, and local media coverage on market factors and financial problems can be telling, she said. “When you’re doing this research, Google can be your friend, but physicians also shouldn’t be afraid to ask questions about how the organization is positioned financially,” she said, especially if it’s a private practice.

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Unusual Parts of Compensation Packages

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine.

In speaking to so many about their job offers, I’ve realized that we’re often myopic in terms of what we think can be negotiated when discussing a contract. There are the traditional things everyone asks about—salary, bonus structure, call responsibilities, vacation schedule, and signing bonuses, to name a few. However, when talking to people about what their ideal job looks like, there’s often more random things on a wish list. What we fail to realize is that those are all things that can be asked for, but that nobody else would even think to offer them to sweeten the deal.

Some examples of these?

• An early start and end to the day
• Dedicated academic or administrative time
• Unique FTEs such as 0.7 or unique structuring of their FTEs, such as alternating four-and two-day weeks
• Bonuses for creation of alternative revenue streams for the practice
• Changes in the amount of allotted CME money or money for office furnishings or technology
• The ability to work from home a certain number of days a week (for example, doing telehealth)
• A specified patient population according to their area of academic interest/desired practice panel
• An increased number of support staff such as scribes or medical assistants
• The speaker system which you will have in your operating room

Some of these may sound silly to you to ask for, but I know of physicians who have asked for and received these things as part of their contract negotiations. Remember, what brings happiness in your day-to-day life as a physician is very individualized, and therefore, asking for those things that will enhance your satisfaction (e.g., career longevity) at that job is not unreasonable.
Of course, asking for these things can be an art form. Understand that every institution has different flexibility or bandwidth for accommodating individual requests. You may want to look at what other accommodations have been made for other physicians on staff as precedent for what may be realistic prior to compiling your list of asks. Also, be careful about how many of these additional things you ask for. If you have 10 unusual requests, even if they are relatively minor, the message to the employer could be that this is a pattern of behavior where you will always be asking for exceptions to normal operating procedures.

Figure out which ones mean the most to you. Also figure out which ones are going to be harder to negotiate later, as your negotiating power is always greatest before you sign a contract. Be prepared to justify the asks so they understand why they would make accommodations. For example, if you are able to clearly articulate why something will lead to increased efficiency, lead to better patient outcomes, or contribute to your career longevity and prevent burnout, this would help your case. It would also help them to explain to others who question why these special accommodations were granted.

As demographics in medicine change, unusual asks will become more frequent. The sustainability of our health care workforce requires out-of-the-box solutions, and for some of you, these may be part of them! If you don’t ask, you won’t get it.

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low back pain probably develops from the interaction of biologic, psychological, and social factors, and it accounts for approximately 80 to 90% of all cases of low back pain. Low back pain is usually classified according to pain duration as acute (<6 weeks), subacute (6 to 12 weeks), or chronic (>12 weeks).

RISK FACTORS
Risk factors for an episode of nonspecific low back pain include physical risk factors (e.g., prolonged standing or walking and lifting heavy weights), an unhealthy lifestyle (e.g., obesity), psychological factors (e.g., depression and job dissatisfaction), and previous episodes of low back pain. In a case–crossover study that included 999 patients with sudden-onset acute low back pain, performance of manual tasks (e.g., those involving heavy loads or awkward postures) and distraction during an activity or task were identified as triggers of a new episode of pain.

NATURAL HISTORY AND PROGNOSIS
Low back pain is increasingly understood to be a long-lasting condition with a variable course rather than isolated, unrelated episodes. According to a systematic review of prospective inception cohort studies (33 cohorts and 11,166 patients) that were conducted mainly in primary care and involved a variety of approaches to treatment, new-onset episodes of low back pain generally abated substantially within 6 weeks, and by 12 months the average reported pain levels were low (6 [95% confidence interval (CI), 3 to 10] on a scale of 0 to 100, with lower scores indicating less pain). Research on the course of nonspecific low back pain has identified three main pain-trajectory subgroups that emerge in the year after presentation and apply to both acute and chronic low back pain: a recovery trajectory in which the patient’s condition improves rapidly or gradually toward a state of no or little pain, an ongoing trajectory in which the patient has moderate or fluctuating pain, and a persistent trajectory in which the patient perceives constant and severe pain (Fig. 1). The majority of patients with acute low back pain (approximately 80%) have a pain trajectory that is prognostic for recovery, whereas this trajectory is less frequent in patients with chronic low back pain (approximately 30%), a population in which 10% to 50% of patients (40 to 50%) have an ongoing pain trajectory.

According to a review of observational studies, factors that are consistently associated with poor outcomes (i.e., ongoing pain, disability, or both) in patients with low back pain included the presence of widespread pain, poor physical functioning, somatization, high pain intensity, long pain duration, high levels of depression or anxiety (or both), previous episodes of low back pain, and poor coping strategies. An observational study with 5 years of follow-up that involved 281 patients with chronic low back pain showed higher risks of a persistent pain trajectory among patients with high pain intensity (relative risk ratio per unit increase, 1.87 [95% CI, 1.33 to 2.64]), low socioeconomic status (relative risk ratio, 3.95; 95% CI, 1.38 to 10.2), negative illness perceptions (negative cognitive and emotional responses to low back pain) (range of relative risk ratio per unit increase, 0.39 [95% CI, 0.21 to 0.74] to 1.19 [95% CI, 1.06 to 1.34]), and passive coping behaviors (helplessness and reliance on others with regard to coping with low back pain) (relative risk ratio per unit increase, 1.90 [95% CI, 1.17 to 3.06]).

**Figure 1. Simplified Principal Trajectories of Pain Intensity among Patients with Low Back Pain.**
Adapted from Kongsted et al.12

**Diagnosis and Evaluation**
Diagnosis of nonspecific low back pain is made after specific disorders of spinal and nonspinal origin are ruled out. A detailed history taking and physical examination can point to spinal or nonspinal conditions or nonspinal conditions that may lead to specific intervention. The history should include attention to red flags (e.g., history of cancer or trauma, parental drug use, long-term glucocorticoid use, immunocompromise, fever, and unexplained weight loss), since their presence warrants consideration of an occult serious diagnosis (e.g., cancer, infection, or inflammatory disease) and close follow-up, although only some of these historical features have been shown to be useful predictors of such serious diagnoses. For example, in systematic reviews, a strong clinical suspicion for cancer or a history of cancer has been associated with an increased likelihood of a malignant condition, whereas other classic red flags (e.g., unexplained weight loss or fever) did not substantially affect the post-test probability of cancer. Older age (>70 years), trauma, and the prolonged use of glucocorticoids have been associated with a high specificity for and considerable increased probability of spinal fracture, with the highest probability of fracture seen when multiple features are present. History taking should also elicit whether pain is limited to the lower back or is more widespread; the latter may point to other conditions, such as fibromyalgia.

If a herniated disk is suspected, a positive ipsilateral straight-leg-raising test (in which pain results when the leg on the side of the back or leg pain is raised) is highly sensitive (in 92% of patients), and a positive contralateral straight-leg-raising test (in which pain is produced when the leg opposite the side of the back or leg pain is raised) is highly specific (in 90% of patients). In the case of radiculopathy, a neurologic evaluation can rule out weakness, loss of sensation, or decreased reflexes, if any of these features are present, referal to a specialist may be indicated. Other maneuvers on physical examination have generally low diagnostic accuracy for the identification of other sources of low back pain (i.e., facet joints, sacroiliac joints, and disks).

Screening tools can be used to estimate the risk that acute nonspecific low back pain will become chronic. The Predicting the Incurrence of Chronic Pain (PICKUP) tool is a validated prediction model that estimates the risk of chronic low back pain on the basis of five measures (i.e., disability compensation, presence of leg pain, patient intensity, depressive symptoms, and perceived risk of persistent pain) among patients who have an initial episode of low back pain.

A meta-analysis of studies that assessed other screening questionnaires showed that the subgroups for Targeted Treatment (STARt) Back screening tool and the Örebro Musculoskeletal Pain Questionnaire, although not informative for the early identification of patients who are at risk for persistent low back pain–related disorders and may guide treatment.

**IMAGING**
Routine imaging is not recommended in patients with nonspecific low back pain. Systematic reviews of observational studies have shown inconsistent findings with regard to the association between abnormal imaging findings and low back pain (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org). In a study that included patients 65 years of age or older who presented...
with acute low back pain without radiculopathy, the use of early imaging (e.g., radiography, magnetic resonance imaging, or computed tomography) was not associated with improved patient outcomes at 1 year. Nevertheless, imaging may be performed when informative red flags are present, when there is a neurologic deficit, or when persistent low back pain with or without nerve-root involvement does not abate with conservative care.

**TREATMENT**

Numerous randomized, controlled trials and systematic reviews have assessed the effectiveness of interventions for nonspecific low back pain. Tables 1 and 2 summarize the pooled effects on acute and chronic low back pain, respectively, and the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach to the certainty of evidence obtained from systematic reviews of randomized trials that assessed the interventions that have most frequently been evaluated by practice guidelines.\(^2\) Overall, first-line treatments are currently represented by nonpharmacologic interventions, which should be prioritized before pharmacologic treatment is prescribed.\(^6\)

### Acute Low Back Pain

Patient education and advice to remain active should represent routine care for patients with acute low back pain.\(^7\) Education may address the benign, nonspecific nature and favorable course of low back pain, and patients should be encouraged to continue with regular activities. A meta-analysis of randomized trials showed (with moderate-certainty evidence) that individual patient education, as compared with usual care or other control, although not effective for pain, was effective in reassuring patients and reduced primary care visits due to low back pain at 1 year.\(^8\) Meta-analyses of randomized trials support the use of a brief course of spinal manipulative therapy or acupuncture for the reduction of pain, although the certainty of evidence for spinal manipulative therapy is moderate and that for acupuncture is low.\(^9\) Heat and massage therapy are without risks and are reasonable to try, although the benefit of these therapies is supported only by limited data.\(^10\) Exercise therapy that is prescribed or planned by a health professional has not been shown to be effective in patients with acute low back pain (Table 1),\(^11\) but may be considered in patients at risk for poor recovery, given evidence from randomized trials of the effectiveness of exercise therapy in alleviating chronic low back pain\(^12\) (Table 2) and in reducing the risk of episodes of low back pain.\(^13\)

Among pharmacologic interventions, acetaminophen was not shown to be effective in a large clinical trial (Table 1),\(^14\) whereas nonsteroidal antiinflammatory drugs (NSAIDs) have shown benefit.\(^15\) However, caution is advised in the use of NSAIDs in older adults and in patients with coexisting conditions such as renal disease. Topical NSAIDs (e.g., topical diclofenac) have been shown to have fewer adverse events than oral NSAIDs, but their efficacy has not been rigorously studied in patients with low back pain. Results of a meta-analysis of the effects of muscle relaxants suggested that the use of nonbenzodiazepine antispasmodics began within the first 2 weeks of the onset of pain had positive effects, but the analysis was based on very-low-certainty evidence.\(^16\) These and other muscle relaxant agents had no significant effect on pain or disability during longer follow-up and were associated with a higher risk of adverse events.\(^17\) Given the lack of data and the associated risk of addiction, the use of opioids should be minimized; weak opioids (e.g., tramadol) may be considered for use in carefully selected patients.\(^18\)

**Chronic Low Back Pain**

In patients with chronic low back pain, education should play a key role, with supervised exercise and behavioral therapy as other first-line therapeutic options. Head-to-head randomized, controlled trials that compared these approaches have shown similar beneficial effects on pain in the short term (with low-to-moderate-certainty evidence), although the effects of exercise and behavioral interventions over longer follow-up are unclear as compared with the effects of usual care or other conservative interventions.\(^19\) A recent systematic review with network meta-analysis that included more than 300 randomized trials of 11 different types of exercise showed that most types of exercise had beneficial effects on alleviating pain and improving functioning.\(^20\) As compared with other exercises, Pilates therapy (which is focused on isometric contractions of the core muscles, attention to body movement, and improved posture)\(^21\) and McKenzie therapy (which involves repeated movement direction exercises, postural training, and education about patients’ self-management of pain) resulted in reduced pain and improved functioning.

Behavioral therapies include respondent ther-apy (which involves relaxation techniques to re-duce the physiologic response to pain), operant therapy (which is aimed at ceasing positive rein-forcement of pain behaviors and promoting

#### Table 1. Effectiveness of Interventions on Pain Intensity and Physical Functioning Outcomes at Immediate-Term Follow-up (0–4 Weeks) in Patients with Acute Nonspecific Low Back Pain.

<table>
<thead>
<tr>
<th>Intervention vs. Control</th>
<th>Pain Intensity</th>
<th>Physical Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Studies</td>
<td>Pooled Effect (95% CI)</td>
</tr>
<tr>
<td><strong>Conservative intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice to stay active vs. bed rest(^\ast)</td>
<td>3</td>
<td>−0.4 (−0.0 to 3.2)</td>
</tr>
<tr>
<td>Individual patient education vs. no intervention(^\ast)</td>
<td>3</td>
<td>NS</td>
</tr>
<tr>
<td>Individual patient education vs. non-conservative interventions(^\ast)</td>
<td>6</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Exercise therapy vs. no intervention or sham</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise therapy vs. other conservative interventions(^\ast)</td>
<td>7</td>
<td>−0.3 (0.7 to 1.0)</td>
</tr>
<tr>
<td>Spinal manipulative therapy vs. sham or other interventions(^\ast)</td>
<td>NK</td>
<td>−9.8 (−17.0 to −2.5)</td>
</tr>
<tr>
<td><strong>Opioid vs. placebo</strong>(^\ast)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture vs. sham(^\ast)</td>
<td>1</td>
<td>−24.8 (−37.0 to −12.8)</td>
</tr>
<tr>
<td><strong>Pharmacologic intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen vs. placebo(^\ast)</td>
<td>1</td>
<td>1.5 (−1.3 to 4.3)</td>
</tr>
<tr>
<td>NSAID vs. placebo(^\ast)</td>
<td>4</td>
<td>−7.3 (−11.6 to −3.0)</td>
</tr>
<tr>
<td>Muscle relaxant vs. placebo</td>
<td>16</td>
<td>−7.7 (−12.1 to −3.3)</td>
</tr>
<tr>
<td>Nonbenzodiazepine antispasmodic agent(^\ast)</td>
<td>1</td>
<td>−16.5 (−35.3 to 12.1)</td>
</tr>
<tr>
<td>Benzodiazepine(^\ast)</td>
<td>1</td>
<td>2.0 (−9.8 to 13.8)</td>
</tr>
<tr>
<td>Opioid vs. placebo(^\ast)</td>
<td>0</td>
<td>−0.0 (−0.0)</td>
</tr>
</tbody>
</table>

\(^\ast\) No trials of opioids for the treatment of acute nonspecific low back pain are available.

\(n\) engl j med 386;18 nejm.org May 5, 2022

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Clinical Practice

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In this study cited for opioid versus placebo, physical functioning was not a specified outcome, so pooled effect and evidence certainty for that outcome are not applicable (NA).

Other therapies for chronic low back pain include spinal manipulative therapy, massage therapy, yoga, and multidisciplinary rehabilitation. A systematic review with moderate-certainty evidence showed no clinically relevant differences in effects on pain and functioning with spinal manipulative therapy as compared with recommended first-line options (Table 2). Multidisciplinary interventions that combine physical and psychological components may be especially suited for patients with low levels of functioning and with psychosocial risk factors for poor outcomes, although data showing superior effectiveness for this patient group are lacking.

There is at best moderate-certainty evidence to support various pharmacologic options for the management of chronic low back pain (Table 2). NSAIDs can be considered in patients at low risk, although the effects appear to be modest and are supported by low-certainty evidence. Muscle relaxants and antidepressants (e.g., serotonin and norepinephrine reuptake inhibitors) may be used as adjuvant therapy in some patients, although they have had limited effectiveness (with evidence of moderate to very low certainty) (Table 2) and have potential risks. The use of opioids should be limited to very carefully selected patients and only for short periods of time with appropriate monitoring. Invasive therapies, such as epidural glucocorticoid injections and surgery, are rarely indicated for nonspecific low back pain.

### Areas of Uncertainty
There is some controversy regarding the term “nonspecific” low back pain, since structures such as muscles, joints, or disks (or a combination of these) may be causing the pain but are not readily identified by means of history taking and physical examination. Some patients with nonspecific low back pain may have symptomatic spinal osteoarthritis; in contrast to osteoarthritis of the peripheral joints, there are no diagnostic criteria for spinal osteoarthritis, and data are needed to guide its diagnosis and management.

High-quality randomized trials are needed to assess the effects on pain and function of several interventions, including heat, massage therapy, NSAIDs (oral and topical), muscle relaxants, and opioids for acute low back pain and NSAIDs, muscle relaxants, and antidepressants for chronic low back pain. Also, data are needed to inform whether the effects of these or other interventions vary according to patient characteristics. A meta-analysis of individual patient data from 27 trials did not show clinically relevant modifiers of the effect of exercise on chronic low back pain. In a trial involving patients with low back pain that compared usual care with care stratified according to prognosis (estimated with the use of the START back tool), patients at low risk received minimal intervention, those at medium risk received physical therapy, and those at high risk received “psychologically informed” physical therapy, patients in the stratified-care groups had greater reduction of disability and low back pain–related health care costs than those who received usual care. However, these positive findings were not confirmed by subsequent trials conducted in primary care settings in the United States.

### Guidelines
A previously published overview summarized the recommendations of 15 clinical practice guidelines for the management of nonspecific low back pain in primary care. More recent guidelines (e.g., those of the American College of Physicians) have moved away from pharmacologic therapy (owing to limited efficacy and risk of adverse effects) in favor of initial nonpharmacologic care for both acute and chronic low back pain. The recommendations presented here are generally consistent with those guidelines.

### Conclusions and Recommendations
The patient described in the vignette is experiencing an acute episode of recurrent low back pain, including exercise, and cognitively negative (which focuses on identifying and modifying negative thoughts with regard to pain and disability), randomized, controlled trials comparing these therapies have shown they have similar effects on pain and functioning. The choice of therapy from among conservative interventions should take into consideration the patient’s preferences and other factors, such as out-of-pocket costs.

Other therapies for chronic low back pain include spinal manipulative therapy, massage therapy, yoga, and multidisciplinary rehabilitation. A systematic review with moderate-certainty evidence showed no clinically relevant differences in effects on pain and functioning with spinal manipulative therapy as compared with recommended first-line options (Table 2). Multidisciplinary interventions that combine physical and psychological components may be especially suited for patients with low levels of functioning and with psychosocial risk factors for poor outcomes, although data showing superior effectiveness for this patient group are lacking.

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pain. In the absence of worrisome findings on the history and physical examination, imaging would not be recommended. The pick-up tool or the Orefeo Musculoskeletal Pain Questionnaire may be used to evaluate the patient for risk of the episode becoming chronic. The patient should be reassured of the very high likelihood that there is no serious condition causing his low back pain and encouraged to continue his regular activities, even if he has some pain when engaging in them. We would suggest considering the use of a heating pad (although this recommendation is based on limited data39); short-term use of NSAIDs may be helpful in the absence of contra-indications. If the low back pain does not abate within 2 months after the first visit, we would recommend referral to a specialist for supervised exercise or behavioral therapy. We would consider referral for exercise therapy earlier if there is concern about the risk of the condition becoming chronic, given the evidence of the benefit of chronic low back pain in minimizing the risk of recurrent low back pain. We would engage in shared decision making with the patient, with treatment decisions guided by his preferences and priorities.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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