Back from the Brink: Return to Function

British Institute of Musculoskeletal Medicine Spring Symposium 2009

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In musculoskeletal disability, deterioration gathers pace as effects of the initial problem accumulate and summate to hasten the sufferer's worsening plight, risking a plunge into long-term disability:

> *Unresolved dysfunction, unrecognised pathology, faulty perceptions, vulnerability to stress poor body skills, neuroplasticity, anxiety, deleterious behaviour, anger, inflexible employers, depression, workplace bullying, addiction, job loss, loss of fitness, marital breakdown, isolation, homelessness, helplessness, early death.*

Obviously, this Hogarthian descent is a worst-case scenario avoided by most but real enough to warn clinicians that they must take early and effective action to neutralise as many of the compounding elements in this suffocating web that many of our patients risk entering.

Roderic MacDonald
BIMM President

FORUM – Looking at ourselves: what are musculoskeletal doctors doing in the UK?

A selection of services from around the United Kingdom, and their characteristics:

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1 Ealing PCT Integrated Musculoskeletal Service

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Ealing Primary Care Trust (PCT) is situated in West London and serves a population of 364,000 people. The Ealing PCT Integrated Musculoskeletal Service evolved from fund-holding clinics in 1995 and subsequent pilot projects and is now the sole provider of musculoskeletal services in the PCT. Care is provided in four streams: general physiotherapy and three specialist streams – spinal, upper limb and lower limb. Care is provided from multiple locations – community hospitals, community clinics, GP practices and health centres.

With the current incidence of musculoskeletal problems in primary care, GPs are expected to look after half of new presentations in general practice, refer one-third to 20 general physiotherapists (Band 7 grade), one-sixth to the specialist interface clinic's eight extended scope physiotherapists (ESPs; Band 8a grade) and one in 25 to the musculoskeletal (MSK) physicians. The lead clinician is Stephanie Griffiths, consultant physiotherapist, who is responsible for the clinical governance of the team. Three MSK physicians make up 1.3 whole-time equivalents and have graduated from the London College of Osteopathic Medicine. Other clinical staff include physio-assistants and a liaison podiatrist. GPs are the principal source of referrals and patients are booked by a single point of access 'Central Booking Service'.

The Central Booking Service handles 22,000 referrals per year for the MSK service. In addition, 11,000 GP referrals per year, directly to hospital are triaged by a separate GP-led paper-based triage system: the 'Clinical Assessment Service' (CAS). The CAS triages all GP referrals to secondary care, for all specialties and is unrelated to the MSK Central Booking Service. Currently, 15% of these CAS referrals to orthopaedics are diverted to the community MSK service. Following a recent audit, this is expected to rise to 60%.

The specialist streams, staffed by ESPs and MSK physicians see patients with complex or multiple problems including co-morbidity; those needing biopsychosocial assessments, pre-operative assessments and diagnostics, injections, assessment of severe pain or possible red flags and for caudal epidurals.

The MSK service uses a 'See and Treat' model, without triage, and is fully '18 weeks' compliant. X-rays, ultrasound, MRI and blood tests are available to ESPs and MSK physicians. Web-PACS is available for viewing images in community clinics. Access, by referral, is available for image-guided injections (peripheral, facet, epidural and nerve root) and nerve conduction studies.

A major highlight of the service is that it is commissioned to provide a strong educational component. The service organises regular seminars for GPs, practice-based small group teaching for GPs, locums, salaried doctors, assistants and nursing staff as well as teaching GP registrars both in the clinics and lectures. Within the service, there are regular 'whole team' workshops and separate in-service training for the specialist and general streams. The aim is to influence referral patterns by improving GPs' confidence and competence at managing musculoskeletal conditions.

The PCT provider's finance department has developed a scalable model which calculates all the costs of patient contact (staff salaries, equipment, investigations, *etc*.), administrative and secretarial overheads, teaching, human resources, premises, capital costs, employer's National Insurance and pension contributions and includes the costs of patients who do not attend as well as allowing flexibility for different consultation times and rates for different parts of the service. This allows the PCT provider to tender for future services of any size or volume as the costs are accurately known.

Using the provider cost model, the cost per case in the community clinics varies from £260 to £296 including 'Did Not Attends' (DNAs), depending on the stream. The hospital 'Payment By Results' tariff for similar cases, investigations and treatments is £434 including DNAs. The number of appointments per

patient episode varies from 2.6 (spinal MSK physicians) to 3.5–4.5 (ESP streams), excluding DNAs.

Audit and performance monitoring are key components of the service provision. The service enjoys high patient and GP satisfaction. More robust audit of outcome is being piloted and will use patient-reported outcome measures: EuroQol EQ-5D and MYMOP. Tracking by NHS number will allow accurate determination of all MSK activity for the PCT population, including the proportions of patients seen in the community and in hospital, as well as surgical conversion rates. This will also provide data about patients who bypass the community MSK service because of direct GP referral to hospital, referral from casualty or secondary care 'consultant-to-consultant' referrals.

2 Craven Musculoskeletal Clinic

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The clinic was initially set up to provide a service to the patients of the six practices in the Skipton area of the Yorkshire Dales. The catchment population is approximately 60,000. With the advent of 'patient choice', the clinic now receives some referrals from outside the Skipton area.

My background was general practice and 2 years in another MSK service as well as the BIMM modular programme for GPSIs in musculoskeletal medicine. I also work as an Associate Postgraduate Dean at the Department of Postgraduate Medical Education at the University of Leeds.

I joined forces with Rachel Tiplady an Extended Scope Physiotherapy Practitioner and our initial task was to manage the 'overflow' of orthopaedic referrals. At the time, the local orthopaedic department could accept approximately 60 referrals per month from the Craven practices. This was being 'overshot' by approximately 20 patients per month. We began triaging referrals and selecting out obvious non-surgical cases to be seen in our own clinic. We began running a clinic alternate weeks. As is often the case, referrals increased exponentially and, before the year was out, we had increased our capacity to weekly clinics and then twice weekly. At this point, I made the decision to retire from my practice and concentrate on musculoskeletal work.

Initially, we found we were triaging approximately half of all orthopaedic referrals into our clinic and sending half onto our surgical colleagues. As 'Choose and Book' was rolled out to the Craven area. we found that our GP colleagues began to learn the kind of patients to refer to the MSK clinic and which to refer to orthopaedics. We currently triage very few patients to orthopaedics. Virtually all referrals now are seen in the MSK clinic. We receive approximately 50–60 referrals per month.

The majority or our work falls neatly into five areas: (i) back and neck pain; (ii) osteoarthritis; (iii) tendonopathy; (iv) joint pain and injury; and (v) chronic pain syndromes.

We feel we use relatively few investigations. Injured joints (except shoulders and mainly knees) will often have an MRI scan. Patients with tendonopathy and injured shoulders will often have an ultrasound scan.

Approximately half of all referrals are referred on to physiotherapy – mostly with a view to exercise programmes for self-management of their problems. Other onward referrals include podiatry, rheumatology and pain management. Small numbers are referred for spinal injections, image-guided injections, orthopaedic or neurosurgery and neurology.

However, the most important part of our work (I feel) is to perform a thorough assessment and then provide the patient with information and explanations about their condition. We try to involve the patients in the management of their problems and, hopefully, enable greater self-management. Much of this work might be categorised as in the cognitive and behavioural domain. We are also able to identify patients with chronic pain syndromes and move them appropriately away from the biomedical world into a multidisciplinary pain management service.

Our surveys suggest high levels of patient satisfaction with the time spent assessing and explaining.

From the outset, we wanted to include a training post for GP trainees in our service. We already had one such post at the clinic in North Bradford and we obtained the resources to allow a trainee based in a local practice to attend our clinics twice weekly. They also attended orthopaedic clinics, rheumatology clinics, local osteopaths, physiotherapists and a chiropractor. In 2006, we were rewarded for this work by the Royal College of General Practitioners with the Paul Freeling Award for 'innovative or meritorious work in the field of vocational training for general practice'. Of the 11 trainees who have experienced our training posts, four are now working as GPSIs in musculoskeletal medicine.

3 Musculoskeletal service provision in Birmingham

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Two different models of musculoskeletal service currently being provided in the city of Birmingham are described below: (i) a musculoskeletal triage clinic; and (ii) a hospital-based secondary care musculoskeletal service.

Musculoskeletal Triage Clinic

This clinic was started in 2004 and commissioned by Heart of Birmingham PCT. This PCT covers a population of approximately 300,000 in central Birmingham and has a diverse ethnic and socio-economic mix with large areas of relative deprivation.

The clinic is based at two different sites and acts both as a triage service and an interface clinic where those patients suitable for single treatment intervention can be treated and discharged back to the general practitioner (GP). The clinic has a musculoskeletal physician, GPwSIs in orthopaedics, physiotherapists and podiatrists, and consultant orthopaedic surgeons who have out-reach clinics in the premises. There is good access to high quality investigations including X-ray, MRI and neurophysiology tests. Treatments offered are advice regarding medication and life-style and joint and soft tissue injections. The orthopaedic surgeons also perform carpal tunnel release procedures on site. The maximum waiting time from referral to assessment in the clinic is generally 4 weeks and the new to follow-up patient ratio is approximately 4:1. GPs refer using a proforma. Exclusions are patients with red-flag symptoms and those who are cases where the GP wishes to refer directly for physiotherapy or podiatry treatment. The strengths of this service are shorter waiting times and service delivery closer to home for patients. Choice of secondary care provider is offered for those requiring onward referral. From the clinicians' point of view, there is job satisfaction seeing patients earlier in their illness than perhaps is possible in secondary care, rapid access to good quality diagnostic tests (MRI wait-time usually 1 week) and interaction between doctors, physiotherapists and podiatrists.

Musculoskeletal Service at the Royal Orthopaedic Hospital

This was originally started by Dr Graehame Brown in 1996 as a member of the spinal team. The service was set up to provide a musculoskeletal physician whose expertise could be used alongside surgical and physiotherapy teams in the management of spinal problems, sports injuries and other non-surgical musculoskeletal problems. Over time, this expanded: Dr Robin Chakraverty joined the team to make two musculoskeletal physicians and later three clinical assistants and physiotherapists expanded the team further. Dr Ketkar joined the team in 2004.

Referrals are from GPs, orthopaedic consultants, and extended-scope physiotherapists and from the armed forces rehabilitation centre. The clinic has developed a reputation for providing high quality care

and follow-up for non-surgical musculoskeletal problems. Advantages of this clinic are access to good quality diagnostic tests and, being a hospital clinic, a wider variety of available tests than in a community clinic. Treatments offered are brief counselling, peripheral joint and soft tissue injections, spinal manipulation, diagnostic and therapeutic spinal injections and prolotherapy and denervation treatments where appropriate. The ratio of new to follow-up patients is reversed from the triage clinic being on average 3 new patients and 12 follow-up patients per clinic. Follow-up of patients is easier and, again, interaction between different clinicians is facilitated by the hospital environment. Disadvantages for patients are a longer wait on average for their first consultation and, for some patients, a longer distance to travel.

4 East Lancashire PCT Musculoskeletal Service

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East Lancashire Primary Care Trust serves a population of 382,000 covering a wide geographical area encompassing the Pennine mill towns of Burnley and Accrington and outlying areas of the Ribble and Rossendale valleys. The PCT was formed following the amalgamation of Burnley, Pendle and Rossendale, Hyndburn, and Ribble Valley PCTs in 2007; both PCTs had separate MSK services which have also merged.

The MSK service is currently run by the provider arm of the PCT. The service operates from three LIFT (Local investment finance trust) buildings in Accrington, Burnley and Rossendale. Administration is based at Accrington which is the hub, with teams working out at the other sites.

The initial aims of the service were: (i) triage all orthopaedic and MSK referrals; (ii) comprehensive assessment including biopsychosocial; (iii) diagnostics; (iv) treatments including peripheral injections and caudal epidurals; (v) management plans; and (vi) referral as appropriate.

The triage of referrals led to a significant reduction in local orthopaedic waiting times with the service seeing over 65% of all referrals. There was a reported rise in surgical conversion rates. With the advent of free choice, the service is no longer performing comprehensive triage but receives referrals direct from GPs via a booking centre. Patients are also referred via the physiotherapy service. Patients will be directly booked from May 2009. The service currently receives an average of 250 referrals each week and the average wait is 4 weeks, compliant with the 18-week target.

The service employs four musculoskeletal physicians including a Clinical Lead & Education/Training Lead. They have qualifications including diploma in orthopaedic medicine, musculoskeletal medicine, sports and exercise medicine and osteopathic medicine. There are 10 ESP physiotherapists and two ESP podiatrists. A number of the physiotherapists are employed by the acute trust and seconded to the service and are number a directly employed by the PCT. The service also employs two assistant practitioners and a pain management nurse practitioner for one session.

The clinical staff work in three teams: (i) cervical and upper limb; (ii) lumbar, thoracic and lower limb; and (iii) foot and ankle.

Patients are booked into one of the three clinical streams and are given choice as to which clinic location they attend.

The service also provides GP education in the form of local workshops and forums. A GP registrar ITP post has also been developed with the Northwest Deanery, and this is proving highly popular. The service also provides placements for medical students, FY2 doctors and physiotherapists.

The service makes use of an EMIS-based clinical software package that facilitates the collection of clinical and clerical data. Performance is currently monitored around the 18/52 targets, patient satisfaction surveys and clinical audit. We are currently looking at which clinical outcome measures to incorporate into our practice. Presently, we use Roland Morris Disability and Linton & Hallden

(yellow flags) questionnaires for spinal patients, Oxford scores for shoulder and Lower Extremity Functional Scale for lower limb conditions.

I have been involved in the service since the start, early in 2005, as a full-time musculoskeletal physician directly employed by the PCT. The experience has been equally rewarding and frustrating as we are constantly responding to change. I believe we offer a quality service that is meeting patients' needs. We now face challenging times with changes to PCT commissioning. The service will have to respond and prove both clinical and cost effectiveness in the future landscape of the NHS.

5 Leicester City Musculoskeletal, Sports and Exercise Medicine Clinic

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The city of Leicester has a population of about 280,000 people and is served by one PCT 'NHS Leicester City'. Compared to England as a whole, Leicester has a relatively young population with a very varied ethnic mix. Leicester was ranked as the 20th most deprived local authority in 2007 and, despite significant health improvements, Leicester still has a lower than average life-expectancy which is particularly noted in the more deprived areas of the city.

The Leicester City M-SEM Clinic has been running since December 2006 and is located in the north-west area of Leicester City. There are two other similar, smaller MSK clinics within the boundaries of the PCT and the original idea was to try to set-up the clinics independently, which due to bureaucratic hurdles took some time, and then to try to merge the clinics together at a future point to provide a comprehensive service. To date, this merger has not occurred. As the local PCT divested itself of any provider function early on, this clinic was set up through the PBC mechanism which proved to be a time-consuming and frustrating process. However, setting it up in this manner meant some degree of autonomy from PCT-control as long as service specifications were maintained.

The M-SEM Clinic is funded on a fee-per-patient basis which is substantially lower than the tariff costs for secondary care creating a cost-saving for referring GPs. The cost of investigations is borne by the referring practice, although the low investigation rate makes this still an attractive option for local GPs. Patients are seen by Dr P. Wheeler, a Sports and Musculoskeletal Physician (GPwSI Sports and Musculoskeletal Medicine), ideally within 2 weeks of referral from the local GP. Dr Wheeler works full-time in Sport and Exercise Medicine/Musculoskeletal Medicine and this clinic runs one day per week. He maintains multiple contacts with other colleagues to ensure that his scope of practice is not seen as isolated, and has a strong commitment to CPD. He possesses an MSc in Sports and Exercise Medicine, Apothecaries Diploma in Musculoskeletal Medicine and is part-way towards an MSc in Physical Activity & Public Health.

The M-SEM Clinic typically receives between 20–25 new referrals per month and sees an additional 10 follow-ups per month which remains small enough to be managed in its current format. The M-SEM clinic is set up on a 'See and Treat' model, with new patients being allocated 45 min for their first appointment, the use of 'open appointments' and a low follow-up rate. Within the clinic, interventions include home-based therapeutic exercises and mobilisations, joint and soft tissue injections, acupuncture, life-style advice, and medication advice. Manipulations are no longer routinely provided within this clinic, but instead patients who may benefit from this are directed to other practitioners. Intervention rates for all consultations include: therapeutic home exercises (62%), injections (21%), written materials (26%), and orthotic recommendations (10%).

The M-SEM Clinic has access to all imaging modalities and interventional procedures through the local secondary care radiology department. A number

of patients referred have already had investigations performed; the numbers of these has not been recorded. The rates from the M-SEM Clinic for all consultations are: ultrasound (3.4%), MRI (3.1%), X-ray (0.5%), and nerve conduction studies (0.5%)

Any onward referrals are also directly sent by the M-SEM Clinic, rather than having to go back via their own GP. Referral rates from the M-SEM Clinic include: orthopaedics (4.6%) and rheumatology (0.4%). Where possible, outcomes of these referrals are obtained to guide further practice and surgical/intervention conversion rates from first orthopaedic appointment are in the region of 85%.

Patients seen at the M-SEM Clinic are asked to complete satisfaction questionnaires examining various aspects of the running of the M-SEM Clinic and we have received over 800 responses. The figures of those responding as 'excellent', 'very good' or 'good' were as follows: waiting times (94%), ease of booking (98%), convenience of M-SEM Clinic location (86%), receptionists (99%), quality of clinical care received (99%), time spent in clinic (99%). In addition, when asked, 100% of all patients surveyed would recommend the clinic to their friends or family members.

The data collected from the M-SEM Clinic are reported back to the PCT on a quarterly basis and the figures from the last 2.5 years have shown this to be a cost-effective service providing a service that the local patients and GPs rate highly. This is a simple model for other Sports/MSK Physicians to adopt and show that small, local clinics are adaptable to need and highly valued by patients. Although this should be seen within the scope of a wider job-portfolio which includes CPD and regular professional contacts for governance purposes.

6 Some clinics associated with musculoskeletal physicians

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MSK clinic: Leicester City Musculoskeletal, Sports and Exercise Medicine Clinic

MSK physician	*Patrick Wheeler*
New patients p.a. (*n*)	*360 (+ 4% DNA)*
Clinic booking ratio new to follow-up	*3:1*
Average consultation rate/episode	*1.53*
Referrals to secondary care	*5%*
Pathology	*0.7%*
X-rays	*0.5%*
MRI	*3.1%*
Ultrasound	*3.4%*
Other	*0.36%*
Cost per case episode	*£125 new; £60 follow-up*
ESP triage (%)	
Allied health professionals in service team	
Available Rx within service	*PhysioRx, rehabilitation, manipulation, injections, acupuncture, medication*

MSK clinic: Birmingham (Heart of Birmingham PCT)

MSK physician	*Vinay Ketkar*
New patients p.a. (*n*)	*3200*
Clinic booking ratio new to follow-up	*4:1*
Average consultation rate/episode	
Referrals to secondary care	
Pathology	
X-rays	
MRI	
Other	
Cost per case episode	*~£200*
ESP triage (%)	
Allied health professionals in service team	
	Podiatry, physician assistants, physiotherapists
Available Rx within service	*Soft tissue injections*

MSK clinic: Birmingham (Royal Orthopaedic Hospital)

MSK physician	*Vinay Ketkar*
New patients p.a. (*n*)	*200*
Clinic booking ratio new to follow-up	*1:4*
Average consultation rate/episode	
Referrals to secondary care	
Pathology	
X-rays	
MRI	
Other	
Cost per case episode	*~£450*
ESP triage (%)	
Allied health professionals in service team	
Available Rx within service	*Podiatry, orthopaedic GPwSIs, physiotherapists*

MSK clinic: Craven Musculoskeletal Clinic, Yorkshire

MSK physician	*Adrian Dunbar*
New patients p.a. (*n*)	*~650*
Clinic booking ratio new to follow-up	
Average consultation rate/episode	
Referrals to secondary care	*Small percentage*
Pathology	
X-rays	
MRI	*20% (includes ultrasound)*
Other	
Cost per case episode	
ESP triage (%)	*50% to physiotherapy*
Allied health professionals in service team	
Available Rx within service	*Injections (5–10%), exercise(s) and acupuncture*

MSK clinic Ealing Primary Care Trust

Scope of practice	*Lower limb ESP*
MSK physician	
New patients p.a. (*n*)	*785 (+ 15% DNA)*
Clinic booking ratio new to follow-up	*1:3*
Average consultation rate/episode	*3.5 (excluding DNA)*
Referrals to secondary care	*~20%*
Pathology	*1%*
X-rays	*~7%*
MRI	~15%
Other	10% ultrasound
Cost per case episode	*£262 including DNAs, Ix, all overheads (hospital = £434)*
ESP triage (%)	*None within service. 'See and treat' model*
Allied health professionals in service team	*ESP, general physiotherapy, podiatry, OT*
Available Rx within service	*Manipulation, acupuncture, injections (1%)*

MSK clinic Ealing Primary Care Trust

Scope of practice	*Upper limb ESP*
MSK physician	
New patients p.a. (*n*)	*471 (+ 15% DNA)*
Clinic booking ratio new to follow-up	*1:4*
Average consultation rate/episode	*4.5 (excluding DNA)*
Referrals to secondary care	*~20%*
Pathology	*1%*
X-rays	*~7%*
MRI	*~15%*
Other	*7% ultrasound*
Cost per case episode	*£268 including DNAs, Ix, all overheads (hospital = £434)*
ESP triage (%)	*None within service. 'See and treat' model*
Allied health professionals in service team	*ESP, general physiotherapy, podiatry, OT*
Available Rx within service	*Manipulation, acupuncture, injections (1%)*

MSK clinic Ealing Primary Care Trust

Scope of practice	*Spinal ESP*
MSK physician	
New patients p.a. (*n*)	*1885 (+ 15% DNA)*
Clinic booking ratio new to follow-up	*1:4*
Average consultation rate/episode	*4.5 (excluding DNA)*
Referrals to secondary care	*~15%*
Pathology	*1%*
X-rays	*~7%*
MRI	*14%*
Other	*0% ultrasound*
Cost per case episode	*£296 including DNAs, Ix, all overheads (hospital = £434)*
ESP triage (%)	*None within service 'See and treat' model*
Allied health professionals in service team	*ESP, general physiotherapy, podiatry, OT, MSK physician, osteopath*
Available Rx within service	*Manipulation, acupuncture*

MSK clinic Ealing Primary Care Trust

Scope of practice	*Spinal MSK physician*
MSK physicians	*Ian Bernstein, Rod MacDonald, Davinder Gunjal*
New patients p.a. (*n*)	*1036 (+ 7% DNA)*
Clinic booking ratio new to follow-up	*1:2*
Average consultation rate/episode	*2.6 (excluding DNA)*
Referrals to secondary care	*8% to hospital, 6.3% to physiotherapy*
Pathology	*5.6%*
X-rays	*12%*
MRI	*7%*
Other	*1% ultrasound*
Cost per case episode	*£259 including DNAs, Ix, all overheads (hospital = £434)*
ESP triage (%)	*None within service. 'See and treat' model*
Allied health professionals in service team	*ESP, general physiotherapy, podiatry, OT, osteopath*
Available Rx within service	*Injections (9%), epidurals (15%), manipulation, osteopathy, acupuncture*

MSK clinic Plymouth

Scope of practice	*Acute back pain only*
MSK physician	*Mike Hopkins*
New patients p.a. (*n*)	*1149 (+ 17% DNA)*
Clinic booking ratio new to follow-up	*1:2.5*
Average consultation rate/episode	*3.4*
Referrals to secondary care	*4% to secondary care, 9.4% to subacute clinic*
Pathology	
X-rays	
MRI	*6.4%*
Other	
Cost per case episode	*£120 excluding MRI*
ESP triage (%)	*100%*
Allied health professionals in service team	*Osteopath*
Available Rx within service	*Manipulation, osteopathy, epidurals*

MSK clinic Northumberland

MSK physician	*Graeme Dunbar*
New patients p.a. (*n*)	*1152*
Clinic booking ratio new to follow-up	*1:0.6*
Average consultation rate/episode	
Referrals to secondary care	*24% (mostly orthopaedics)*
Pathology	*1.5%*
X-rays	*8%*
MRI	*15%*
Other	
Cost per case episode	*£108*
ESP triage (%)	
Allied health professionals in service team	
Available Rx within service	*Injections*

MSK clinic Fulham. London	
MSK physician	*Jens Foell*
New patients p.a. (*n*)	*165*
Clinic booking ratio new to follow-up	*1:3*
Average consultation rate/episode	
Referrals to secondary care	*4%*
Pathology	
X-rays	*3%*
MRI	*4%*
Other	
Cost per case episode	
ESP triage (%)	
Allied health professionals in service team	
Available Rx within service	*Manipulation, exercise Rx, acupuncture*

7 The Alexander Technique: can it really be as effective as the recent MRC trial findings suggest?

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Professor Paul Little and colleagues reported in August 2008 their randomised controlled trial of lessons in the Alexander Technique in cases of chronic and recurrent low back pain (Little P, Lewith G, Webley F *et al.* Randomised controlled trial of Alexander Technique lessons, exercise and massage for chronic and recurrent low back pain. *BMJ* 2008; **337**: 438–445). They found that the mean Roland Morris score reduced by 1.40 with 6 lessons and by 3.40 with 24 lessons; the number of days with back pain in the past 4 weeks (control 21 days) reduced by 10 days (6 lessons) or 18 days (24 lessons). Exercise (mostly walking) after 6 lessons in the Alexander Technique achieved 72% of the RM score improvement that 24 lessons achieved alone.

In the economic analysis paper (Hollinghurst S, Sharp D, Ballard K, et al. RCT of AT for chronic and recurrent back pain: economic evaluation. *BMJ* 2009; **337**: a2656), the best-value dual intervention was 6 lessons in Alexander Technique followed by exercise. The most beneficial and most expensive effective intervention was 24 lessons in the Alexander Technique with exercise, at £607.

The unexpectedly favourable evidence for the value of one-to-one lessons in the Alexander Technique was discussed in the light of the trial design, the nature of the technique itself and the teaching methodology.

The teaching method depends on specialised hand contact and practical demonstration together with verbal guidance and explanation. This combination of implicit and explicit teaching helps learners understand and attend to their manner of going about activities, helps them attend to proprioceptive input, suspend reaction and learn to respond thoughtfully in ways that avoid interference with co-ordination and balance systems. Through visual observation and hand contact, teachers gain immediate feedback about subtly changing conditions within learners as they prepare for, and engage in, activity. Consequently, teachers are able to reply with a few key words and by adjusting hand contact before the moment has passed. This is effective and efficient.

The Alexander Technique is the process and approach taught to learners for them to use themselves, not something that teachers do to them, and it includes the prevention of over-hasty responses to stimuli. The refusal to react immediately in an automatic habitual way allows time for brief consideration, a choice of response and the manner of responding. Change becomes possible.

Both teachers and learners pay attention to the activity of spinal musculature, to lengthening of the spine and to head poise. With help and advice, learners discover how to 'project messages from the brain to the mechanisms' in a way that enlivens muscle tone, facilitates muscle lengthening, co-ordination, flexibility and the smooth initiation of movement. Learners are then able to adopt a different approach to sitting, standing, walking and any other activity.

Use of the Alexander Technique improves the performance of both everyday and specialised activities. General health and well-being benefit as the progressive decrease in poor habits leads to increasing improvement in the functioning of physiological systems.

The Alexander Technique is also valued for its contribution to self-development: people learn to increase their attention level, gain poise, presence, and ease of movement and find it easier to remain calm and rational under pressure. It is taught in many different areas such as the performing arts, education, sports and leisure, as well as in healthcare.