

## Letter to the Editor: Comments on ‘Physiotherapy-led Care Versus Physician-led Care for Persons with low Back Pain: A Systematic Review’ by Severijns et al.

Jean-François Kaux<sup>1</sup>, Marc Schiltz<sup>1</sup>, Patrick Linden<sup>1</sup>, Geoffrey Brands<sup>1</sup>, Bruno Schoonejans<sup>1</sup> and Thierry Lejeune<sup>1</sup>

<sup>1</sup>*Scientific (RBSPRM), Professional (GBS-VBS) and Labor (ABSyM-BVAS) societies of PRM, Belgium*

### Keywords

Low back pain, physiotherapy, primary care, emergency care, direct access

We read with interest the systematic review by Severijns et al. and appreciate the authors’ efforts to examine direct access to physiotherapy for low back pain.<sup>1</sup> However, we have concerns about several critical issues.

First, this systematic review includes 18 trials (1,481,980 people), most of which (72%) are retrospective and prone to bias. Only one study, the oldest published in 1988, is a randomised controlled trial (174 people). The authors did not have the possibility to carry out a meta-analysis to quantitatively synthesise the outcomes of these 18 trials. Study quality, assessed via the Newcastle- Ottawa scale, varies from low to high risk, with follow-up duration and adequacy as key weaknesses. The GRADE assessment rated 72% of primary care outcomes as very low and the rest as low, while all emergency department outcomes were very low. Overall, the evidence supporting direct access to physiotherapy remains weak.

The authors highlight the benefits of early physiotherapy for acute low back pain, citing McDevitt et al.<sup>2</sup> However, they may overestimate its findings.

Based on three trials (fewer than 300 people), they suggest a possible small beneficial effect of early physiotherapy compared with no physiotherapy in the short term, but not in the long term. Severijns et al. also included studies mixing different pain durations despite differences in management and physiotherapy’s role. Moreover, not all studies assessed true direct access (some compared self referral with physician-referred care). Notably, guidelines do not systematically recommend physiotherapy for acute low back pain, reflecting the ongoing debate about its effectiveness.<sup>3</sup>

In addition, the review inadequately addresses the risks of misdiagnoses and inappropriate treatments. While red and yellow flags aid diagnosis, even trained professionals struggle with their accuracy, leading to potential delays or misinterpretations.<sup>4</sup> Physiotherapists, primarily trained in functional assessment rather than medical diagnosis, vary in their ability to manage direct access, depending on training differences within and across countries.

Moreover, the authors suggest that direct access to physiotherapy may reduce healthcare costs but lacks rigorous economic analysis. No health economist contributed, and hidden costs (e.g., delayed diagnoses, inappropriate treatments...) were overlooked. Claims of safety are also weakened by short follow-up and limited data on diagnostic errors or missed serious conditions, making comparisons with physician-led care premature.

Finally, the review includes studies from diverse healthcare systems with varying physiotherapy training and regulations, making it difficult to extrapolate conclusions universally. In many countries, the absence of regulatory oversight raises concerns about quality assurance and patient safety. Any policy changes regarding direct access to physiotherapy should be accompanied by stringent guidelines on training, governance, and patient safety monitoring.

In conclusion, the evidence supporting direct access to physiotherapy for low back pain remains limited. It is premature to conclude that physiotherapist-led care can safely replace physician-led care worldwide. If implemented, significant reforms would be needed, including improved training, regulatory oversight, and limits on unsupervised physiotherapy sessions. Medical supervision should be required if there is no improvement. A well-regulated, interdisciplinary approach (ensuring collaboration between physicians and physiotherapists) remains the safest and most effective strategy to prevent diagnostic errors and optimize patient outcomes.<sup>3</sup>

### **Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### **Funding**

The authors received no financial support for the research, authorship, and/or publication of this article.

### **References**

1. Severijns P, Goossens N, Dankaerts W, et al. Physiotherapy-led care versus physician-led care for persons with low back pain: A systematic review. *Clin Rehabil* 2024 Dec; 38: 1571–1589.
2. McDevitt AW, Cooper CG, Friedrich JM, et al. Effect of physical therapy timing on patient-reported outcomes for individuals with acute low back pain: A systematic review with meta analysis of randomized controlled trials. *PM R* 2023 Nov; 15: 1466–1477.
3. van Wambeke P, Desomer A, Jonckheer P, et al. The Belgian national guideline on low back pain and radicular pain: Key roles for rehabilitation, assessment of rehabilitation potential and the PRM specialist. *Eur J Phys Rehabil Med* 2020 Apr; 56: 220–227.
4. Tsiang JT, Kinzy TG, Thompson N, et al. Sensitivity and specificity of patient-entered red flags for lower back pain. *Spine J* 2019 Feb; 19: 293–300