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The 50 Treatment Lumbar Strain

Serious Questions about Treatment Protocols in an Era of Managed Care

By John Raymond Baker

Poor Harvey Lillard. Unfortunately he and D.D. Palmer, the magnetic healer and father of chiropractic, didn't have the help of a modern DC in figuring out a treatment plan. Poor Harvey's body was not educated enough to know that he shouldn't have had his hearing restored until far along in his care when his insurance had been verified and any pre-certification had been done. Both of them probably didn't know that the whole neck would have to be "stabilized" prior to Harvey's release from care. One treatment miracle doesn't pay the bills.

In 1989, \$45 billion (capital B) was spent on workmens' compensation. The vast majority of costs of workers' compensation involves low back injuries. It has been reported that five percent of people suffering an episode of acute low back pain (our alleged forte and something we are known for managing better than allopathic care) later develop chronic low back pain; this group is said to account for an astounding 85 percent of workers' compensation costs (Frymoyer 1988).

Back Pain Has a Natural History

There is something we can't ignore. Back pain like other health problems, has a natural history. Frymoyer (1988), after an extensive review of the available literature, found that the natural history of acute low back pain (i.e., what will happen in patients with the problem if no intervention is undertaken), is such that the symptoms resolve in six weeks in 90 percent of cases, with only five percent still having symptoms after three months. Thus, extrapolating to your patient population, are 90 percent of patients with uncomplicated back pain (i.e., osteoarthritic problems, no disc displacement) getting pain free within six weeks, and 95 percent within three months?

But they Have Exacerbating Factors

Yes, granted, patient's do things they shouldn't. They pick up things the wrong way; they bend too much; they work on their cars or play weekend warrior in touch football. But people in previous studies on the natural history of acute low back problems didn't live in glass houses either. A pamphlet and serious talk about using proper biomechanics could help eliminate this if the talk and literature were effectively presented. And this, without one adjustment.

Development of Appropriate Treatment Guidelines a Must

For all the harm that the "20/20" hatchet job did, it did underline a serious concern in our profession. We need to develop standard protocols and in this, I am not just talking about a revised copy of the Mercy Guidelines. And these must be based on proven concepts. For example, let's say you have Joe American playing softball and he reaches out too far to snag a ball and he gets low back pain. You take x-rays, he has some levorotatory deviation consistent with lumbar sprain/strain, he has no radicular signs or symptoms. He has a normal lumbar lordotic curvature. How long do you treat him? What therapies do you use? What techniques do you use? Do you employ just an activator on a 200 pound, 6' 2" adult male, or do you perform a lumbar side posture diversified?

If Joe comes to you for seven treatments and he has full range of motion, no pain, do you release him or tell him, "No, now we have to rehabilitate or stabilize that area." And, if you do that, do you have double blind studies which can prove that continue care of whatever type you use will make this person any less likely to experience re-injury to that area? The hard evidence in this latter regard is woefully lacking. I maintain that an area of the body which has been injured will remain more susceptible to reinjury, independent of rehabilitative efforts. In an article in the April 1994 issue of the American Journal of Occupational Therapy (LO Niemeyer, K Jacobs, K Reynold-Lynch, C Bettencourt, S Lang: "Work Hardening: Past, Present, and Future -- The Work Programs Special Interest Section National Work-Hardening Outcome Study," pp. 327-335), it was found that the best return to work group involved two health care professionals working with the injured worker; the worst group was the one in which four health care professionals were involved in the workers' care (p. 332). Perhaps it is an example of too many cooks spoiling the stew.

The point here is that we need to develop a consistent algorithm for patient management which is based on controlled, double blind studies. You don't go to an MD with a sore throat and have an MD order gall bladder surgery and then go to another and have him prescribe Flexeril. Misguided though they are in their

treatment, there is a uniformity of care for low back problems of a mechanical origin (i.e., muscle relaxants, pain killers, anti-inflammatory medications, and rest).

But Your Insurance Will Pay, You Can't Be Well Yet

Can you guarantee that you can restore a normal cervical lordotic curve to the neck of a motor vehicle accident injury patient even if you could treat them for years? Or can you guarantee that if a patient follows whatever rehabilitation program you prescribe, that they will not be more prone to re-injury. Are there any studies which suggest you should keep treating this patient past the six weeks of the natural history of acute, uncomplicated low back pain? Is it strictly a coincidence that the 20 treatment regimen (i.e., a daily regimen for two weeks, then with good progress, every other day) is accomplished in the same six week natural history?

We Need Evidence

For our own sake, comparison studies involving patients who become symptom free within 10 treatments and who are released and patients who are symptom free after the same amount of time, but who are not released and carry on through with the 20-25 treatment plan, should be conducted. An analysis of the incidence of recurrence of symptoms should be done.

In light of managed care scrutiny, 20 treatments which coincide with the natural history of acute low back pain will become increasingly more suspect. Are the treatments we render to this class of patients, facilitating recovery at all, or in some cases, are they impeding resolution (i.e., with patients who are kept coming treatment after treatment for months on end).

These are not abstract philosophical musings my colleagues, they are bread and butter questions that sooner or later you are going to have to come face to face with.

The Average Patient Visit Nonsense

It is possible that I am the only doctor who finds this preposterous, but maybe not. Believe it or not, there are people who want associate doctors to see patients at least up to some "average patient visit" number which supposedly establishes how many times the "average" doctor sees the "average" patient. To me, this is like some sort of sales statistic. It does a disservice to patients to hold them hostage to an arbitrary number of visits based not on how long it should take them to resolve their problems, but based on some artificial

national average. If you are keeping patients coming for x number of visits with tunnel vision only focused on maintaining a certain number without looking at their progress, are you a doctor or a sales manager? To be sure, one has to make a living and a profit and I encourage everyone in that regard. However, because of the nature of our profession, we must do this ethically and honestly. To treat patients longer than needed, or to try to scare them during reports into thinking they may become impotent from a lumbar muscle strain, is prima facie malpractice.

Pain Free Does Not Equal Well

Pain free, symptom free is not the same as healthy. Public re-education concerning the need for prevention based and not symptom based health care is essential and in fact should be the goal of allopathic and chiropractic physicians alike. Under the present system, earlier cures are not promoted: they are in fact discouraged. If our health care system is to ever be brought under control, those who get patients better, quicker must be rewarded and those who keep patients coming "forever," should be penalized. At this point, in the topsy-turvy system which exists, the opposite is the case. This is not to say that there are not complicated cases which require extended care. In my proposed changes there would be allowances for these cases. What I am talking about is the uncomplicated case where a patient comes 30, 40, 50, 60 visits and the SOAP notes show that the patient still hurts or is sore visit after visit after visit. This is obvious improper case management. It may be just incompetence or outright fraud, but either way, contributes to the overall health costs and to a degradation of the public image of our profession. Like it or not, the shady practices of the chiropractor down the street often leaves their victims with the notion that all chiropractic physicians are similarly afflicted with a congenital agenesis of a conscience and living in a moral and ethical vacuum.

I urge and welcome open and genial discussion of these matters. Let's make our profession all that it can and should be, not let it become what it might if greed becomes the order of the day.

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