

**Critique of
“Aspects of Chronic Pain and Chiropractic Management”
Distributed by the
Ohio Society of Chiropractic Physicians**

Respectfully Submitted by Ronald J. Farabaugh, D.C.

The Ohio Society of Chiropractic Physicians, composed of a small group of chiropractors, has distributed a paper on the treatment of chronic care patients to various workers' compensation stakeholders. This critique is offered to correct what I perceive as serious flaws in the resources cited.

The majority of resources cited as evidence, as well as the writer's own conclusion, are in direct conflict with the basic supposition presented. The writer set out to demonstrate that the continued use of passive chiropractic treatment for *chronic pain* does little more than create physician dependence. Yet the vast majority of the literature cited is merely a discussion of the difference between *chronic pain syndrome* and *chronic pain* and does little to discuss appropriate treatment for either condition. In fact, throughout the entire paper, the writer jumps back and forth between *chronic pain* and *chronic pain syndrome*, often inappropriately mixing and confusing the two.

The writer's conclusion also states that for *chronic pain* “..a multidimensional treatment approach is more appropriate...[where].. manipulative therapy **is** one component of a broad spectrum of treatment approaches”. Thus the conclusion supports that passive treatment is, indeed, appropriate for *chronic pain*. There is no conclusive opinion as to the appropriate treatment for *chronic pain syndrome*.

This could be due to the fact that there really are no clinical studies of any significance supporting the writer's theories. The writer states, “There are **no known clinical trials** in the literature that demonstrate efficacy (or inefficacy) of ongoing passive care for *chronic pain syndromes*. Likewise, there are **no known studies** pertaining to treatment dependency”. (Parenthetical comment added)

I will attempt to bring clarification to the confusion presented in the paper and present a logical approach to treatment for *chronic care*, which represents the majority of patients that present themselves in the Workers' Compensation system.

First, as to *chronic care syndrome*. The writer correctly points out that “*chronic care syndrome* is a diagnosis of exclusion and these patients have different clinical signs and symptoms, versus those suffering from *chronic pain* due to an unresolved or permanent local injury”. With that we agree.

The writer goes on to say “*Chronic Pain* patients, on the other hand have very localized pain, with observable dermatomal, myotomal, and anatomical signs.... Regardless of the mechanism, *chronic pain* tends to affect the patient's mood, social relationships, and personality. People with *chronic pain* tend to have sleep disturbance, depression, fatigue

and deconditioning.” The writer also cites a comprehensive review conducted by the Ontario Workplace Safety and Insurance Board in August 2000 that defines *chronic pain* as “pain that persists six months after and injury and beyond the usual recovery time for a comparable injury.”

Chronic pain is a debilitating condition that can develop secondary to soft tissue damage caused by the work injury. One of the most prolific writers on chronic pain, Nikolai Bogduk has repeatedly demonstrated that the cause of chronic pain is found in the facet joints and disc. The benefits of spinal manipulation for facet joint and disc related pain are well documented. In fact, no other treatment has more proven benefit in the restoration and maintenance of joint function.

The question that we need to ask ourselves is what are the goals of *chronic pain* treatment? The answer should be simple: (1) control pain, (2) maximize function (3) decrease reliance on drugs, and (4) keep the patient working. If therapeutic withdrawal fails to maintain these goals, and treatment is of documented benefit, reasonable people must ask themselves: “Why stop or deny care?”

While my learned colleague would like to attempt to support his position by listing a number of unrelated and misleading excerpts, I remind you that according to the British Medical Journal, valid medical evidence supports only about 15% of all medical interventions. Many treatments have never been assessed at all. Thus professional clinical consensus remains the gold standard in all of medicine. That “gold standard” consensus opinion in the chiropractic profession in Ohio suggests that supportive care rendered in 2-6 visit episodes for mild cases, and 1-2 treatments per month for more unstable cases is acceptable. Anything beyond “mild” logically reverts to acute care guidelines versus supportive care guidelines. Complicating factors affecting care and the uniqueness of each patient must be considered. If Ohio practitioners were to rely on the writer’s premise, no patient would benefit from any treatment, whether medical or chiropractic, beyond the first six weeks. We can all see this is an unrealistic viewpoint in determining patient treatment and completely dismisses any individualized care, chiropractic or otherwise.

A golden rule of medicine is that the efficacy of care is not found in the literature, it is found in each individual patient’s documentation. This issue is best characterized by the writings of one of this nation’s most well respected clinicians, author, lecturer, and practicing chiropractor, Dr. Scott Banks, who states:

“Simply, the science is imperfect and clinical judgement is perhaps the clinician’s best tool. Arbitrary management guidelines are not useful in chronic back pain. The clinician’s findings and observations may be the only tool that can help define the best management for each patient.”

In conclusion, while I respect the writer’s somewhat illogical and often confused attempt to defend his position, he fails to answer such questions as:

- How does one best manage a case that entered a chiropractic office already chronic?
- How does one best manage an acute patient who never fully recovers, demonstrates permanent partial impairment and advances to a chronic state?
- How does one manage a mildly chronic and relatively stable patient, versus a chronic pain patient subject to significant soft tissue damage and a physically stressful job?

The writer provides no guidance as to the proper management of the various levels of chronic pain scenarios found in the real world.

The vast majority of clinical opinion demonstrates that *chronic pain* is best managed on an individual basis using the well-established chiropractic guidelines as outlined by both the Ohio State Chiropractic Association Guidelines and the Mercy Guidelines. If appropriately followed, these guidelines allow the most flexibility for the individual patient and promote the quickest return to work, which will support the objective of both the provider and the BWC.

About Dr. Farabaugh:

- In 1994 he was appointed by Governor Voinovich to serve on the Healthcare Quality Advisory Council to help design managed care programs for the BWC, specifically QHP. As a chiropractic liaison to the BWC, he also works closely with the BWC on matters associated with HPP.
- In 2003 Dr. Farabaugh was appointed to serve on the Council for Chiropractic Guidelines and Practice Parameters (CCGPP) a group created at the behest of all member organizations of the Congress of Chiropractic State Associations (COCSA) shortly after publication of the original Guidelines for Chiropractic Quality Assurance and Practice Parameters (Mercy). Current efforts are underway to update the original Mercy document.
- Past President of the Ohio State Chiropractic Association. He now serves as Treatment Guideline Chairman (2001-2003).
- Appointed as an alternate Chiropractic representative for the HB 222 committee.
- Provides malpractice review services for National Chiropractic Mutual Insurance Company (NCMIC).
- Consults for numerous MCO's around the state and has lectured extensively on documentation and Chiropractic Guidelines.

- He is certified in **LOW SPEED REAR IMPACT CRASH RECONSTRUCTION** through the Spine Research Institute of San Diego (SRISD), and also holds a subspecialty as a Certified Chiropractic Sports Physician.
- Lectures on Low Speed Rear Impact Collision, research, documentation, guidelines.
- Dr. Farabaugh has been in practice since 1982. He currently practices in Columbus Ohio, 2879 East Dublin-Granville Rd., Columbus, OH 43231. Phone number: 614-898-0787.

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