

PHYSICIAN DEPENDENCY and PASSIVE CARE

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This paper will critically examine the truths and myths surrounding the controversial issue of physician dependency (PD) as it pertains to Chiropractic healthcare. Research on the topic is difficult to find, because at least to date, there is none. In running the keywords through Pubmed (an internet search engine linked to Medline/Silver Plater), under physician dependency there are 468 returns, none of them are associated with manipulation. Under ligamentous laxity/manipulation = 0. Under passive modality/side effects = 0, etc.

Chiropractic chronic pain management is often inappropriately denied due to concerns over physician dependence, even when care provided is rendered at only 1-2 visits per month. In general, concern over Chiropractic physician dependency is unwarranted, except in extreme cases, and denials are probably based more on limited understanding of the current literature (or lack thereof), personal bias, and/or secondary gain (deny-minded consulting can be very profitable), than on solid scientific investigation. One of the most lucid statements concerning PD can be found in the Journal of the American Chiropractic Association, *Focus: Chronic Back Pain*, October 2000. In an interview with several notable researchers/clinicians, Dr. Hansen stated, **“In the same way a doctor can give patients too much medication, which makes them dependent on it, chiropractors can make patients dependent on them. I see no reason for chronic pain management to include chiropractic visits greater than TWICE A WEEK [emphasis added].”** Quite literally, there is no scientific evidence to indicate that adjusting someone frequently would do any damage, let alone cause physician dependency, especially if the frequency of chiropractic spinal adjustments was only 1-2 *per month*.

The issue of physician dependency was presented in print in Mercy, Chapter 8, page 118, but it is not referenced.

“Supportive Care: Treatment/care for patients having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. Supportive care follows appropriate applications of active and passive care including lifestyle modification. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modifications, have been considered and attempted.

Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behavior, or secondary gain.” [page 118]

Despite warnings against taking statements out of context and using isolated statements for denial purposes, this section is probably the most mis-quoted and misinterpreted

portions of Mercy. Notice that the definition when read closely, does NOT prevent ongoing care, if the benefits of care outweigh the risks (ie, drugs, work loss, etc). Most critics of chiropractic chronic pain management fail to acknowledge Mercy page 125 which certainly supports passive care including manipulation as part of a multidimensional chronic pain management program.

Supportive Care: Supportive care using passive therapy may be necessary if repeated efforts to withdraw treatment/care result in significant deterioration of clinical status. (Mercy Guidelines, Chapter 8: Page 125.)

In general, passive care alone (whether it be pharmacological or spinal manipulation) may be considered poor chronic pain management in advanced cases. However, mild to moderate chronic pain is often managed quite effectively with singular treatment interventions, along with home care recommendations. Mercy supports the use of passive therapy, in combination with active care recommendations.

Without research, how do we manage chronic pain? In the absence of hard-core scientific evidence, professional consensus opinion remains the gold standard. Currently, the consensus opinion in Ohio (which is consistent with Mercy) is that with proper documentation in certain cases, 1-2 visits per month, and/or 2-6 visits per episode are appropriate along with instruction on active care, and home management. You can obtain the entire Supportive Care Consensus Opinion from the Ohio State Chiropractic Association by calling (614) 221-9933, or by accessing their website at OSCA.org.net. Suggestions on documentation, “The Supportive Care Worksheet/Medical Management of Chronic Pain” can also be obtain by contacting the OSCA.

In summary, when a patient attains maximal therapeutic benefit, was unable to achieve complete resolution of the condition, soft tissue residual damage is evident, active care recommendations provided, and therapeutic withdrawal from care attempted, several scenarios exist:

1. Patient remains stable, no ongoing care necessary, instructed to return PRN,
2. Patient managed with acute episodic care, 2-12 visits/episode,
3. Patient scheduled for supportive care, 1-2 visits per month on average, if therapeutic attempts failed to sustain recovery, to be re-evaluated every 6-12 months.

Treatment of chronic pain using spinal manipulation is supported by the literature and includes four primary goals:

1. Relieve/control pain,
2. Maximize joint function which keeps the patient functional,
3. Minimize use of drugs,
4. Keep the patient employed.

Chiropractic management of chronic pain, when appropriately administered, is safe, effective, cost efficient, and useful in keeping the patient employed.

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Recommended reading to fully understand the scope of chiropractic chronic pain management includes the following references.

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