Dynamic Chiropractic

PAIN RELIEF / PREVENTION

Pain Is Only a Piece of the Puzzle

Douglas R. Briggs, DC, Dipl. Ac. (IAMA), DAAPM, EMT

More often than not, when a patient presents to the office, it is for a pain complaint: headache, neck pain, low back pain, sciatica, carpal tunnel, etc. The pain is often the focus of the patient's mindset, and they don't often have any thought of what comes after the pain. When talking with attorneys or case managers, I often comment that my primary job is *not* to fix the patient's pain – my job is to fix the problem. That may sound like semantics, but the difference can be significant.

Think about someone with a broken arm – a cast is not comfortable or convenient, but it is necessary for support while the bone heals. I am quite sure there are medications that would take the pain away from the broken arm, but they won't set the bone or keep it in position to heal. Not all care is about pain relief; often, the more important care is about fixing the problem.

Reconciling Pain With Its Impact on Daily Activities

First and foremost, pain is a symptom. It is subjective. Pain is a personal experience that will differ from one patient to another. Every patient's perception of and tolerance for pain is different, and can change with activity, environment and mental investment. This is neither wrong nor misleading, but we must appreciate that the individual experience of pain is variable – both from one visit to the next and one patient to the next.

You may find one patient with a sprained ankle who ends up in a soft cast on crutches for a month, and another who will lace up their work boot tight and limp back to the job site.

The point is, when documenting a patient's complaints of pain, just keeping a tally of the daily pain score is inadequate – there must be some discussion about how the pain affects their individual daily routine.

Perhaps the best example I can give involves a patient who came to me a few years ago. He had a lower back disc injury and was looking at a surgery he did not want. With care, we were able to get him off medications and back to work. The problem – his pain level would drop to a 2/10 and then bounce back up to a 7/10.

When the case went to hearing, the argument was made that my care was ineffective because the patient had started with a pain score of 7/10, and six months later his pain score was the same – obviously no change in his condition. When I had the opportunity to discuss my care, I was able to elaborate: Yes, the patient did still have a recurring complaint of pain, but with care he had discontinued all narcotic medications and had progressively increased his work status.

At the time of the hearing, he was back to working full time. His pain was back up that particular day because he had just worked a 12-hour shift in the rain in December. Safe to say that most people would be tight and sore with that activity. While it could be argued that his overall pain level would occasionally flare, I was able to show that my care had measurably improved his condition.

Focus on the Quantitative: Functional Tests / Measures

The difference can be defined as *quantitative* versus *qualitative* measures. As noted above, pain is personal – it is *qualitative*. There is no serum level of pain we can measure. The 1-10 pain score is one tool, but it is probably the least reliable measure of a patient's true condition. A patient's perception can be quickly modified by any number of influences, including medications and recreational drugs.

However, *quantitative* measures are objective – these can show a measured change in the status of the person. Taking less medication, increased work time or capacity, improved range of motion – these are quantitative, measured improvements that can document your care is making a measured change in the patient's status.

Many insurance companies now require evidence of measured improvement to authorize additional or continued treatment. During the course of your care, make sure you regularly discuss not just the pain levels, but how the patient is doing: Are they more active? Are they taking less medications? How are they different with your care? These changes can carry much more weight in evaluating how beneficial your care is than just a simple change in a pain score.

Another tool that can be easily employed is the outcomes assessment questionnaires. Forms such as the *Neck Disability Index* or the *Oswestry Low Back Pain Questionnaire* are considered objective because the patient provides information not only on their pain, but also how their perception of their pain affects their daily activities. With effective care, the scores on these forms should progressively come down over a period of time.

The *McGill Pain Questionnaire* also assesses a patient's psychodynamics, and can be used to identify symptom magnification. *Waddell's testing* is a great set of pseudo-orthopedic maneuvers to indicate non-organic pain or symptom magnification. Also consider the use of an *algometer* to measure how much pressure is used to produce pain at a certain location. *Computerized dual inclinometry* is the current standard of care for measuring range of motion. There are many other outcomes questionnaires, orthopedic tests, and functional studies that will provide legitimate, objective data of the change in a patient's condition with care.

Moving Beyond Pain Helps Validate Your Care Plan

Don't be afraid of pain. Pain is typically what drives people to your door, but be willing to explain to your patient that you want to not only address their pain, but also the cause of the pain so the problem does not recur. In the end, fixing an acute lower back today, only to have the pain return tomorrow, does not help the patient. Tell the patient your findings and plan right up front – if you wait until they are out of acute pain to say, "Now we are going to fix the real problem," you have lost their attention. The perception then becomes more that you are trying to drag them in for unnecessary care.

I will tell my patients that I have to get the inflammation (and the pain) down before I can fix the problem – they get that. But remember, we are here to help the patient. We are more than an aspirin for pain – we can help to fix the problem.

As always, remember to completely and clearly document your findings, correlate with the patient's case history, and logically outline your care plan. These extra notes help document the severity of the patient's complaints and can then show the progressive response to care. This extra documentation can also help make the difference if you must justify your diagnosis to an insurer or third party. Take the extra few seconds to note the quantitative changes during your exam routine – it will validate your care.

APRIL 2015

©2024 Dynanamic Chiropractic™ All Rights Reserved