

# THE CHIROPRACTIC REPORT

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## PROFESSIONAL NOTES

**Cost-Effectiveness – LBP.** JMPT has just published a landmark new study comparing the cost-effectiveness of medical and chiropractic care for patients with acute and chronic mechanical low-back pain (LBP). It provides better evidence than any previous single study of cost-effectiveness because of:

(a) *Its source and design.* This is an economic analysis from the large (2,870 patients) and rigorous practice-based LBP study from Western States Chiropractic College and the Department of Family Medicine, Oregon Health and Sciences University in Portland funded by the US federal government's Department of Health and Human Services. (There was contributory funding from NCMIC Insurance and FCER).

Whereas the clinical results have been reported by health science researchers, led by Mitchell Haas, DC from Western States and Bruce Goldberg, MD from OHSU, these new cost-effectiveness results are principally from health economists – Haas is joined by Rajiv Sharma, PhD from Portland State University

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## THE ART OF COMMUNICATION

### Explaining Chiropractic to Others: Interprofessional Correspondence

#### A. INTRODUCTION

**C**HIROPRACTORS GENERALLY have excellent communication skills with their patients, a fact that is reflected in the profession's consistently high ratings in patient satisfaction surveys. Paradoxically, they tend to have communication difficulties with everyone else.

This is well illustrated by a recent letter to the weekly newspaper for the Canadian medical profession, *The Medical Post*. The newspaper, helpfully, had published an article advising physicians of the increased evidence supporting the effectiveness of chiropractic manipulation for patients with low-back pain. However the next issue carried a letter to the editor from a concerned chiropractor, advising medical readers that chiropractors did not use manipulation or treat back pain. Chiropractors know what he was trying to say, medical readers were perplexed – the effort at communication was both ineffective and counter-productive.

The causes of this communication paradox are not hard to find. To a degree they apply to everyone. However they apply particularly to minority groups that have undergone a long struggle to be heard and understood in a world where they are dominated by others – whether in a professional, commercial, religious, ethnic or national context. The root causes are over-enthusiasm for one's own interests, and failure to appreciate the other person's point of view. The letter writer to *The Medical Post* had no concept of the perspective of the readers of that publication and, as a result, could not communicate with them.

This issue of *The Chiropractic Report* deals with the art of communication. Firstly we review general principles. Then there is discussion of:

a) How to introduce others to the pro-

fession in a 10-15 minute presentation – maybe on radio/television, or in person to professional or public groups. How is that done effectively? What is important? How, for example, do you explain the difference between chiropractic and osteopathy and physical therapy?

b) Correspondence with medical colleagues. When should letters be sent, how should they be structured, what should they contain?

#### B. GENERAL PRINCIPLES

**1. Mutual Respect.** Communication is not about you and what you want to say. It takes two. In the words of Cleveland, Phillips and Clum, North American leaders in the profession, speaking of interprofessional relations in a recent text, successful communication must be “based on mutual respect and understanding”.<sup>1</sup>

**2. Understand who you are talking to.** Young, inexperienced litigation lawyers lose their early cases because they fail to understand that their client's view of the facts is not the only one. The other party to the dispute and the judge or jury may see things very differently. They soon learn that, to win, they need to spend 75% of their preparation time thinking about the likely views, interpretations and biases of the others involved in the litigation – and presenting their case accordingly.

When you prepare to speak about chiropractic to a group of people who have never been chiropractic patients, to a government official or third party payor, to a radio interviewer and audience, or to another health professional, do you spend adequate time assessing their background, their capacity to hear and their level of interest? Do you modify your presentation accordingly? If not you will have much less success with what you say, even when those listening

to you nod, smile and tell you that you were most helpful.

For example, you are finally meeting with a decision-maker in an insurance company or the Ministry of Health or a medical family practice group to discuss access to patients or reimbursement or other issues that are important to your practice and profession. You want to address the appropriateness of chiropractic care. You have 20-30 minutes.

Do you start as if this is your big moment, taking the allotted time to present chiropractic services as superior to all others and stretching interpretation of the supporting evidence to the limit? Do you make unfair criticism, explicitly or impliedly, of other competing health professionals?

Alternatively, do you understand that this decision-maker is also meeting during the same day or week with representatives of other professional groups – say nursing, family medicine, surgery and physical therapy. S(he) will be matching your claims and performance against them. S(he) may be married to or the child or parent of one of them. S(he) may have a good or bad personal experience of chiropractic care.

If you adopt the latter perspective you will start the meeting focusing on the other participants, and with introductions during which you learn the background of the person(s) you are meeting. Unless you have clear facts to the contrary you will assume that the decision-maker is fair, has other advisors who know at least as much about the research evidence as you (most large health insurers now have staff epidemiologists for this purpose), and respects other groups of health professionals as much as you. This means you will not misrepresent the evidence and will not criticize other professions as you advance your case. (It is always a good idea to begin by confirming how much time is available. No one hears anything while waiting to leave for another commitment).

**3. Address the things that interest them, not you.** This is a fundamental rule, discussed more fully below under the topic of effective presentations. Never assume that anyone other than a chiropractor is really interested in chiropractic. When did you last lose sleep over whether or not you should be using traditional Chinese medicine, or the injustices within the health care system

faced by psychologists, dental hygienists or audiologists?

**4. Demonstrate balance and objectivity.** Here is a test. Speaking in public, may be for example with a group of medical students or insurance adjusters, would you ever think of using the old joke “how many chiropractors does it take to change a light bulb? One – but it may take 50 visits.” No, you may say, and you may even be offended to see it in print here.

The reason you might consider doing so is because it would demonstrate your balance and objectivity. The ability to engage in self-criticism, to admit faults and limitations, makes you so much more credible on the good things you say in support of your profession and practice. Strong enthusiasm and belief may be good with patients and in life in general, but these are not convincing qualities with others unless tempered with signs of objectivity. It is universally agreed says the Hungarian humorist George Mikes, whose best selling book *How to be an Alien* was written about his experiences when immigrating to England, that the two best forms of humor in the world are Jewish and British – and this is because people from these cultures can laugh at themselves.

The light bulb joke would give you an opportunity to acknowledge over-treatment by some members of the profession, which then makes you more credible on explaining the need for ongoing supportive care in some cases, and the difference between necessary and elective care, and why some patients choose the latter for reasons of prevention and overall well-being and health. You could even follow the joke with one of your own – such as “how many family physicians does it take to change a light bulb? One, if s(he) is good, and works in collaboration with a good chiropractor”

**5. Use independent sources of evidence.** When a drug company funds a successful trial of its own products, or an orthopedic surgeon explains the benefits of yet another new approach to spinal fusion surgery, or a chiropractor quotes evidence for the benefits of chiropractic, there is suspicion of self-interest. Third party or independent evidence is always best if available.

Therefore, to return to the example of duration and frequency of care, the traditional medical view has been that spinal manipulation, where indicated

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for patients with back pain, should work within a few treatments if at all. Well-developed, evidence-based chiropractic guidelines in the US<sup>2</sup> and Canada<sup>3</sup> in the early 1990s support an initial course of 12 treatment visits (3 per week for 4 weeks) for patients with uncomplicated, acute back pain, with treatment continuing if there is objective evidence of improvement but some continuing pain and disability. That approach, however, is also supported by independent sources of evidence. These include a multidisciplinary evidence review and report from the prestigious RAND Corporation<sup>4</sup> and more recently an evidence-based program of care adopted by one of the largest workers' compensation authorities in North America, the government-sponsored Ontario Workers' Safety and Insurance Board (WSIB)<sup>5</sup>. All the above authorities can be quoted – but the best ones to focus on are those that are independent.

**6. Be concise.** Brevity is a virtue in both oral and written forms of communication. Increasingly, in a world shaped by television and now computers, attention

span is short. No one has time. Years ago health science journals developed abstracts so readers could get an overview of articles. In the last generation, to maintain reader interest and subscriptions, journals have learned that these abstracts must be increasingly brief and structured. See Figure 1 for a recent example from the *British Medical Journal*.

### 7. Avoid jargon/technical language.

The two problems are first that your technical language is of little interest to others, and second that it is an active barrier to communication. We say more on this below.

## C. SHORT ORAL PRESENTATIONS

8. You have been invited to talk about chiropractic for 10-15 minutes on a radio or television program, or at a service club luncheon. We now put the above principles into practice.

**a) Who is listening and what interests them?** Like a preacher delivering a sermon, you have only about one minute to connect. Most of the audience will know little or nothing about chiropractic. Introducing them to a new philosophical approach to health, or describing research and scientific evidence is not going to work. Your listeners have no perceived need to know about chiropractic. Why should they listen?

Accordingly avoid abstract principles (e.g. the role of the nervous system and homeostasis in health) and professional issues (e.g. the difference between adjustment and manipulation), however interesting these things may be to you. What you might start with is "Imagine you have back pain, leg pain, persistent headaches, or restricted movement in a shoulder or hip and that you have decided to give chiropractic treatment a try – what would happen to you when you arrived for examination and treatment?" Nearly everyone is interested – they, or someone in their family, will have one of these problems. Lack of knowledge or fear of the unknown may have prevented them from consulting a chiropractor – they likely want to know what would happen if they walked into your clinic. Explain patient assessment, diagnosis and treatment in practical terms that listeners can easily understand. Cover points that public surveys have shown are important to potential patients – understanding what you do, cooperation with other health professionals, the

Figure 1

### Randomised controlled trial to compare surgical stabilisation of the lumbar spine with an intensive rehabilitation programme for patients with chronic low back pain: the MRC spine stabilisation trial.

Jeremy Fairbank, Helen Frost, James Wilson-MacDonald, Ly-Mee Yu, Karen Barker, Rory Collins for the Spine Stabilisation Trial Group.

#### Abstract

**Objectives** To assess the clinical effectiveness of surgical stabilisation (spinal fusion) compared with intensive rehabilitation for patients with chronic low back pain.

**Design** Multicentre randomised controlled trial.

**Setting** 15 secondary care orthopaedic and rehabilitation centres across the United Kingdom.

**Participants** 349 participants aged 18-55 with chronic low back pain of at least one year's duration who were considered candidates for spinal fusion.

**Intervention** Lumbar spine fusion or an intensive rehabilitation programme based on principles of cognitive behaviour therapy.

**Main outcome measure** The primary outcomes were the Oswestry disability index and the shuttle walking test measured at baseline and two years after randomisation. The SF-36 instrument was used as a secondary outcome measure.

**Results** 176 participants were assigned to surgery and 173 to rehabilitation. 284 (81%) provided follow-up data at 24 months. The mean Oswestry disability index changed favourably from 46.5 (SD 14.6) to 34.0 (SD 21.1) in the surgery group and from 44.8 (SD 14.8) to 36.1 (SD 20.6) in the rehabilitation group. The estimated mean difference between the groups was -4.1 (95% confidence interval -8.1 to -0.1,  $P = 0.045$ ) in favour of surgery. No significant differences between the treatment groups were observed in the shuttle walking test or any of the other outcome measures.

**Conclusions** Both groups reported reductions in disability during two years of follow-up, possibly unrelated to the interventions. The statistical difference between treatment groups in one of the two primary outcome measures was marginal and only just reached the predefined minimal clinical difference, and the potential risk and additional cost of surgery also need to be considered. No clear evidence emerged that primary spinal fusion surgery was any more beneficial than intensive rehabilitation.

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quality of your chiropractic education, and treatment that works.

**i) Assessment and diagnosis.** Mention differential diagnosis to determine whether the case falls within the scope of chiropractic practice or may involve disease or pathology requiring medical referral (for this there will be a detailed history, various orthopedic and neurologic tests as in medical practice, use of x-ray and other imaging as necessary); the specialized chiropractic neuromusculoskeletal assessment (assessing joint and muscle function and reproducing pain through static and motion palpation and diagnosis; the relationship between leg length/pelvic balance/compensations elsewhere in the spine; referred pain – and how headache, leg pain and other extremity problems frequently arise from the spine). Note that about 90% of patients with the problems being discussed do not have medical pathology, do fall within your scope of practice, and can be greatly helped by chiropractic care.

**ii) Treatment.** Explain the use of a wide

variety of manual techniques to restore function to joints, muscles and other soft tissues, with an emphasis on joint manipulation or adjustment – the quick, precise techniques that most people identify with chiropractic – because of its particular accuracy and effectiveness; use of rehabilitative exercises, modalities and education; no use of drugs or surgery, but referral to family physicians or specialists when these are needed.

**iii) Use practical demonstrations** of palpation and adjustment wherever possible, using assistants or powerpoint video clips. Other than patients, no one appreciates the levels of specificity and skill in chiropractic technique. Everyone has an exaggerated impression of forces used and ranges of motion. Few realize that the amount of joint movement is similar to that when they pull and click a finger joint.

**iv) Education and licensure.** The essential points are the duration and level of chiropractic education – in North America, a minimum of seven years fulltime

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## Cost-Effectiveness – LBP

*continued from page 1*

and Miron Stano, PhD from Oakland University, Rochester, Michigan.

(b) *Its findings.* These are that LBP patients, particularly those with chronic pain (defined here as a current episode of pain of only 7 weeks or more), achieve better and more cost-effective results under chiropractic care as opposed to medical care when assessed at 3 months and 12 months. Chiropractic patients do better in terms of reduced pain, reduced disability and greater overall satisfaction with care. Direct costs (i.e. all treatment costs) are such that chiropractic care is cost-effective even before one considers indirect costs (e.g. disability and compensation costs, lost efficiency in production, etc.)

(c) *The objectivity of the published paper.* The main article of this issue of *The Chiropractic Report* is about the art of communication. This new paper from Haas, Sharma and Stano, quite apart from the strength of its data, is written with evident balance, thoroughness and conservatism. It is research that may be relied upon with great confidence.

(d) *Its overview of the practical importance of comparing the cost-effectiveness of chiropractic and medical care of LBP patients.* Points made include:

i) It is expected that the treatment costs of patients with LBP in the US in 2005 will be \$48 billion or 2.5% of national health care expenditures.

ii) A substantial proportion of care is by chiropractors, so the relative efficacy and cost-effectiveness of chiropractic and medical care “have emerged as important issues in the broader debate on evidence-based medicine.”

iii) There is a large body of research evidence demonstrating that “spinal manipulation-centered therapy is at least as good as, and in some cases better than, other treatments of LBP;” but the cost-effectiveness evidence suffers from design weaknesses. As LBP is experienced by 80% of adults during their lives and accounts for such large costs, “the relative cost-effectiveness of medical and chiropractic care is an urgent economic and health policy issue . . . With their mission to increase value and respond to patient preferences, health care organizations and policy makers need to reevaluate the appropriateness of chiropractic as a treatment for LBP.”

This publication has previously reviewed clinical results from the Oregon study, which is understood to be the largest and most thorough practice-based study of the management of LBP anywhere. It involved 2870 patients of 60 doctors of chiropractic and 111 medical doctors in 51 chiropractic clinics and 14 general practice community clinics in Oregon and Washington commencing treatment during the two year period from 1994 to 1996. (There were particularly good clinical results for chiropractic patients with chronic LBP and leg pain. See TCR July 2004, Vol. 18 No. 4, pg. 1). Economic results will be reviewed more fully in a future issue but summary points are:

a) As in past studies in-office costs were higher for chiropractic visits than medical primary care visits. However, medical

referrals for specialist services (e.g. imaging, physical therapy, surgical consultations) were much more frequent and expensive. Therefore, for example, average DC office costs over 12 months for a chronic LBP patient were \$222.00, average total costs (i.e. including any referral costs) were \$232.00 – only \$10.00 more. For MDs these figures were \$146.00 and \$281.00 – \$137 more for total costs. (All figures in 1995 constant dollars).

b) Various important cost centers for which one would expect chiropractic care to be more cost-effective were not included – notably the cost of hospitalizations and surgeries (only surgical consultations were included) and over-the-counter (OTC) drug costs.

c) For chronic LBP patients there was actually an average greater total direct cost of \$5.00 for chiropractic patients at three months after adjustment for patient differences at baseline (e.g. medical patients with chronic LBP had greater average disability than chiropractic patients). However, this \$5.00 cost was accompanied by:

- A 10.5-point advantage in pain reduction (on a 100-mm Visual Analogue Scale).
- An 8.8-point advantage in reduced disability (Revised Oswestry Disability Questionnaire).
- Much higher patient satisfaction.

Overall, the Oregon study gives us powerful new evidence supporting the cost-effectiveness and patient preference for chiropractic management of LBP. To conclude, it should be emphasized again that the cost figures reported do not consider all direct treatment costs and, even more significantly, do not consider indirect costs at all. The significantly lower disability of chronic pain patients under chiropractic care at three months and 12 months must have led to considerably lower indirect costs.

(Haas, M, Sharma R, Stano M (2005) *Cost-Effectiveness of Medical and Chiropractic Care for Acute and Chronic Low Back Pain*, J Manipulative Physiol Ther 28:555-563).

## RESEARCH NOTES

### 1. Neck Pain from Transient Nerve Root Compression.

*Spine* has just published an important study from basic science researchers from the Department of Bioengineering, University of Pennsylvania, that is the first animal experiment to investigate whether transient (temporary) cervical nerve root compression produces prolonged pain responses. It does. After a micro-vascular clip producing a force of only 10 grams is applied to the C7 nerve root in rats for just 15 minutes then removed:

- a) There is allodynia (i.e. pain caused by a stimulus that does not normally provoke pain) in both the ipsilateral and contralateral forepaws which still persists seven days later.
- b) There are immuno-histological changes in the dorsal and ventral horns of the C7 spinal cord that suggest the mechanism of increased sensitivity and pain – astrocytic and microglial activation.

## NEWS AND VIEWS

Experimental rats received either 10 grams (6 rats) or 60 grams (6 rats) compressive force for 15 minutes. Interestingly there was just as much pain reaction and allodynia in each group, and the authors conclude that “the force threshold for persistent pain after transient compression is likely less than 10 grams.”

A sham group of rats (8) received the preliminary surgical procedures to expose the nerve roots, then repair, in the same way as the experimental rats, but not the temporary nerve root compression, and did not develop any pain reaction.

Abnormal pain sensitivity was demonstrated in the experimental rats by forepaw pain and withdrawal when there was a normally non-noxious light stimulation of the plantar surface of the forepaw with a filament. Explaining the significance of their findings Hubbard and Winkelstein note:

a. “Chronic neck pain has a reported prevalence as high as 30% with annual costs reaching more than \$29 billion”. (These figures relate to the USA.)

b. “Although injuries to many spinal tissues, including facet joints, ligaments, and surrounding muscles, can lead to chronic neck pain, *cervical nerve roots are at particular risk because of their structural frailty and potential for compression resulting from foraminal shape changes during vertebral motions.*” (Italics added).

c. “Coupling the mechanical risk for transient cervical nerve root compression with the known capacity of lumbar nerve roots to elicit low back pain (LBP), nerve root compression in the cervical spine is a likely mechanism for producing pain injuries.”

d. With nerve root compression “responses in the cervical spine cannot simply be assumed as similar scaled versions of the same cascades (as in lumbar nerve root compression). In fact

the close proximity to the brain and its supraspinal influences on pain may imply a wholly different or more severe response for these same injuries in the neck.”

e. “Nociceptive responses can lead to central sensitization, causing a decreased threshold and an enhanced responsiveness of the CNS for afferent inputs. Bilateral behavioral hypersensitivity and pain symptoms can result from spinal changes, and have been reported in both animal models of LBP and clinical studies of neck pain. While suggesting that cervical nerve root compression may elicit bilateral sensitivity, no previous work has experimentally investigated this or its associated CNS nociceptive responses for painful injuries in the neck”.

This important new study is such an investigation, and Hubbard and Winkelstein conclude that “the injury model presented here mimics a unilateral, transient loading of the C7 nerve roots, which produces bilateral behavioral hypersensitivity sustained for 7 days. For these injury conditions, findings suggest that compressive loads  $\geq 10$  gf can induce persistent allodynia, which may be mediated to glial activation”.

(Hubbard, RD, Winkelstein BA (2005) *Transient Cervical Nerve Root Compression in the Rat Induces Bilateral Forepaw Allodynia and Spinal Glial Activation*, Spine 30:1924-1932.)

### 2. Neck Pain – Adverse Reactions to Chiropractic Care.

A further paper from Hurwitz, Morgenstern et al. from their University of California at Los Angeles (UCLA) neck pain trial looks at the adverse effects of chiropractic treatment of patients with neck pain, and possible clinical predictors of these effects. It is consistent with the earlier study by Senstad, Leboeuf-Yde et al. in Norway in finding that minor adverse symptoms are quite common following chiropractic treatment, but that serious adverse reactions are extremely rare.

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### RMIT Japan becomes Asia's First Accredited School of Chiropractic

Dr. Phillip Ebrall, Head, Division of Chiropractic, RMIT University, Melbourne, Australia, addresses a ceremony in Tokyo on September 17, 2005, to celebrate two milestones achieved by the RMIT Japan Unit in Tokyo – its 10th anniversary and, more significantly, its achievement that month of becoming the first school in Asia to receive full accreditation. This was from the Australasian Council on Chiropractic Education. Dr. Ebrall paid tribute to key leaders, most notably Dr. Kazuyoshi Takeyachi (pictured with Dr. Ebrall).



university level education, followed by government-mandated licensing exams.

v) *Safety*. With a general audience there is no need to address either safety or effectiveness in any detail – both are assumed. However, you may be asked a question about safety, maybe in a sudden and hostile way in a media interview. It is a mistake to try to avoid an answer, or to answer at length– you may then be trapped in spending half of your available time on a negative issue. It is also a mistake with a general audience and in limited time to talk about comparative risk rates with medical and surgical treatments – whatever you might say it will sound defensive, critical of the medical profession and too complex to be understood. The better approach is to reply as follows:

- The issue for all treatments is *appropriateness* which involves an assessment of the scientific evidence of both *risks* and *benefit*. On such an assessment all chiropractic treatments are appropriate.
- The only chiropractic treatment associated with any significant risk of harm is manipulation or mobilization of the upper joints of the neck or cervical spine. Even these treatments have extremely low risks of serious side effects – medical experts agree about 1 in one million treatments.
- On the other hand upper cervical spine manipulation has proven benefit for patients with common forms of neck pain and headache.
- Experts agree that neck manipulation – which is most commonly associated with chiropractors but also used by other health professionals including medical doctors with specialist training, is *appropriate* – given low *risk* and proven *benefit*.

b) **Media interviews**. There are some particular issues with respect to media interviews and these include:

i) *Control the discussion*. There is no rule that you have to talk about what interests the radio/TV presenter. Know the key points you want to address and, whatever you are asked, raise them. If, for example, you are asked a second question on safety, after dealing with it fairly as above, move to another subject you wish to discuss – related if possible, but not necessarily so. This might be a brief and interesting case example from your practice of a patient referred by his or her family physician, having a history of chronic headaches and daily reliance on medication, and experiencing excellent relief following a course of chiropractic neck adjustments/manipulations.

ii) *Time is up*. In all presentations, but particularly media interviews, time is up and you reach the end more quickly than you can believe. Accordingly, speak in headlines and move to your main points as soon as possible in the interview.

iii) *Be prepared*. Know in advance what difficult questions you may be asked and how you will deal with them. As mentioned, be able to refer to independent authorities and references wherever possible.

c) **Presentations to other health professionals**. Additional points for such audiences include:

- i) *Avoid over-claim*. Be sure that what you say is accurate and defensible.
- ii) *More science and research*. Your address should be tailored to their probable interests. Like the general public they will want to know about your education and clinical skills, but in more detail. With respect to education, you should have a powerpoint and handout of a chart summarizing the components of

chiropractic education (see Table 2 in the May 2005 issue of *The Chiropractic Report* for a sample of this). You should also have one or two ready examples demonstrating the specialized knowledge acquired in chiropractic education. In spinal anatomy, for example, the different planes and morphology of the facet joints in different spinal segments and the biomechanical significance of this; the safety of lumbar manipulation in the presence of disc degeneration because the structure of the lumbar facets only allows two to three degrees of rotation – whereas 14 degrees of rotation are required for potential mechanical damage to degenerative discs, 23 degrees for healthy discs.<sup>6</sup>

With respect to clinical skills, focus on your presumed and actual area of expertise – the physiology and presumed mechanisms of action of manipulation, and then a brief overview of the research evidence on effectiveness and patient satisfaction. Demonstrate palpation and adjustment, with an assistant or by means of video.

iii) *Question time*. Note at the outset what areas you are going to cover and that there will be time allotted for questions – and make sure that there is.

d) **Difference between chiropractic and osteopathy and PT manipulative therapists**. Many people have great difficulty in understanding the differences between these professional groups, and some chiropractors have difficulty in explaining it. Possible approaches include:

i) *Unique language and philosophy*. This simply doesn't work. To illustrate this, last year there was a World Health Organization (WHO) meeting in Geneva to discuss the difference between chiropractic and osteopathy. Experts from both professions were present. One chiropractor made a 15 minute presentation on the philosophical and clinical aspects of vertebral subluxation complex and concluded that this is what made the chiropractic profession separate and unique. In reply the President of the American Osteopathic Association, who was seeking in this meeting to show that osteopathy was very similar to chiropractic, explained that osteopathy was essentially the same except that it called the subluxation the osteopathic lesion. In the ensuing discussion, it was clear that WHO officials were confused and unable to understand any major difference.

ii) *Treatments*. This approach is also unsuccessful. Outsiders ask how different an adjustment or an osteopathic manipulation or PT manual treatment can really be. Those trained in the field of manual therapy know much about, specificity, skill levels, the crucial importance of where, how and why treatment is being given, etc. Those outside the field assume that all professionals using manual therapy have a variety of techniques and skill levels, but are basically applying similar treatments.

iii) *Different education leading to a different approach to patient assessment and diagnosis*. It is suggested that these are the areas in which there is a true and demonstrable difference between the professions, and these are the areas you should focus on if faced with this issue in a public presentation.

With respect to education, note that chiropractic education is distinct and different both in terms of selection of subjects and then the specialized study of them. This applies to chiropractic principles and philosophy of health, a specialized approach to the basic sciences (spinal anatomy, applied neurology, biomechanics of the neuromusculoskeletal system), the diagnostic sciences and exact treatment methods.

What this means for the patient is that s(he) is assessed and

diagnosed in a very different way – leading to a different treatment approach. To discuss the difference in a relevant and immediate manner you might ask this question: “How would each of a chiropractor and a physical therapist and an osteopath examine and diagnose a patient with headaches?” This gives you the opportunity to explain the chiropractor’s whole body structural assessment including functional short leg, pelvic balance, compensations in the spine, etc. A chiropractor may be adjusting the patient’s sacroiliac joint and providing a heel lift and quite detailed dietary recommendations as a result of the chiropractic diagnosis of the causes of headache – this is a fundamentally different approach from that that would be taken by an osteopath or a manipulative therapist.

#### D. PROFESSIONAL CORRESPONDENCE

9. Effective communication on paper has become particularly important for all health professionals in recent years because they work increasingly in a health team environment in which their patients are likely to be receiving care from more than one provider. Additionally care is often managed and/or funded by third parties. Further, written communications provide the most ready and powerful form of market visibility in a world where professionals are too busy to meet in person.

For chiropractors, new evidence supporting chiropractic care and other developments mean that in many countries medical referrals represent the largest potential source of new patients – and effective letter writing skills are a main prerequisite for a referral practice.

10. **When to write.** Letters should always be sent when a patient is referred either way between health professionals, and when a referred patient completes the course of treatment. There are good arguments for adopting a practice of generally writing to each new patient’s family medical doctor. Goals are to make the MD aware of chiropractic treatment being given, which is clearly in the patient’s best interests, to promote cooperation, to promote better understanding of chiropractic, and to encourage future referrals. Ensure that the patient knows and approves in advance of your intention to write.

11. **General principles.** These are basically those already mentioned – correspondence should be professional in appearance (state-of-the-art for all professions in your community), short and concise, highly organized and accessible, and free of jargon. Everyone is rushed, and has no time. You will only write letters and reports, and others will only read them, if they are succinct and to the point. Be ruthless in being brief. Understand the reason for your communication. It is never to give a full explanation of what you found and did with a patient, or to provide an introduction to or explanation of chiropractic. It is to:

- a) Illustrate, by the mere fact of the letter or report, that you understand your responsibilities and role, and can be trusted to operate within a professional and team approach.
- b) Give the essence of findings, management, prognosis, reason for referral, etc. One important and excellent technique for keeping general correspondence short, if there is need to make various points or present detailed evidence on some issue, is to put the issue and conclusion in a brief letter and enclose a separate memorandum and/or other documents with the details.

12. **Organization and Accessibility.** These are crucial to readability, effectiveness and reputation for competence and professionalism. This means short paragraphs (never write a paragraph

over 10 lines – do you realize that most newspaper articles start a new paragraph every sentence) and liberal use of sub-headings. See the sample letters in Figure 2 overleaf. These contain a four paragraph format recommended by Cassidy, Mierau et al.<sup>7</sup> You may have a preferred system. The point is to adopt a standard format, practising this until you have the skills to draft a steady volume of correspondence efficiently. As Cassidy, Mierau et al. say:

“Letter writing is a skill that must be developed by practice. In our clinic, over 25 letters are dictated each day. We have an exceptional secretarial staff that can handle the typing load. It may seem like a lot of work, but our dictations help to build our practice. By keeping our medical colleagues in touch with what we do, they learn to trust us with their patients and are educated about chiropractic.”

#### E. CONCLUSION

This article has said very little about aspects of chiropractic health care that are important to the profession and patients. These include the philosophy of chiropractic, with its biopsychosocial model of health and its focus on the regulatory function of the nervous system and the impact of subluxation/spinal joint dysfunction on that system and general health. Little has been said on these things because they are beyond the interest and understanding of the general public in a short presentation.

It is quite a different story with more extended presentations to those who choose to attend a public or patient lecture on chiropractic. In those circumstances there is a demonstrated level of interest that makes it important to deal with the wider principles of chiropractic care. Finally, from the patient’s perspective a chiropractor’s best communication is with his or her hands, identifying points of restriction, pain and tenderness and then treating them by hand with surprising accuracy, skill and results. It is only following that manual communication that most people are ready and able to hear the matters of health and well being that most interest chiropractors themselves. TCR

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continued from page 5

Amongst 280 neck pain patients receiving chiropractic manipulation or mobilization, about 1 in 3 (85 or 30.4%) reported adverse reactions following care. By far the most common reaction was neck pain or stiffness (25%) followed by headache (15%) and tiredness or fatigue (10%). Slightly more patients reported these reactions after manipulation (48 patients) than mobilization (37). Most adverse reactions were very minor and temporary. To quote, “the vast majority of symptoms began within 24 hours of treatment, disappeared within 24 hours of onset, and did not highly impair activities or daily living. None of these reactions was deemed serious enough to require notification of our institutional review boards.”

The researchers, an interdisciplinary chiropractic and medical team from UCLA, further note that “published results of neck pain clinical trials involving spinal manipulation and other physical or exercise methods used by chiropractors have not included any reports of serious complications. Complication rates from surgical and pharmaceutical treatments for neck pain are estimated to be much higher than those from spinal manipulation and other chiropractic interventions.”

Possible clinical predictors of adverse reactions to chiropractic treatment that were identified included history of neck trauma, increasing pain since onset, severe pain and disability, moderate or severe headache, nausea during the past month and lack of treatment confidence.

(Hurwitz EL, Morgenstern et al. (2005) *Frequency and Clinical Predictors of Adverse Reactions to Chiropractic Care in the UCLA Neck Pain Study*, Spine, 30:1477-1484)

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**Figure 2**

**A. Referring a patient**

Dear Dr. Brown:

**Re: John Jones, WCB. #946384, Accident Date: June 5, 2005**

**History.** Thank you for seeing Mr. Jones. He is a 30-year old truck driver with a 2-year history of unremitting low-back pain which came on after lifting a large steel pipe off a loading dock. The pain radiates down the right posterolateral thigh and leg to the dorsum of the foot and big toe. He has been off work since this accident and is presently on compensation. He is unable to sit for long periods of time and, as a result, unable to return to work. He has had a course of physical therapy, various medications for pain, two weeks of bed rest under traction, and now three weeks of chiropractic care with little relief. He has no bowel or bladder dysfunction and is otherwise healthy.

**Examination.** On examination he is unable to flex his spine and stands with an antalgic list to the left. There is marked paraspinal muscle spasm and tenderness at the L4-L5 level. The right ankle jerk is depressed, but other deep tendon reflexes are active and symmetrical. He has decreased sensation over the right L5 dermatome and weakness of the ankle dorsiflexors graded at 4/5. His straight leg raising is only 20 degrees on the right.

**Imaging.** X-ray examination of the lumbar spine shows a loss of disc height at the L4-5 level with marginal osteophytes.

**Reason for Referral.** I think Mr. Jones has L5 radiculopathy from a small disc herniation at L4-5. Since he has not improved with conservative measures, I consider he should be assessed by an orthopedic surgeon. You will be seeing him on Tuesday August 12 and we will look forward to your opinion.

Yours sincerely,

cc: GP, WCB

**B. Receiving a Referral**

Dear Dr. Brown:

**Re: Janine Jones, Accident Date: August 19, 2005**

**History.** Thank you for asking me to see Miss. Jones, an 18-year old student involved in a motor vehicle accident one month ago. She was the driver of a car which was hit from behind unexpectedly. She was not wearing her seat belt and was thrown forward, hitting her chest against the steering wheel. She did not lose consciousness, but experienced immediate chest and neck pain. She was taken to and kept in hospital for one week after the accident. X-rays and other investigations were negative and she was discharged with a cervical collar for whiplash injury to the neck. Neck pain is now predominantly left-sided with referral to the left periorbital region of the face. Past history includes a similar injury to the neck three years ago, and she is presently on medication for epilepsy.

**Examination.** On examination she appears fit but somewhat depressed. The range of motion of her cervical spine is reduced by 50 percent on extension, 25 percent on forward flexion, and 50 percent on left rotation, 25 percent on forward flexion, and 50 percent on left rotation. Reflexes, sensations, and motor power are all intact in the upper extremities. The cranial nerves are normal. There is marked tenderness and muscle spasm over the atlantoaxial joint on the left and digital pressure at this level reproduces her symptoms.

**Imaging.** Thank you for sending her x-ray report which states that her cervical spine is normal.

**Management.** I think that this woman, following a hyperextension-hyperflexion injury to her cervical spine, is now suffering from upper cervical joint dysfunction, particularly at C1-2 on the left. We have arranged to give her a regimen of manipulations to her cervical spine over the next two weeks, and we shall keep you informed on her progress.

Thank you for this referral.

Yours sincerely,

**C. The Follow-Up Letter**

Dear Dr. Brown:

**Re: Janine Jones, Accident Date: August 19, 2005**

Ms. Jones has now completed her regimen of manipulations for upper cervical joint dysfunction secondary to a whiplash injury. I am pleased to report that her progress has been good, and she is 75 percent improved. She still suffers occasional back pain, but has returned to school and her daily activities.

On examination she has a full, pain-free range of motion in her cervical spine. There is only slight tenderness over the paraspinal muscles and articular pillars.

I have arranged to see her periodically over the next three months to ensure her full recovery. Such problems are often recurrent, but settle quickly with prompt treatment. If she develops similar trouble in the future, I would be happy to see her again for you.

Yours sincerely,