



Professional Notes

US Veterans' Health Administration: Neck Pain Results

Dr. Andrew Dunn, staff chiropractor at the US VHA Western New York Medical Center in Buffalo New York, has authored a new study describing chiropractic management as delivered in the Veterans' Health Administration (VHA) and reporting good clinical results with complex neck pain patients. Points are:

- a) This is a case series of 54 VHA patients receiving chiropractic care for neck pain. They were complex in that 20 (37%) had post-traumatic stress disorder (PTSD), 17 (32%) had depression, and 16 (30%) had military service disability related to their complaint of neck pain.
- b) Treatment included manual therapies (manipulation, mobilization, flexion/distraction, myofascial release) and instructions on therapeutic exercises and stretches. Treatment visits were typically 1 to 2 per week with an average number of treatments of 8.7 (range 2-24).
- c) Outcome measures were an 11 point numeric rating scale (NRS) for pain sever-

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The Art of Writing Letters and Reports

A. Introduction

CONSULTING ENGINEERS, lawyers, chiropractors, medical specialists and all professionals face two common realities with respect to correspondence and written reports:

- Such communications are of pivotal importance in building and maintaining a practice. (One skillful letter from a lawyer can solve a dispute, avert protracted and expensive litigation, and lead to referral of new clients. A timely and appropriate letter from a chiropractor can prevent arbitrary closure of a workers' compensation claim or initiate many referrals over a period of years. Conversely, failure to send an appropriate letter can terminate professional cooperation after one case).
- Formal education leaves all these professionals ill-prepared for effective communication on paper in their respective market places. (Opinions from young lawyers are generally far too technical, long, padded with the relevant research and issues, and are confusing to the client. Letters and reports from newly graduated chiropractors often display the same faults.)

2. Competence on paper has become particularly important for health professionals in recent years because:

- a) They work within an increasingly complex health team environment. The patients are likely to be receiving care from more than one provider.
- b) Care is generally managed and/or funded by third parties such as employers, private insurers, managed care organizations, workers' compensation boards or the government. These third parties require written reports to justify continuing treatment.
- c) Written communications provide the most potent form of market visibility and advertisement of ability for professionals. As a child you may have been

told by a wise parent that three things were essential to making your way in the world – good handwriting, speech and appearance. These days, when no one writes longhand anymore, professionals are too busy to meet in person, and most communication is on letterhead – correspondence is all three of these attributes rolled into one.

3. For chiropractors, who once worked in relative isolation and could manage with less developed writing skills, there is still often misunderstanding of the new importance of written communication today. This is that:

- a) Medical doctors are generally frustrated by patients with back pain. As Cherken observes they “have a long history of negative feelings and frustration” for patients with back pain because “they have little to offer....and believe they can do little to prevent patients with acute pain from developing chronic pain.”¹
- b) They are increasingly willing to refer patients with nonspecific back and neck pain to chiropractors for conservative care, including manipulation, as a first line of treatment. Reasons include evidence-based guidelines from medical associations² and national interdisciplinary panels,^{3,4} patient demand and the more established role of the chiropractic profession in mainstream health care. The recent Canadian trial by Bishop, Quon et al. shows that such evidence-based care for patients with back pain does produce superior results to usual physician care.⁵
- c) Indeed, there is an emerging trend of third-party payers requiring such referrals as a precondition of approvals for advanced imaging or surgical or injection therapy interventions for patients with chronic spinal pain. As of January 1, 2012 the United Pennsylvania Medical Care Health Plan (UPMC Health Plan) has a new policy under which,

to be considered for authorized spinal injections or surgery, patients with chronic low-back pain must have tried and failed a three month course of care that includes chiropractic care.⁶

d) Accordingly medical referral represents by far the largest current source of new chiropractic patients. In many communities in North America and Europe and other countries the quickest way to establish a new chiropractic practice is in a multidisciplinary setting, initially with reliance upon medical referrals.

e) Effective reporting, writing and communication skills are main prerequisites for a referral practice.

4. Correspondence and reports can become the bane of practice, a prime source of stress and a major limitation for an otherwise competent professional. With the right approach, and a limited period of discipline and practice, skills can be learned that remove the stress and greatly enhance professional image and opportunity. This issue of the Report reviews the principles of effective professional writing and provides samples of letters and reports.

B. When to Write

5. **Letters.** Letters should always be sent:

- a) When you refer a patient.
- b) When a patient is referred to you.
- c) When a referred patient completes his/her course of treatment.

There are good arguments for adopting a practice of generally writing to each new patient's family medical doctor. Many chiropractors now do this. Purposes are to make the MD aware of chiropractic treatment being given – which is clearly in the best interests of the patient, to promote cooperation, to promote better understanding of chiropractic, and to encourage future referrals. Ensure that the patient knows of and approves in advance of your intention to write.

6. If you are referring one of your patients to a specialist copy the letter to the patient's family MD, who may be responsible for follow-up care (e.g. medication after spinal surgery by the specialist to whom you have referred the patient.) Often it will be wise to contact the family physician prior to referral. This earns respect and future cooperation. Procedure is:

a) Call and explain who your mutual patient is, your intention to refer, and that you will forward a copy of the referral letter. You may even decide to seek approval – you do not need it, but such evidence of courtesy, thoughtfulness and respect goes a long way in promoting relationships.

b) Make the appointment with the specialist.

c) Write your letter of referral, seeing that the specialist receives it well prior to the patient and recording that it is copied to the family physician.

7. **Reports.** Generally reports are written in response to:

a) Mandatory requirements – e.g. terms of the insurance policy or legislation governing third-party payment.

b) Specific requests – e.g. from a lawyer for the purposes of litigation.

Experience often leads to preparation of brief letter reports in other circumstances. For example, you may have been treating a patient with whiplash injury for 3 months without request for a follow-up report from the insurance carrier. A brief report explaining the current rationale for treatment and commenting on prognosis and management plans may be the document on file that prevents an arbitrary administrative decision rejecting continued coverage at about that time.

C. Principles

8. The same few important principles apply to all written communications, whether by letter or more extended report. Keep them:

- a) Professional in appearance.
- b) Short and concise.
- c) Highly organized and accessible.
- d) Free from jargon.

9. **Professional in appearance.** Everyone who influences your practice and professional life, other than your patients and staff, will judge you more by your correspondence than your clinical skills, character and real professional competence. This includes third-party payers and lawyers deciding what weight to give to your professional opinion, medical doctors deciding on whether to trust and refer, and everyone else. This means:

a) You should select and periodically review your letterhead with more care

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than your clothes, car or office furnishings.

When your letterhead lies in the in tray at an insurance company, lawyer's office, government department or family physician's office, it is amongst letterhead from other professionals and corporations. Are you satisfied with the image it gives of you and your profession? In this competitive environment does the appearance enhance the substance of what you have written?

b) Quality word processing equipment is essential – printer and font must be state-of-the-art for professional offices in your community.

c) Strong secretarial support is vital. Your secretary must be the guarantor of professional format, accurate grammar and spelling. (S)he must be able to format from your draft e-mails/letters/reports on computer, prepare from dictaphone, and send correspondence in your absence. In these circumstances

the letter should be noted 'Prepared from dictation but not read'.

Learn to use a dictaphone and/or the latest more accurate versions of voice recognition software. (Dragon 11 Professional is excellent.) These are the key to maximum time-saving and efficiency.

If your correspondence is your market image – your dress, speech, handwriting and major professional presence in the world – the necessary investment is well worthwhile, and of high priority in your practice.

10. Short and Concise. Brevity is a virtue. Everyone is rushed, has no time. You will only write the letters and reports needed, and others will only read them, if they are succinct and to the point. Be ruthless and fearless in being brief. Understand the reason for your communication, which is never:

- To give a full explanation of what you found and did with the patient.
- Provide an introduction to chiropractic.

Your purposes are 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 team approach.
- b) Give the essence of findings, management, prognosis, reason for referral, etc.
- c) In the case of a medical legal report, to give a basis for negotiating settlement of a claim. This is:
 - Express acknowledgment that history, exam and findings are consistent with an accidental injury as alleged by the patient.
 - As specific an assessment of disabilities and their impact on this particular patient as is possible.
 - A summary outline of the basis for these conclusions.

That is what the lawyer or insurer is paying you for, not an essay on all aspects of your management with multiple findings, opaque jargon and a valueless conclusion such as "prognosis is guarded". To a lawyer this means "I am unable to help you with a professional judgment in this case".

11. One 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 then enclose a separate memorandum and/or other documents with the details.

12. Organized and Accessible. Organization is crucial to readability, comprehension, appearance of competence, persuading the reader to accept your conclusions and expertise, and thus the whole exercise. This means:

- a) Liberal use of subheadings and paragraph numbers, especially in reports. However a letter that takes two or more pages will also need subheadings and likely numbered paragraphs.
- b) Many short paragraphs. *Never write a paragraph over 10 lines.* Do you realize that most newspaper articles start a new paragraph for every sentence? Editors know that if they did not, you and others would not read them. The same principle applies to your writing.

13. The increasing volume of communications has brought major changes in organization of professional material in recent years. For example major research journals not only have an abstract summarizing the content of each research article but also now divide the abstract by subheadings. For

an example see Figure 1. This is in recognition of the fast pace and short attention span of readers in modern life. If major journals need to pander to readers in this way to keep them reading, so do you.

14. Free of Jargon. Perhaps the major fault of professional writing generally, and chiropractic writing specifically, is inappropriate use of jargon. In the words of Canadian chiropractor Dr. David Cassidy and colleagues, who have long experience:

"The problem with most letters that we see written by chiropractors is that they are too long and full of jargon... (Other professionals) are very busy and receive many letters each day regarding patients... If the letter is too long and unintelligible they simply will not read it.

They are not interested in, nor understand, subluxation listings or motion palpation findings... They are interested in history, disability, range of motion, sensory, reflex and motor

Figure 1 Sample Abstract¹

Background Context: Evidence-based clinical practice guidelines (CPGs) for the management of patients with acute mechanical low-back pain (AM-LBP) have been defined on an international scale. Multicenter clinical trials have demonstrated that most AM-LBP patients do not receive CPG-based treatments. To date, the value of implementing full and exclusively CPG-based treatment remains unclear.

Purpose: To determine if full CPGs-based study care (SC) results in greater improvement in functional outcomes than family physician-directed usual care (UC) in the treatment of AM-LBP.

Study Design/Setting: A two-arm, parallel design, prospective, randomized controlled clinical trial using blinded outcome assessment. Treatment was administered in a hospital-based spine program outpatient clinic.

Patient Sample: Inclusion criteria included patients aged 19 to 59 years with Quebec Task Force Categories 1 and 2 AM-LBP of 2 to 4 weeks' duration. Exclusion criteria included "red flag" conditions and comorbidities contraindicating chiropractic spinal manipulative therapy (CSMT).

Outcome Measures: Primary outcome: improvement from baseline in Roland-Morris Disability Questionnaire (RDQ) scores at 16 weeks. Secondary outcomes: improvements in RDQ scores at 8 and 24 weeks; and in Short Form-36 (SF-36) bodily pain (BP) and physical functioning (PF) scale scores at 8, 16, and 24 weeks.

Methods: Patients were assessed by a spine physician, then randomized to SC (reassurance and avoidance of passive treatments, acetaminophen, 4 weeks of lumbar CSMT, and return to work within 8 weeks), or family physician-directed UC, the components of which were recorded.

Results: Ninety-two patients were recruited, with 36 SC and 35 UC patients completing all follow-up visits. Baseline prognostic variables were evenly distributed between groups. The primary outcome, the unadjusted mean improvement in RDQ scores, was significantly greater in the SC group than in the UC group ($p=.003$). Regarding unadjusted mean changes in secondary outcomes, improvements in RDQ scores were also greater in the SC group at other time points, particularly at 24 weeks ($p=.004$). Similarly, improvements in SF-36 PF scores favored the SC group at all time points; however, these differences were not statistically significant. Improvements in SF-36 BP scores were similar between groups. In repeated-measures analyses, global adjusted mean improvement was significantly greater in the SC group in terms of RDQ ($p=.0002$), nearly significantly greater in terms of SF-36 PF ($p=.08$), but similar between groups in terms of SF-36 BP ($p=.27$).

Conclusions: This is the first reported randomized controlled trial comparing full CPG-based treatment, including spinal manipulative therapy administered by chiropractors, to family physician-directed UC in the treatment of patients with AM-LBP. Compared to family physician-directed UC, full CPG-based treatment including CSMT is associated with significantly greater improvement in condition-specific functioning.

1 Bishop PB, Quon JA et al. (2010) *The Chiropractic Hospital-based Interventions Research Outcomes (CHIRO) Study: a randomized controlled trial on the effectiveness of clinical practice guidelines in the medical and chiropractic management of patients with acute mechanical low-back pain.* The Spine Journal 10:1055-1064.

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ity and the Neck Bournemouth Questionnaire (NBQ) for disability. A 30% change from baseline on both the NRS and NBQ was assessed as minimum clinically important difference (MCID). Two out of three (67%) of these complex neck pain patients reported clinically significant improvement.

(Dunn AS, Green BN et al. (2011) *Chiropractic Management of Veterans with Neck Pain: A Retrospective Study of Clinical Outcomes*. *J Manipulative Physiol Ther* 34:533-538.)

Other Research

1. UK - Prognosis for MSK Disorders – Early Improvement is the Key

A new study from Jennifer Bolton, PhD, at the Anglo-European College of Chiropractic (AECC) and Hugh Hurst, DC, PhD, a UK clinician, adds to the evidence that early improvement remains a better predictor of longer, overall recovery than any particular baseline patient characteristics for patients with musculoskeletal pain.

The study also highlights the practical point, challenging to researchers, that real patients usually have pain in more than one body region (e.g. neck, back, shoulder, leg). Comments are:

a) The study involves 2,422 consecutive patients with a range of musculoskeletal pain conditions consulting Dr. Hurst at his practice in Bristol in the UK from November 2001 to December 2009. Over 1691 (70%) had back pain, but approximately 25% of them also had leg pain and 30% neck or shoulder/arm pain. Of those with neck or shoulder/arm pain, almost half (555 or 46%) also had back or leg pain. In other words, most patients had pain in more than one region.

b) A number of chiropractors in the practice treated the patients with manipulation and mobilization, dry needling, exercise and advice.

c) At baseline patients completed demographic information, a pain diagram and the Bournemouth Disability Questionnaire (BQ). At the 4th/5th treatment and the 10th treatment (if still under care) they completed the BQ, the pain diagram and a Patient Global Impression of Change (PGIC) Scale.

On this Scale those who reported a score of 7 ("a great deal better, and a considerable improvement which has made all the difference") or 6 ("better, and a definite improvement that has made a real and worthwhile difference") were regarded as improved – all others were regarded as having no meaningful improvement.

d) Results included:

- Patients with acute pain (less than 7 weeks) had higher pain and disability on entry to care than those with persistent/sub-acute/chronic pain, but also had higher self-rated improvement at the 4th/5th visit (70.6% vs 44.3%).
- There were specific factors or prognostic indicators associated with improvement. In acute patients these included being

male, taking medication for the pain complaint, being in paid employment, and expecting to make a good recovery. However, in both acute and persistent pain patients, the various predictors "explained very little of the variance in improvement by the 4th/5th visit" and "showed little ability to discriminate between improved and non-improved patients." The only exception was "expecting to make a good recovery", which "was strongly associated with early improvement by the 4th to 5th visit in both acute and persistent pain patients."

- With respect to prognostic factors for improvement found at the 10th visit, no conclusions were possible for acute patients for the otherwise good reason that most patients had ceased care by that stage. However, for persistent pain patients "in the final predictive model being better at the 4th/5th visit was by far the strongest predictor, together with being in paid employment and reporting a decline in work fear-avoidance behaviour at the 4th/5th visit."

Bolton and Hurst conclude that early self-reported improvement is a key predictor of later improvement. They point to other research showing that improvement by the second visit – not measured by them – is a predictor of improvement at the 4th visit. One other prognostic factor of likely importance they suggest, again not measured by them, is duration of pain prior to treatment.

(Bolton, JE, Hurst HC (2011) *Prognostic Factors for Short-Term Improvement in Acute and Persistent Musculoskeletal Pain Consultants in Primary Care*. *Chiro & Manual Therapies* 19:27-1-27.)

2. US and Canada – Exact Location of Joint Cavitation

Cramer, Ross et al., a research team from the National University of Health Sciences, Chicago and the Canadian Memorial Chiropractic College (CMCC), Toronto report on the exact joint location and distribution of cavitations following spinal manipulative therapy (SMT) in an award-winning paper from the Association of Chiropractic Colleges Research Agenda Conference (ACC RAC) held in Las Vegas last March and just published in *JMPT*. Cramer, Ross et al. were testing these two hypotheses:

- That upside Z joints during side-posture lumbar SMT would cavitate more than downside joints.

That Z joints targeted for gapping would cavitate more frequently than those outside the target area.

Both these hypotheses were supported in the trial and points are:

a) In this randomized controlled trial (RCT) 40 healthy adults aged 18-30 were randomly assigned to either Group 1 (side-posture lumbar manipulation from an experienced chiropractor, involving two thrusts in rapid succession), or Group 2 (control group – side-posture positioning only).

Fifty-six cavitations were recorded from 46 joints and central findings were:

- The upside cavitated significantly more frequently than the downside (93.5% vs 6.5% of the 46 cavitations).
- Cavitations occurred significantly more frequently in target area joints than non-target area joints (71.7% vs 28.3%).

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- In seven instances there were two cavitations from the same Z joint – something not previously reported.

- Group 1 SMT subjects cavitated more frequently than subjects in Group 2 with side-posture positioning only (96.7% vs 30%) but this means that cavitation occurred in 3 of 10 control group subjects.

b) “The cavitation vibrations/sounds are thought to be the result of gas (probably carbon dioxide) entering the Z joint during the vacuum (cavitation) created when the joint surfaces are separated by SMT. More specifically cavitation vibrations/sounds may be related to the elastic recoil of the synovial capsule away from the joint space as the gas enters the joint during the gapping caused by SMT. Brodeur speculated that the recoil of the Z joint capsule, which he associated with cavitation, stimulated capsular mechanoreceptors initiating the beneficial neurologic reflex actions (decreased pain and muscle relaxation) that have been associated with SMT.”

c) Mechanisms of relief mentioned by Cramer, Ross et al. include:

- Breaking up connective tissue adhesions.
- Stimulating mechanoreceptors in the Z joint capsule to produce decreased pain (via a gating mechanism in the dorsal horn of the spinal cord), decreased muscle tension (via reflex pathways) and reflex changes in the autonomic nervous system.
- Reflex immunologic responses.

(Cramer GD, Ross JK et al. (2011) *Distribution of Cavitations as Identified with Accelerometry During Lumbar Spinal Manipulation*, J Manipulative Physiol Ther, 34:572-583.)

3. US – Measuring Psychological Factors in Chiropractic Practice

Another ACC RAC 2011 award-winning paper just published in JMPT comes from Donald Murphy, DC, from Rhode Island and Eric Hurwitz, DC, PhD, from the University of Hawaii. Data were collected on 355 patients, 95 with neck pain (NP) and 260 with low-back pain (LBP), for two purposes:

- Using established screening tools for different psychological factors – fear, catastrophizing, passive coping, anxiety, depression, etc. – to assess the correlation between these factors in patients with NP and LBP.
- To determine whether a relatively simple and minimally burdensome questionnaire on psychological factors can be given to spinal pain patients in chiropractic practice to yield important and clinically relevant information.

Murphy and Hurwitz, appreciating that several extensive and time-consuming questionnaires on psychological factors cannot be given to patients in a regular and busy practice, developed their own brief, combined questionnaire. This had 11 items on fear of movement (abbreviated from 17 items on a larger scale), 2 questions taken from 44 in the Coping Strategies Questionnaire, and 2 questions on anxiety and depression from the Bourne-mouth Disability Questionnaire. Conclusions included:

a) The various psychological factors are different in kind, but they are generally closely associated in patients. For example patients with LBP scoring below the median on the anxiety

scale were much more likely than others to also score below the median on the depression scale (2.59 times). [611/2/bottom].

b) The screening instrument used in this study did seem to be useful for a clinician “in quantifying multiple psychological dimensions in an integrated fashion with minimal burden to the patient.”

Murphy and Hurwitz are continuing their research to try to produce an optimal questionnaire covering all psychological factors for spinal pain patients in a valid and practical way. When they find it this Report will tell you.

(Murphy DR, Hurwitz EL (2011) *The Usefulness of Clinical Measures of Psychologic Factors in Patients with Spinal Pain*, J Manipulative Physiol Ther, 34:609-613).

Success at Pan American Games

The XVI Pan American Games were held in Guadalajara and Puerto Vallarta, Mexico from October 14-30, 2011. Under an agreement between COPAG, the organizing committee, and the Federation International de Chiropratique du Sport (FICS), the international body representing sports chiropractors, a team of 44 specialist sports chiropractors from 8 countries provided chiropractic care as part of the host sports medicine services available to all athletes at the Games Village Polyclinic and the various sports venues (eg. aquatics, athletics, basketball, combat sports, cycling, equestrian, gymnastics, and tennis).

As COPAG Director of Chiropractic Services, Dr. Saul Luengas of Mexico reports, chiropractic services were welcomed by athletes and other health professionals and heavily used, with more than 1900 treatment visits from athletes from 40 countries during the Games. In the words of experienced team member Dr. Bill Bon-sall from the US:

Over the years I have worked well over 400 events, including national and world championships in eleven sports, summer and winter Olympics and the World Games. However this is the best event I have ever worked. We truly used the opportunity we had to show the world what a good sports chiropractor is capable of.

For a comprehensive report with photos see the December 2011 issue of the FICS News available at www.fics-sport.org.



Members of the sports chiropractic team and some of the 27 chiropractic students who gave administrative assistance (front row in white).

deficits, straight-leg raising, tenderness, x-ray findings and diagnosis...

Contrary to popular belief a short, concise and to the point letter is more impressive than a complex essay full of jargon."

Thus in a letter to a medical doctor your chiropractic finding of 'L4 - L5 subluxation', necessarily confusing since the word has more than one meaning in this context, becomes 'marked muscle spasm and tenderness and joint restriction at the L4 - L5 level'.

In a report to a lawyer or other layperson, who you must assume may not understand 'L4 - L5', refer to 'restricted movement in the lower lumbar spine principally at the L4 - L5 joint level (left lateral and rotation)'.

15. Assume for a moment that you are a lawyer or an insurance claims adjuster. Which of the two following descriptions, both extracts from actual reports, is more helpful to you and convincing?

a) "Segmental examination of the spine brought out pain and asymmetry and apparent restricted movement at C1 - C2, C4 - C5, T1 - T2, T3 - T4 and L4 - L5 which I would describe all as flexed, rotated and side bent left. There was also dysfunction of the right sacroiliac joint, which I would describe as left on left axis.

These are simply terms to describe the position of the vertebra in space; the barrier to joint movement must be palpated, but the positional diagnosis allows one to derive the direction

in which manipulation should take place in order to free the joint and restore physiological movement."

b) "Digital palpation of the patient's cervical, thoracic and lumbar spinal regions revealed spasticity as well as tenderness involving the following muscles: bilateral sub occipital, right paracervical, right levator scapula, bilateral trapezius, bilateral rhomboid and the right erector spinae group.

Multiple rotatory fixations and subluxations were noted throughout the cervical, thoracic and lumbar spinal regions. Ranges of motion testing of the cervical spine revealed limitation in neutral extension at approximately 30°, forward flexion at 40°, left rotation at 40°, and right rotation at 45°. Neutral foraminal compression as well as both right and left Kemp's (extension, rotation and compression) exacerbated the patient's cervicothoracic and right suprascapular symptomatology."

Without knowing anything of their respective clinical competencies, the adjuster 'knows' that the first chiropractor is more skilled and easier to communicate with, will gossip about this to colleagues, will allow the claim more readily, and will refer himself/herself and friends when they need chiropractic care.

D. Sample Letters and Report

16. **Sample letters.** These appear in Figure 2. They contain a format recommended by Cassidy and colleagues of a four paragraph structure:

Figure 2 Sample Referral Letters

A. Referring a patient

Dear Dr. Brown:

Re: John Jones W.C.B. #946384, Accident Date: June 5, 2010

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.

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.

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

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 I 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, 2010

Thank you for asking me to see Ms 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.

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.

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

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. Smith:

Re: Janine Jones, Accident Date: August 19, 2010

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 para-spinal 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,

Figure 3 Sample Legal Report

Dear Mr. D:

Re: Mr. L.L.

At your request I forward the following report on your client.

History

Mr. L., a 44 year old mechanic, consulted me on May 7, 2010 as the result of an injury suffered in a motor vehicle accident on March 21, 2010.

At the time of consultation Mr. L. informed me that he had developed left hip and leg pain one day after his vehicle had been rear-ended by another vehicle. He stated¹ that at the time of the accident he could see the impending collision coming in his rear view mirror. He braced himself with his left foot but was thrown forward and backward within the constraint of his lap-shoulder-harness seat belt.² He felt no ill effects immediately after the accident, denied any cuts or bruises, could walk and move all parts of his body and was conscious at all times.

Mr. L. was first examined by Dr. R. of Bramalea on March 22, 2010. X-rays were taken and he was prescribed medication. He subsequently saw Dr. H. (March 26, 2010) for additional clinical evaluation and was referred for physical therapy.³

The first evening after the accident Mr. L. experienced stiffness in his left leg, but did not relate this to the accident at the time. He was able to sleep that first night. The following day, however, his left leg became sore and stiff and the pain increased in intensity over a two to three week period to the point where he spent four days in bed. Subsequent to this he developed some numbness in his left leg and foot and experienced difficulty standing on his left leg. He had trouble sleeping and felt that the medication and physical therapy was of limited help.⁴

On May 7, 2010, Mr. L. presented himself to our office for evaluation. He related an intense uncomfortable ache in his left posterior buttock and leg. His pain was aggravated by prolonged sitting and not appreciably relieved by rest. There were neither bowel nor bladder disturbances accompanying the pain.⁵ He had no history of lower back, hip or left pain prior to the date of the accident.⁶

Examination

On physical examination Mr. L. did not appear to be in acute distress. However, it was evident that he was uncomfortable and he had difficulty getting up from a chair. General trunk motions were painfully limited in flexion, left lateral bending and extension. Specific motion palpation of the lower back revealed blockage⁷ of the right lumbosacral joint to articular challenge. The left piriformis and gluteal muscles were moderately hypertonic and painful near their medial insertions adjacent to the left sacroiliac joint.

Passive straight leg raising was painful over his left hip bilaterally to about 40-45 degrees. Dorsiflexion of the left foot intensified his left buttock pain with the left leg raised to 40 degrees. He noticed a sharper sensation (hyperaesthesia) over the posterior aspect of his left leg to about the ankle. Dorsiflexion of the left great toe was about 20 percent weaker than the right.

The left sacroiliac joint and gluteal muscle insertion were extremely tender and on provocation produced scleratogenous pain referral down the posterior aspect of his left leg to the ankle. Lower limb reflexes were difficult to elicit bilaterally and were not helpful in isolating specific nerve root involvement. Neck flexion was mildly painful at the lumbosacral junction. Peripheral pulses were equal in character, rate and intensity. Abdominal palpation was negative.⁸

Radiographs of the left hip and lumbar spine were taken on April 19, 2010 at Finchgate Medical Centre in Bramalea. Mineralization was adequate for the patient's stated age. Slight spondylitic spurring was evident at the L4 to L5 interspace although this and all discal spacings are reasonably well maintained. Slight roughening of the iliolumbar ligament insertion was evident. The sacroiliac and hip joints were unremarkable.

The above findings on examination are consistent with and suggest an accidental injury such as that described by Mr.L.⁹

Clinical Impression¹⁰

1. Left L5 disc protrusion producing S1 nerve root compression (discogenic sciatica).
2. Left sacroiliac strain producing scleratogenous pain referral.

Management¹¹

Management of the patient's condition included:

1. Restoration of spinal mobility by various techniques of joint manipulation.

Adjustments employing traction forces were given in the direction of pain-free motion in order to reduce discoradicular irritation.

2. Soft tissue mobilization and massage to relieve hypertonic musculature.

3. Ultrasound and electrotherapy to reduce inflammation, pain and spasm.

4. The patient was instructed to take hot showers, restrict certain stressful movements and positions and shown how to mobilize (exercise) the lower back in order to reduce muscle tension once correction and healing was evident.

Prognosis

At the time of Mr. L.'s last visit on July 19, 2010, he had shown remarkable improvement. His lower back and pelvic mobility was painless and essentially full in all planes of motion. The muscles were not tender and were free of tension and spasm. All tests of provocation were unremarkable including straight leg raise, foot dorsiflexion and neck flexion.

Injuries such as those sustained by Mr. L are likely to have permanent effects. Every moderate to major traumatic episode has a mechanical wear-and-tear effect on the discal and posterior joint structures. The frequency and severity of future symptoms depend upon a number of factors.

Based on Mr. L.'s progress I feel that he has undergone the worst of his disorder, but I cannot exclude the possibility of relapse considering all aspects of the case including his quite prolonged convalescence. Given his employment as an auto mechanic, even if he is careful of certain work postures and does not experience any setback or symptoms over the next six months, it is likely that his spine will be subject to postural and mechanical disadvantage. I expect that there is a 30% probability of recurrent lower back and leg pain given his signs and symptoms.¹²

Disabilities¹³

Mr. L. has noted the following disabilities or changes in lifestyle:

1. He is more limited in his work as a mechanic in terms of agility, confidence and endurance. He manages well at present but only through careful compliance with various exercise, rest and postural procedures.
2. He was involved in competitive motocross cycle racing prior to the accident. Two attempts to resume this activity have produced severe discomfort. I have advised him to abandon off-road racing permanently.
3. He is a skilled carpenter and has enjoyed home and cottage renovations over the years. He had to cancel plans to build a cottage extension this summer.
4. He states that he has always led a very physically active lifestyle but feels he must be more limited and cautious in everything now.

If I can be of any further assistance to you or Mr. L. in this matter, please contact this office.

Yours truly,

James Smith, D.C.

Notes to Report

- 1 With respect to the circumstances of the accident and all matters arising outside your office, you are reporting the patient's evidence, not verifying the facts yourself. Make that clear as you commence the history.
- 2 Give good detail here because it is relevant to the precise biomechanical forces, and thus injuries, symptoms, management and your prognosis. If the patient has his/her head slightly turned in anticipation that is highly relevant biomechanically - include it.
- 3 No detail here - for example we don't need to know what sort of medication - because this is not fundamental to your management and report. You are merely recording economically that these things happened.
- 4 The tone of your report, and your credibility, will be much better if you do not openly criticize treatment by others.
- 5 This sort of comment indicates thoroughness and that various screening was done. However don't lengthen and burden the report with details, or all tests and negative findings.
- 6 Of vital relevance on whether or not all pain and disability arose from the accident - always indicate presence or absence of relevant past history.
- 7 'Blockage' not 'subluxation'. Avoid all unnecessary use of terms of art, chiropractic or medical, especially ones like subluxation which have more than one meaning and thus confuse.

continued overleaf

Figure 3 continued

8 You may have performed many more tests during physical exam. This is enough - there are already three paragraphs. These have given the necessary, clear, overall picture and sense of competent examination. Will more detail help resolution of this matter by the insurance company or attorney? No - it only obstructs the flow of the report and detracts from overall impression.

9 This conclusion, if correct, must be set forth expressly in your report. It is crucial to the legal issue of 'causation', the link between accident and injury and thus the patient's claim.

10 Select the few major findings, itemize them by number, keep the language simple for the lay reader, and ignore the detailed findings.

11 'Management' is preferred to the narrower concept of 'treatment'. Read this section as a lay person - that is who is using the report. Do not list treatment dates. If these details are specifically requested list them on a separate page appended to the report.

12 You are being asked for a concrete opinion that will help settle a claim - that is the whole point of the exercise. 'Prognosis guarded' is entirely valueless. Provide something firm - this is within your area of expertise and no one can do it better than you. Different jurisdictions develop different approaches towards disability rating and compensation. None of the many different disability scales has been accepted as correct. Use a method accepted where you practice. If in doubt call the lawyer who requested the report for guidance - the most knowledgeable people get that way by being prepared to seek guidance all the time, and the lawyer will appreciate the call. See next note.

13 Courts and compensation tribunals in many North American jurisdictions now prefer expression of disability in terms of concrete activities the patient cannot now perform - this section of the sample report gives examples.

- History.
- Exam findings.
- Imaging findings.
- Diagnosis, prognosis, course of action/outcome.

You may have a preferred system. The point is to adopt a standard format, then practice until you have the skills to draft a steady volume of correspondence efficiently.

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17. **Sample Report.** An annotated sample report appears in Figure 3. See the comments made in the footnotes.

18. Quite simply, individual chiropractors who hope to fulfill their potential in an era when the medical profession and wider world have a new level of acceptance of chiropractic must be skilled in written communications. As Cassidy and colleagues concluded in their article on effective correspondence a generation ago:

“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.”⁷ **TCR**

References

1 Cherkin D, Deyo R et al. (1991) *Evaluation of a Physician Education Intervention to Improve Primary Care for Low-Back Pain: Impact on Physicians and Patients*, Spine 16(10): 1168-1179.

2 Chou R, Qassem A et al. (2007) *Diagnosis and Treatment of Low-Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society*, Ann Int Med 147: 478-491.

3 UK NICE Guideline (2009) *Early Management of Persistent Non-Specific Low-Back Pain*, National Institute for Health and Clinical Excellence CG 88 www.nice.org.uk/cg 88.

4 Haldeman S, Carroll LJ, Cassidy JD, and the Scientific Secretariat (2008) *The Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders*. Spine 33(45): S1-S206.

5 Bishop P, Quon J, Fisher C, Dvorak M (2010) *The Hospital-Based Interventions Research Outcomes (CHIRO) Study: A Randomized Controlled Trial on the Effectiveness of Clinical Practice Guidelines in the Medical and Chiropractic Management of Patients with Acute Mechanical Lower Back Pain* The Spine Journal 10:1055-1064.

6 UPMC Health Plan (2011) Policy and Procedure Manual: Policy #MP.043 available at www.upmchealthplan.com.

7 Cassidy JD, Mierau DR et al. (1985) *Medical-Chiropractic Correspondence*, JCCA 29(1):29-31.



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