

PROFESSIONAL NOTES

Chiropractic Services for U.S. Military.

On October 30, 2000, in the biggest legislative victory for chiropractors and their patients in the U.S. for more than 25 years, President Bill Clinton signed into law legislation mandating that chiropractic care be made available to all active duty personnel in the U.S. Armed Forces on a permanent basis.

The law, formally known as the National Defence Authorization Act for Fiscal Year 2001, requires a full implementation plan to be developed by the Department of Defence by March 2001. The chiropractic benefit is for all three service branches of the military and, when fully phased in, will give all active duty personnel stationed in the US and overseas access to chiropractic services.

This impressive achievement follows nearly a decade of joint lobbying efforts by the American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC), and a five year demonstration project at 13 military treatment facilities across the U.S. Data in the

continued on page 4

CHIROPRACTIC IN COURT

Expert Witness, Freedom of Choice, Reasonable Acute and Supportive Care

A. INTRODUCTION

THREE recent legal cases, one from Australia and two from Canada, present facts and findings that will be of interest to all chiropractors:

- The first is another example of a court preferring the expert evidence of a chiropractor to that of an orthopaedic surgeon, here on the issue of lumbar disc degeneration. Following a review of that case this Report discusses the principles underlying effective testimony as an expert witness.
- The second is an arbitration demonstrating what the automobile insurance system in the Canadian province of Ontario regards as reasonable frequency, duration and cost of chiropractic services for acute and subacute care of uncomplicated soft-tissue whiplash injuries.
- The third, also involving an automobile accident in Ontario, relates to chiropractic supportive care after the patient has reached a maximum level of recovery, and demonstrates an appeal court rejecting medical and insurance evidence against supportive chiropractic services and strongly endorsing a patient's right of choice.

B. CHIROPRACTIC EXPERT EVIDENCE

2. There have now been many cases in which chiropractic evidence has been preferred to medical evidence in litigation. *Engel vs WorkCover Queensland*¹ is a fresh example from Australia.
3. This was a workers' compensation claim in Townsville, Queensland, in which the central issue was whether or not the appellant Mr. Engel's back problem was a work injury. To be a compensable injury under the relevant legislation it was necessary to establish that "the employment is a major significant factor

causing the injury." (Section 34(1), WorkCover Queensland Act 1996).

• Mr. Engel alleged the cause of his problem was heavy lifting over a period of time, rather than a specific incident or non-work causes. An orthopaedic surgeon testifying for WorkCover Queensland said the main problem was underlying disc degeneration. On this basis Mr. Engel's claim was rejected at first instance and upon review by WorkCover Queensland, the workers' compensation authority.

On final appeal to the Industrial Magistrates Court Mr. Tatnell, the magistrate or judge, disagreed. He observed that he had conflicting opinions from "respected experts" and that he had to accept one. He preferred the chiropractic and medical evidence called by the injured worker, and singled out the chiropractic evidence of Dr. Lynton Giles "who in my view was most impressive in supporting the reasons for (his) conclusions". Dr. Giles' reasons for arguing that this was not a case of disc degeneration as claimed by WorkCover's orthopaedic specialist included:

- Over time a degenerative disc would be accompanied by osteophytic degeneration of the vertebral bodies—no such degeneration could be seen on the imaging here.
- The other lumbar discs showed no signs of degeneration.
- Dr. Giles "was quite certain that you do not see or find a protruded disc of that magnitude unless it has been caused by an injury."

Mr. Engel's appeal was allowed, with costs awarded against Workcover Queensland. Dr. Giles is not only a clinician—he holds a PhD in spinal anatomy and at the time of this case was Director of the Spinal Pain Unit, Townsville General

THE CHIROPRACTIC REPORT

www.chiropracticreport.com

Editor: David Chapman-Smith LL.B. (Hons.)

November 2000 Vol. 14 No. 6



PROFESSIONAL NOTES

Chiropractic Services for U.S. Military.

On October 30, 2000, in the biggest legislative victory for chiropractors and their patients in the U.S. for more than 25 years, President Bill Clinton signed into law legislation mandating that chiropractic care be made available to all active duty personnel in the U.S. Armed Forces on a permanent basis.

The law, formally known as the National Defence Authorization Act for Fiscal Year 2001, requires a full implementation plan to be developed by the Department of Defence by March 2001. The chiropractic benefit is for all three service branches of the military and, when fully phased in, will give all active duty personnel stationed in the US and overseas access to chiropractic services.

This impressive achievement follows nearly a decade of joint lobbying efforts by the American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC), and a five year demonstration project at 13 military treatment facilities across the U.S. Data in the

continued on page 4

CHIROPRACTIC IN COURT

Expert Witness, Freedom of Choice, Reasonable Acute and Supportive Care

A. INTRODUCTION

THREE recent legal cases, one from Australia and two from Canada, present facts and findings that will be of interest to all chiropractors:

- The first is another example of a court preferring the expert evidence of a chiropractor to that of an orthopaedic surgeon, here on the issue of lumbar disc degeneration. Following a review of that case this Report discusses the principles underlying effective testimony as an expert witness.
- The second is an arbitration demonstrating what the automobile insurance system in the Canadian province of Ontario regards as reasonable frequency, duration and cost of chiropractic services for acute and subacute care of uncomplicated soft-tissue whiplash injuries.
- The third, also involving an automobile accident in Ontario, relates to chiropractic supportive care after the patient has reached a maximum level of recovery, and demonstrates an appeal court rejecting medical and insurance evidence against supportive chiropractic services and strongly endorsing a patient's right of choice.

B. CHIROPRACTIC EXPERT EVIDENCE

2. There have now been many cases in which chiropractic evidence has been preferred to medical evidence in litigation. *Engel vs WorkCover Queensland*¹ is a fresh example from Australia.
3. This was a workers' compensation claim in Townsville, Queensland, in which the central issue was whether or not the appellant Mr. Engel's back problem was a work injury. To be a compensable injury under the relevant legislation it was necessary to establish that "the employment is a major significant factor

causing the injury." (Section 34(1), WorkCover Queensland Act 1996).

• Mr. Engel alleged the cause of his problem was heavy lifting over a period of time, rather than a specific incident or non-work causes. An orthopaedic surgeon testifying for WorkCover Queensland said the main problem was underlying disc degeneration. On this basis Mr. Engel's claim was rejected at first instance and upon review by WorkCover Queensland, the workers' compensation authority.

On final appeal to the Industrial Magistrates Court Mr. Tatnell, the magistrate or judge, disagreed. He observed that he had conflicting opinions from "respected experts" and that he had to accept one. He preferred the chiropractic and medical evidence called by the injured worker, and singled out the chiropractic evidence of Dr. Lynton Giles "who in my view was most impressive in supporting the reasons for (his) conclusions". Dr. Giles' reasons for arguing that this was not a case of disc degeneration as claimed by WorkCover's orthopaedic specialist included:

• Over time a degenerative disc would be accompanied by osteophytic degeneration of the vertebral bodies—no such degeneration could be seen on the imaging here.

• The other lumbar discs showed no signs of degeneration.

• Dr. Giles "was quite certain that you do not see or find a protruded disc of that magnitude unless it has been caused by an injury."

Mr. Engel's appeal was allowed, with costs awarded against Workcover Queensland. Dr. Giles is not only a clinician—he holds a PhD in spinal anatomy and at the time of this case was Director of the Spinal Pain Unit, Townsville General

Hospital. Does this mean that the evidence of a chiropractor without those extra qualifications would not have been accepted?

The short answer is no. Additional formal qualifications obviously carry some weight, but if the chiropractor has sound reasons for his or her evidence, and if the issue falls within the expertise of the chiropractic profession, and—importantly in most cases—if the patient is credible, there is an excellent chance of acceptance. A Canadian case given below illustrates that. However, to provide a fuller answer to the question, this Report now reviews the basic legal principles concerning expert evidence—universal principles which apply in all countries.

4. Skill and Admissibility. An expert is anyone the court accepts as having *skill* on the issues upon which he/she is testifying. No one is an expert in general terms—most people are expert in some area. Skill is assessed on both training and practical experience. Experience has particular weight. There is nothing special in a university degree, and in many cases academic qualifications alone have been held insufficient. Anyone with appropriate skill can testify as an expert on health care matters.

These principles are illustrated in a Canadian drunk driving case where the prosecution called a police officer as an expert witness on the effect upon the defendant of a given blood/alcohol ratio as determined by a measuring device. Defendant's counsel objected that an opinion on the physiological effects of different blood/alcohol quantities could only be given by a duly qualified medical practitioner. The judge disagreed, admitted the police officer's testimony as expert evidence and summarized the law thus:

"The test of expertness, so far as the law of evidence is concerned, is skill, and skill alone, in the field in which it is sought to have the witness's opinion. If the court is satisfied that the witness is sufficiently skilled in this respect for his opinion to be received, then his opinion is 'admissible' . . . *A skilled person is one who has, by dint of training and practice, acquired a good knowledge of the science or art concerning which his opinion is sought, and the practical ability to use his judgement in that science.*"²

5. Qualifying the Witness. An expert

must not only have skill, but this must be conveyed to and accepted by the court when the expert is called. This initial process, called qualifying the expert, is the responsibility of the attorney/lawyer calling the witness.

It is particularly important with respect to chiropractic expert evidence since many lawyers and judges have little understanding of current levels of chiropractic education, research, practice and expertise. Qualifying an expert witness involves questions, when the expert is first called to give evidence, establishing his/her level of training, experience, and expertise relevant to the issue involved.

6. Weight of Evidence. Qualifying the witness well is particularly important because most cases, by definition, involve a conflict of expert evidence. This means there are two hurdles—having evidence admitted as expert (relatively easy), but then persuading the court to place sufficient *weight* on the evidence to prefer it to any expert evidence called by the other side.

Take the example of a whiplash case with no bone fracture but soft-tissue injuries, where the opposing witnesses are a chiropractor and an orthopaedic surgeon. If the chiropractor is not qualified well as an expert witness by the lawyer calling him/her, the orthopaedic surgeon's evidence is likely to receive a more sympathetic hearing, be given more weight, and preferred. However if in qualifying his chiropractic witness, and cross-examining the orthopaedic surgeon when he/she is being qualified, counsel shows:

a) The orthopaedic surgeon has little or no formal training in the detection of joint dysfunction and other soft-tissue injuries, has only published and practised in the area of bone pathology (maybe only in the lumbar spine), and rarely treats a patient such as the plaintiff in his/her practice; and that

b) The chiropractor not only has more relevant formal training, but has been in practice 10 years and sees new patients with this type of injury on an almost daily basis—he/she is managing 50 similar cases at any given time;

then the judge will be disposed to give good weight to the chiropractic expert evidence and, if it is given convincingly, prefer it to the other expert evidence.

The Chiropractic Report is an international review of professional and research issues published six times annually. You are welcome to use extracts from this Report. Kindly acknowledge the source. Subscribers may photocopy the Report or order additional copies (.75 cents each—minimum of 20 copies plus shipping) for personal, non-commercial use in association with their practices. However, neither the complete Report nor the majority or whole of the leading article may be reproduced in any other form without written permission.

Subscription: for rates and order form, see page 8. For information on orders call 1-800-506-2225, or telephone 416-484-9601, fax 416-484-9665.

Editorial Board

Daniele Bertamini DC, *Italy*
Alan Breen DC PhD, *England*
J. David Cassidy DC PhD, *Canada*
Peter Gale DC, *United States*
Scott Haldeman DC MD PhD, *United States*
Donald J. Henderson DC, *Canada*
Reginald Hug DC, *United States*
William Kirkaldy-Willis MD, *Canada*
Dana Lawrence DC, *United States*
Miriam A. Minty DC, *Australia*
Michael Pedigo DC, *United States*
Lindsay Rowe MAppSc(Chiropractic) MD, DACBR, FCCR, FACC, FICC, DRACR, *Australia*
Louis Sportelli DC, *United States*
Aubrey Swartz MD, *United States*

Changes of mailing instructions should be sent to The Chiropractic Report, 3080 Yonge Street, Suite 5065, Toronto, Ontario M4N 3N1, telephone 416-484-9601, fax 416-484-9665. Printed by Harmony Printing Limited, 123 Eastside Drive, Toronto, Ontario, Canada M8Z 5S5. Copyright © 2000 Chiropractic Report Inc. ISBN 0836-144

7. Chiropractic Field of Expertise. Litigation and third party compensation schemes frequently involve low-back and cervical spine strain/sprain injuries where there is no bone injury or other pathology evident on x-ray. About 90% of these injuries are labelled 'non-specific' by medicine, tacit acceptance that no specific diagnosis or opinion can be given.

Because standard medical methods of orthopaedic examination reveal no physical cause for the pain and disability, medical expert evidence often is that none exists. When symptoms fail to resolve following rest and medication, persistent pain is explained away in psychosomatic terms (e.g. "psychogenic", "chronic anxiety depression")—and frequently viewed as causally unrelated to the accident, and thus not compensable.

This, as the legal profession is now becoming aware, is a potent area for the use of chiropractic expert evidence. Chiropractic diagnostic techniques frequently discover a real physical basis for disability—joint and biomechanical muscle

dysfunction (pathophysiology) only assessed by skilled methods of palpation not taught in formal medical education at any level. Many prominent medical specialists, especially those working with chiropractors, recognize this important field of expertise beyond their training.^{3,4}

These points can be illustrated from the Canadian case of *Behnke v Barthorpe and Walker*⁵ where:

a) The plaintiff, a middle-aged woman, had been thrown through the front window in a motor vehicle accident. She received a number of head and spinal injuries and, after hospitalization, sought medical care.

b) Her family practitioner, who was also a qualified orthopaedic surgeon, could find no physical basis for her continuing headaches, back pain, and lethargy after a period of months. She was referred to an internist who found nothing, then a psychologist and finally a psychiatrist. The defence medical reports from these specialists concluded that the plaintiff's problems were purely psychological—'chronic anxiety depression'.

c) The plaintiff, however, filed a report from the chiropractor she had consulted some two years after the accident. In sharp contrast to the medical testimony that there was no neurological or physical basis for the plaintiff's persistent headaches, back strain and hip pain the chiropractor reported:

- Gross restriction of cervical motion (palpable dysfunction at the 1st, 2nd, 5th and 6th vertebrae and marked bilateral hypertonicity and increased pain sensitivity of the posterior cervical muscles).

- Gross dysfunction throughout the thoracic and lumbar spine (with specific muscular and neurological involvement as described).

He then documented major improvement in the plaintiff's condition over 18 months, using specific joint adjustment (manipulation) and transcutaneous electrical nerve stimulation (TENS).

d) Given this conflict of evidence the matter went to trial. Oral testimony was given by the family physician/orthopaedic specialist, psychologist and psychiatrist for the defence, by the chiropractor for the plaintiff. The judge expressly preferred the evidence of the chiropractor to that of the medical experts, rejected the sugges-

tion that the basis of the patient's suffering was psychological and awarded substantial general damages.

8. Obtaining Recognition

a) **Increased Damages.** In this area nothing is more important for chiropractors than making lawyers aware that, in appropriate soft-tissue injury cases, they can be successful and gain higher settlements or court awards of damages for their clients by use of chiropractic evidence. Both cases discussed illustrate that.

b) **Good Report Writing.** Quality of report writing is of next importance. First impressions are strong, and all expert evidence commences as a written report. In many jurisdictions, to save cost and time, a case can now go to trial on written reports unless counsel serves notice requiring experts to be called for cross-examination.

c) **The Scientific Literature.** Lastly, every opportunity should be taken to make the legal profession aware of the depth of chiropractic literature now available to support the opinions of the individual chiropractic expert witness. Chiropractic has lacked rigorous scientific literature in the past—but no more. An attorney/lawyer who understands that:

- one of the world's foremost medical experts on the cervical spine, Ruth Jackson, MD FACS, has called a chiropractic text "the most remarkable compilation of scientific and factual data thus far published concerning the many facets of the cervical spine"⁶

- current systematic reviews of the scientific evidence and evidence-based multidisciplinary clinical guidelines and texts prefer the standard chiropractic approach (early mobility, spinal manual therapy, education and exercise—all based on a biopsychosocial model) to the standard medical approach (in the absence of visible medical pathology, rest, medication and passive physical therapies—on a biomedical model) for the management of acute and chronic spinal pain;

immediately develops new respect for what the chiropractic profession has to offer. He/she is well on the way to retaining a chiropractic expert for the first time. If there is the prospect of this evidence pressuring settlement to provide more money

for the client, that will often be the deciding factor.

9. **Presentation in Court.** Should the case go to trial and the experts be called to give oral evidence, the weight to be given to the evidence of each will have already been half decided from the quality of the written reports—already seen by the judge and the basis of opposing counsel's preparation of cross-examination. As has been discussed, take time in advance to ensure that counsel calling you as witness qualifies you well. Much has been written about the techniques of presenting evidence in court, but they can be reduced to a few essentials:

a) The hallmarks of the true expert are firmness and clarity on central findings and conclusions; willingness to admit limitations of knowledge outside the exact area of his/her expertise; impartiality (no appearance of shaping the evidence to suit the case); and use of plain and simple language. The best expert witnesses appear informed but humble.

b) Unless experienced in court, expect to be nervous. Most people are, the judge understands this whatever his/her appearance and mood may be, and a natural manner will be far more effective than bravado. It is a great help to have reviewed your file the night before, be in good time for court, and be dressed conservatively and comfortably. These precautions remove common sources of last-minute panic and unnecessary anxiety.

c) While waiting to give evidence do not constantly review details with the impression that you are faced with a feat of memory, and may forget an important item. Enter the witness stand with your mind focussed on the relatively few central findings you have made and wish to relate to the court. The details will come back to you from your earlier preparation, and they are there in your file anyway. If the issue is important, counsel calling you has the right of re-examination and it is his/her fault, not yours, if a matter of importance is left as a loose end.

C. ACUTE AND SUB-ACUTE CARE – DURATION, FREQUENCY AND COST

10. The chiropractic profession has evidence-based clinical guidelines and fee schedules describing duration, frequency and cost of care from its perspective. On

continued on page 6

continued from page 1

final report from that demonstration program demonstrated:

- Higher levels of patient satisfaction with chiropractic care than traditional care.
- Superior outcomes for patients receiving chiropractic care.
- Fewer hospital stays after chiropractic care.
- Significant improvements in military 'readiness' after chiropractic care because of a large reduction in lost duty time.

Despite these positive results the Department of Defence continued to oppose the integration of chiropractic care forcing the chiropractic members of the demonstration project Oversight Advisory Committee, supported by the ACA and the ACC, to file a minority report with Congress. After fierce lobbying, in which there were unsuccessful efforts by opponents to insert the need for a medical gatekeeper, Congress approved the law now signed by the President.

"A whole new health care system—one of the largest in the nation—will now be opened up to the chiropractic profession", stated ACA Chairman, Dr. Michael Flynn. "Most importantly we have achieved inclusion on a broad scope basis, and have successfully avoided a very narrow, Medicare-like benefit."

"The remarkably focused Oversight Advisory Committee and the doctors of chiropractic at the 13 demonstration sites provided an outstanding service to our nation's military and to the chiropractic profession," explained Dr. Kenneth Padgett, President of ACC. The six chiropractics on the OAC were Dr. George Goodman, Dr. Reed Phillips, Dr. Rick McMichael, Dr. Richard Beecham, Dr. Ronald Evans and Dr. Peter Ferguson. We salute them.

NORTH AMERICA

1. U.S.—Chiropractic Care for Seniors. The population is aging, but there has been little description of chiropractic management of older patients. In a new study from Palmer College co-sponsored by Activator Methods and published in the *Journal of the American Geriatric Society*, Cheryl Hawk, DC PhD and others set out "to describe patient characteristics and features of care provided to patients aged 55 and older" by sampling 805 representative patients from 96 chiropractic practices across the U.S. and Canada. They report that "musculoskeletal complaints compose nearly the entire case load of the chiropractors in this study," which is consistent with other research, and that 2 out of 3 (66.6%) of patients had mild to moderate musculoskeletal pain and a chiropractor as the only health provider for their current complaint. By comparison "patients with more severe symptoms seemed to use both medical and chiropractic care."

Virtually all patients received adjustment/manipulation, with other most common care being recommendations on exercise (41%), heat or cold applications (40.8%) and food supplements (24.5%). The boomers want much better mobility and health in old age than their parents—this study makes it very clear that chiropractic's success with that demographic group will be

through the doorway of musculoskeletal pain.

2. Canada—CCA Practitioners' Guide to Whiplash. The true nature of whiplash injuries and their best management remain controversial problems. The 1995 Quebec Task Force Report's classifications and recommendations are widely used but some of its data and conclusions have been shown by chiropractic and medical experts to be flawed. For example the QTFR conclusion that few patients (1.8%) have chronic symptoms after 12 months is wrong—the best study suggests that 1 in 4 patients (24%) has not recovered. As another example, animal experiments, human autopsy reports and objective diagnostic tests have shown that whiplash injury is not so commonly just a soft-tissue injury—there is damage to bony structures such as facet joints, to the annulus fibrosis, and to the vertebral bodies themselves.

These are a few items from an extremely impressive and readable *Practitioner's Guide to Understanding Whiplash Associated Disorders*, edited by Roly Bryans DC and published last month by the Canadian Chiropractic Association. Leading chiropractic experts (e.g. Dr. Arthur Croft, Dr. Donald Murphy, Dr. Lawrence Nordhoff, Dr. Adrian Grice, Dr. Kim Humphreys, Dr. Howard Vernon, Dr. Craig Morris, etc.) are joined by medical experts (e.g. Dr. Robert Teasell, Professor and Chief of Physical Medicine and Rehabilitation, University of Western Ontario, Dr. Arthur Ameis, physiatrist, Toronto, and Dr. Peter Rothbart, President, North American Cervicogenic Headache Society) and senior representatives of the insurance industry in a multidisciplinary manual that looks in precise expert and practical terms at all aspects of whiplash-associated disorders—physiology, symptomology, grading issues, management, legal and road safety issues and third party perspectives. The CCA advises that a complimentary copy of the manual will be sent in January 2001 to all CCA members and each of the World Federation of Chiropractic's 70 member national associations. As Peter Rothbart, MD says in the foreword "this is an important book that should be on every chiropractor's and physician's shelf." *Contact for more information:* Canadian Chiropractic Association, 1396 Eglinton Avenue West, Toronto, Ontario, M6C 2E4, Tel: 416-781-5656 Fax: 416-781-7344, e-mail: dbegin@ccachiro.org.

EUROPE

1. Sweden—Early Activity vs Rest and Soft Collar for Whiplash. A new trial confirms earlier evidence that neck pain patients have better results with early activity and mobilization rather than the standard medical treatment of rest, use of a soft collar and then gradual return to neck exercises and activities. Ninety-seven patients with acute neck pain were randomly assigned to 1 of 4 groups—the first commencing active treatment within 96 hours (hourly home exercises for the neck during waking hours, with mobilization according to the McKenzie protocol if symptoms persisted for 20 days), secondly active treatment but delayed for 14 days, thirdly standard treatment (a leaflet recommending rest and use of a soft collar, followed by exercises 2 to 3 times daily a few weeks after the injury), and finally standard treatment delayed for 14 days.

Results at 6 months after treatment showed significantly higher pain reduction for those receiving active treatment, with highest pain reduction for those receiving early active treatment. Interestingly though there were no significant differences concerning cervical ROM, and the majority of patients in all treatment groups still had some pain at 6 months. This trial provides clear evidence favoring early mobilization exercises rather than rest—which supports the fundamental orientation of chiropractic practice—but we now need a trial in which patients receive the active treatment plus cervical adjustment. (Rosenfeld M, Gunnarsson R, Borenstein P. *Early Intervention in Whiplash-Associated Disorders: A Comparison of Two Treatment Protocols*, Spine 2000, 25(14):1782-1787.)

2. Norway—Early Activity for Low-Back Pain. Similar to the above, this trial compared standard medical management, based on rest and medication, with positive reassurance and a mobilization program given by an MD and PT in a spine clinic. For 457 patients who had been sick-listed for 8-12 weeks, it was found at 12 months follow up that 68.4% in the mobilization group had returned to full-duty work compared with 56.4% in the medical control group. The researchers conclude that there are significant effects in reducing sick leave and cost if traditional care is replaced with a biopsychosocial model of care. However, with over 50% of these patients still off full-duty work after 12 months, there is obviously scope for much further improvement in management. Accordingly this trial should not be used by the medical research community—as it may be given recent trends—as evidence that merely reassuring patients and getting them into early activity is all you need to do. (Hagen EM, Eriksen HR, Ursin H. *Does Early Intervention with a Light Mobilization Program Reduce Long-Term Sick Leave for Low Back Pain?*, Spine 25(15):1973-1976.)

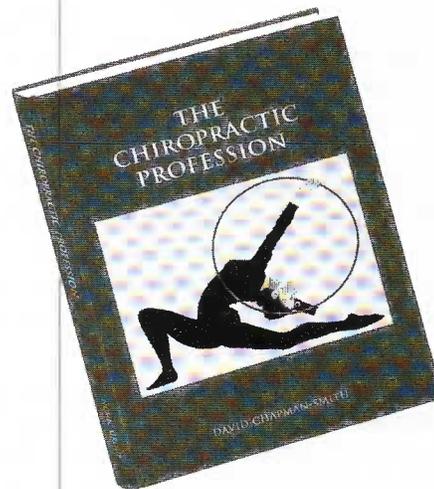
3. U.K.—Who Visits a Chiropractic College Teaching Clinic? At the Foundation for Chiropractic Education and Research's recent International Conference on Spinal Manipulation held at Northwestern College of Chiropractic, September 21-24, Dr. Haymo Thiel, Head of Clinic, Anglo-European College of Chiropractic, Bournemouth, England, presented the first analysis of patients seen at the AECC clinic—the 4,844 new patients who presented between January 1997 and May 1999. Points of interest:

- 40% presented with complaints in multiple areas of the body; 10% were asymptomatic; and 8% were under the age of 3.
- 60% had low-back pain, and 22.6% of them had referred pain to the lower limbs. The second most common complaint was neck pain (34.5%) with 28.2% of them having referred pain in the upper limbs. 21.4% had complaints in the thoracic region.
- 12.4% of patients had headache and/or TMJ pain, with 76% of these having cervicogenic headache. 18.4% had upper limb complaints, with the shoulder accounting for half of these (49.8%) and the arm, elbow, wrist and hand 10% each. 21.8% had lower limb complaints ranging from the knee (28.8%) and the hip (21.3%) to the foot (15.2%), thigh (13.5%) and ankle (11.2%).

(Thiel HW, *Clinical Characteristics of Patients Presenting to the AECC Teaching Clinic*, Proceedings of the 2000 ICSM, FCER, West Des Moines, 113-115.)

OTHER WORLD REGIONS

1. Iran. Dr. Hossein Sabbagh of Tehran, President of Iranian Doctors of Chiropractic Association, a Life-West graduate, reports major advances in the recognition of chiropractic in Iran following a decade of court battles, office closures and even one confiscation of all chiropractic office equipment. Last spring the IDCA managed to gain full recognition for the doctor of chiropractic degree—giving chiropractors the right to practise legally without the requirement of medical referral. In the early summer draft chiropractic legislation was introduced in the Iranian Parliament. It has now been approved by the Parliament's Health Care Committee and is now proceeding back to Parliament for final vote. The IDCA represents Iran's 11 chiropractors, and has a large support group of Iranian chiropractors in the U.S., led by Dr. Matthew Givrad, Cleveland Chiropractic College, Los Angeles Campus. Contact: Hossein Sabbagh, DC, P.O. Box 14455-134, Tehran, Iran 14455, Tel/fax: (9821) 824-6534, e-mail: jcc1376@www.dci.co.ir.



The perfect Christmas/holiday season gift for referring MDs, attorneys, patients, others to whom you want to say thanks.

Now available from The Chiropractic Report - shipping prices for North America only

1 copy	US\$49.95 + \$5.00 shipping	= US\$54.95
	CAN\$69.95 + \$5.00 shipping	= CAN\$74.95
5 copies	US\$20.00 each + \$10.00 shipping	= US\$110.00
	CAN\$35.00 each + \$10.00 shipping	= CAN\$185.00

Orders:

- Call 1-800-506-2225: VISA and MC orders only
- Mail (cheque or credit card) or fax (credit card only - VISA or MC) to *The Chiropractic Report* (see address on order form on page 8).

the other hand third party payors, especially in the managed care war zone of the U.S., have guidelines that often seek to limit care and cost as much as possible. From an independent and neutral perspective, what is a reasonable amount of care and cost for patients with moderate, uncomplicated musculoskeletal soft-tissue injuries?

This was the subject of *Amoa-Williams vs Allstate Insurance*,⁷ a recent automobile insurance arbitration in Canada. Reasons why this decision will be of general interest is that it is from a jurisdiction—the Province of Ontario—with a large chiropractic profession that is well integrated in the health care system (the Ontario Chiropractic Association has over 2,000 members), extensive expert evidence was called by the parties, and in her decision the arbitrator set out to provide “general comments . . . where possible” relevant to all chiropractic services in addition to specific findings in the case. This was because there were other cases awaiting arbitration.

11. Summary background information is:

a) In Ontario, as in all Canadian provinces, legislation identifies the health care and other benefits that all automobile insurance policies must cover. These include “reasonable and necessary services incurred as a result of the accident” provided by various classes of regulated health professionals including chiropractors.

b) Under the law those injured in automobile accidents are entitled as of right to 15 treatments from a chiropractor (DC) or physiotherapist (PT) within the first six weeks following an accident. However all other treatments, including additional treatments from a DC or PT, must be in terms of a treatment plan filed by the health professional and agreed by the insurer. If the insurer disagrees with the treatment plan submitted it can refer the patient to an independent designated assessment centre (DAC).

c) These DACs, selected by the government agency that administers the insurance law, the Financial Services Commission of Ontario or FSCO, provide an interdisciplinary assessment from a health care team that usually includes a physician, DC and PT. The insurer must fund all care assessed as reasonable and necessary. The DAC may also decide upon the reasonableness of fees charged.

12. In the *Amoa-Williams* case Mr. and Mrs. AW were injured in an automobile accident and both received “straightforward moderate soft-tissue whiplash-associated disorder (WAD II) injuries.” (WAD injuries, as described in the Quebec Task Force Report⁸ and accepted by the FSCO, may involve neck pain, stiffness or tenderness without specific musculoskeletal or neurological signs (WAD I), pain with musculoskeletal signs such as decreased range of motion and point tenderness (WAD II), pain with musculoskeletal and neurological signs (WAD III) or injuries that include bone fracture (WAD IV).

Allstate, the insurer, challenged the reasonableness and necessity of the chiropractic and rehabilitative treatments given, and their cost. These included:

- Passive treatments: soft-tissue therapy, ultrasound, electrotherapy and spinal adjustment—labelled ‘chiropractic treatments’ in this case because they were given at the chiropractic clinic.

- Active treatments: an exercise program prescribed by the chiropractor and monitored by a kinesiologist—labelled ‘reha-

bilitation services’ in this case because they were given in a separate but affiliated rehabilitation facility.

The DAC assessment ruled that there was some unreasonable care and cost, a mediation process failed, and Mr. and Mrs. AW filed for arbitration. Findings by the arbitrator included:

a) It was established law that “the choice of the modality of treatment is that of the insured person and his or her health practitioner.”

b) If the chosen treatment has some “legitimate medical and rehabilitative goal” it is reasonable regardless of whether or not others—including the insurer and its medical advisors—regard it as appropriate, and legitimate goals include “promotion of recovery” and also “relief of pain”.

c) As was agreed by all experts—and these included nationally-respected representatives of the chiropractic, medical and physiotherapy professions, including the prominent orthopaedist Hamilton Hall, MD—standard and reasonable chiropractic care “for straightforward soft-tissue injuries” is “between 6-8 weeks of combined passive and active therapy. . . . Passive care to control pain and maintain mobility, including daily chiropractic care, is appropriate in the first 2½ weeks after the accident, with gradual tapering off after that”.

d) Accordingly Mr. AW, who reached his maximum level of exercise and recovery in the rehabilitation program by 6 weeks, should be entitled to recover for 23 treatments over 6½ weeks, including 13 daily treatments in the first 2½ weeks. (Mr. AW had in fact been given 35 treatments over 9½ weeks).

e) For Mrs. AW, who had fewer chiropractic treatments in the first 6 weeks (15) because of the demands of her work schedule, but a slightly higher total of 36 treatments over approximately 4 months, all treatments were found reasonable and necessary because her recovery was slower and the treatments facilitated her exercise program and recovery throughout.

f) The hourly rate of \$250.00 for chiropractic services set forth in the Ontario Chiropractic Association Fee Schedule (OCA Schedule) was appropriate, with the result that the following fees were held reasonable—\$120 for an initial 30 minute consultation that incorporated a treatment; a \$40 block fee for subsequent 10 minute treatment visits (the OCA Schedule also provided the alternative of itemized fees for a minor assessment, adjustment, modality, etc); a \$125 fee for a 30 minute review of the DAC report and discussion with the patient; and a \$75 fee for each paperwork service deemed to take approximately 20 minutes, such as preparation of a disability certificate or treatment plan.

As to reassessment, the arbitrator found that one re-examination/reassessment per month billed at \$45 was reasonable—i.e. a total of \$85 for the treatment visit with the reassessment.

g) With respect to rehabilitative exercises, the evidence was that the supervising kinesiologist was paid \$13 per hour. On this basis it was held that a reasonable charge for prescribed exercises supervised by a kinesiologist was \$80 per person per hour, with charges billed per 15 minute segment. For sessions where there was no effective supervision by the kinesiologist, the kinesiologist being otherwise engaged or the patient being fully familiar with what was required, a reasonable charge was \$50 per person per hour, again calculated according to 15 minute segments.

h) Table 1 summarizes the chiropractic services and fees found to be reasonable and necessary and due from the insurer for these patients with similar uncomplicated WAD disorders—one recovering in 6–8 weeks and the other in approximately 16 weeks because of her different work demands and other circumstances. Rehabilitative services prescribed by the chiropractor were in addition to these. On one hand a number of services billed were disallowed. On the other hand the insurer was required to pay considerably more than it had. Total health care expenses for Mr. AW were \$668.80 (\$453.80 chiropractic expenses and \$215 rehabilitation) and for Mrs. AW were \$2,618.52 (\$1,323.52 chiropractic, \$1,295 rehabilitation).

Table 1: Amoa-Williams Case – Services and Fees Allowed

	Mrs. AW	Mr. AW	Fee
Consultation and initial visit	1	1	\$120.00 ¹
Subsequent treatment visits	36	22	\$ 40.00
Disability certificate	1	1	\$ 75.00
Treatment Plan	1	1	\$ 75.00
Minor Exam/Reassessment	4	2	\$ 45.00
DAC Report Review	1	n/a	\$125.00

¹ Rounded up from \$119.92.

D. SUPPORTIVE CARE AND FREEDOM OF CHOICE

13. *Cubello vs National Frontier Insurance*,⁹ another recent Ontario automobile injury case, was a trial by judge and jury in the Ontario Superior Court, in which Fulvio Cubello and Mary Cubello, his wife, sought damages and recovery of chiropractic and other health care costs for more serious injuries sustained in a major head-on collision. Essential facts for our purposes are:

a) In a 1996 accident Mr. Cubello, a landscaper and a competitive cyclist, suffered a serious whiplash injury including fractures, soft-tissue injuries and injury to the cervical facets. He also aggravated a back injury. Mrs. Cubello, a nationally-ranked cross-country skier, received even more widespread musculoskeletal injuries.

They both strongly preferred natural methods of health care and recovery and, after early hospitalization and medical care, avoided medications and relied upon chiropractic, acupuncture, massage and a rehabilitative exercise program to reach and maintain maximum recovery.

b) Under Ontario's no-fault automobile insurance laws National, their insurer, was obliged to cover their reasonable and necessary health care. Some 18 months after the accident National exercised its right to have an independent examination of the Cubellos at a designated assessment centre (DAC) which reported that they had reached a maximum level of recovery and that further chiropractic, massage and acupuncture treatments and fitness costs were not the responsibility of National—especially for Mr. Cubello who had been receiving chiropractic treatment at a similar frequency prior to the accident anyway.

National, relying on this report as was its right, refused reimbursement for the above services. Further, it was alleged Mrs. Cubello should have been making more use of medication to control her pain.

c) At trial in April 2000 the jury found for the Cubellos and

awarded significant general damages for disability, pain and suffering. The more technical issue of entitlement to special damages for health care costs, including the cost of continuing chiropractic treatments, was left to the judge.

14. In her written decision Judge Eberhard was sharply critical of the suggestion that the Cubellos should have chosen medication rather than natural treatments. Interesting observations and findings include:

a) **Reimbursement for chiropractic supportive care.** In U.S. and Canadian clinical practice guidelines,^{10,11} *supportive care* is defined as “therapeutically necessary care for patients who, despite rehabilitative exercises and other lifestyle modifications, fail to sustain therapeutic gains after treatment withdrawal. Reasons may include the ongoing stresses of work and other activities of daily living.” This may be compared with *preventive/maintenance care* which is elective for patients who have no limiting symptoms but wish to maintain optimum function, and to have functional pathology corrected before pain and disability develop.

The main point argued by National, based on the DAC report by an occupational health physician, was that the Cubellos had reached maximum improvement, the chiropractic and other treatments in dispute would not assist in further improvement, they were not “medically reasonable and necessary”, and were therefore not the responsibility of the insurer.

The judge disagreed. Mr. Cubello was not disabled but had continuing pain that limited his activities. “The relief of pain” was “a valid goal of treatment” making the ongoing care “medically reasonable and necessary.” The same argument applied to Mrs. Cubello.

b) **Existence of prior care.** The insurer then argued it should not be responsible because Mr. Cubello was receiving a similar level of ongoing chiropractic care prior to the accident. Judge Eberhard found there was a similar frequency of chiropractic care before the accident, but that there was now a different reason for Mr. Cubello's care. Formerly it was for pain relief for an injury unrelated to the accident and preventive/maintenance care; now it was for pain relief and the avoidance of disability from injuries caused by the accident. This was supportive care for which National was responsible.

That said, some apportionment or set-off was due on account of the care Mr. Cubello would have undertaken anyway. The judge ruled that the insurer should pay for two-thirds of the chiropractic and massage treatment costs.

c) **Areas of treatment.** The judge expressly acknowledged that chiropractic management involved interrelated structures, so that “treatment at one site (*i.e. spinal region*) may well effect another.” For this reason treatment of spinal areas not “directly impacted by the accident” was an integral part of reasonable and necessary care.

d) **Patient choice.** Judge Eberhard was outspoken in support of patient choice on behalf of both plaintiffs, especially Mrs. Cubello who it was accepted made no use of alcohol, caffeine or tobacco. To quote:

“Case law supports the notion that the insurer should not usurp from the patient the right to make reasonable treatment choices. Mary Cubello has mitigated her injuries in a reasonable and even

remarkable way. It is patently unreasonable to insist upon trials of every possible medication as a pre-condition to continuing benefits that do provide some relief, particularly when expert evidence suggests that these strong medications are not dramatically curative for the type of pain Mary Cubello endures.

Anyone with a legal duty to compensate or provide benefits to (her) as a result of her injuries should thank their lucky stars that she has the character she does. She has gifted them with her effort. As a result of her effort, the benefits she will need are much reduced from what might have been expected by her diagnosed condition.

In this context it is shocking to hear it suggested that Mary Cubello should be trying morphine and the like to control her pain rather than carry on at the gym to control it and remain the Mary Cubello she has always been. I find her expressed reasons for avoiding addictive medications with their possible side-effects legitimate and supported by expert opinion and her treating physicians."

On the facts, which included patients who had made impressive efforts at rehabilitation throughout, the court held the insurer liable for the continuing cost of supportive care approximately 4 years after the accident and 2½ years after maximum level of recovery. The 1994 Ontario case *Lynch vs Halifax Insurance Company*¹² makes a similar finding of liability against an automobile insurer for chiropractic supportive care. These cases demonstrate that, in appropriate circumstances, courts will not hesitate to support both acute and continuing supportive chiropractic care even when challenged by medical expert evidence. **TCR**

REFERENCES

- 1 *Engel vs WorkCover Queensland*, Industrial Magistrates Court, No. AP1598/1999, Townsville, Tatnell SM, Judgement dated May 22, 2000.
- 2 *R v Rodych* (1978) 41 C.C.C. (2nd) 416, 421.
- 3 *Managing Low Back Pain*, ed by Kirkaldy-Willis WH, Bernard TN, 4th Edition, Churchill Livingstone, 1999.
- 4 *The Back Power Approach*, Imrie D and Barbuto L, Stoddard Publishing, Toronto, 1988.
- 5 *Behnke v Barthorpe and Walker*, unreported, No. 9879/1984, District Court of Ontario, Judgement dated September 30, 1986.
- 6 *Whiplash Injuries: The Cervical Acceleration/Deceleration Syndrome*. Foreman SM, Croft AC, Williams and Wilkins, Baltimore and London. 1988.
- 7 *Amoa-Williams v Allstate Insurance*, FSCO A97-001864, Arbitration Order dated June 5, 2000.
- 8 Spitzer WO, Skovron ML et al (1995) *Scientific Monograph of the Quebec Task Force on Whiplash-Associated Disorders: Redefining Whiplash and its Management*, Spine 20:8S.
- 9 *Cubello v National Frontier Insurance Company*. Court file No. G20494-97, Ontario Superior Court of Justice, Judgement dated April 12, 2000.
- 10 *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, (1993) Proceedings of the Mercy Center Consensus Conference, ed. Haldeman S, Chapman-Smith D, Petersen DM, Aspen Publishers, Gaithersburg, Maryland, Chapter 13.
- 11 *Clinical Guidelines for Chiropractic Practice in Canada*, ed Henderson DJ, Chapman-Smith D, Mior S, Vernon H, Suppl. to J Can Chiropractic Ass 38(1): March 1994, Chapter 14.
- 12 *Lynch v Halifax Insurance Company*, Ontario Insurance Commission File No. A-004781, Decision dated December 20, 1994.

SUBSCRIPTION AND ORDER FORM

(6 bi-monthly issues) Year commences January

			Check one
US and Canada (your currency)	1 year	\$84.00	<input type="checkbox"/>
	2 years	\$160.00	<input type="checkbox"/>
Australia	1 year	A\$96.00	<input type="checkbox"/>
	2 years	A\$185.00	<input type="checkbox"/>
Elsewhere	1 year	US\$85.00	<input type="checkbox"/>
	2 years	US\$165.00	<input type="checkbox"/>

Name _____

Address _____

City _____ Province/State _____

Country _____ Postal Code/Zip _____

Telephone (_____) _____

PLEASE CHECK ONE

Visa Card number _____

MasterCard Expiration date _____

Cheque/Check enclosed

Payable to: The Chiropractic Report
3080 Yonge Street, Suite 5065
Toronto, Ontario M4N 3N1 Canada
Tel: 416-484-9601 Fax: 416-484-9665
E-mail: TCR@chiropracticreport.com
Website: www.chiropracticreport.com

I want to offer rehab, but how?

Have you been meaning to incorporate systematic low-tech rehabilitation into your practice, but are unsure where to start—which book, which certification program?

After a close review, and after a test run with a chiropractor just like you, *The Chiropractic Report* strongly recommends the four-tape *Rehabilitation of the Spine Video Series* by an internationally-respected team of rehabilitation experts led by Craig Liebensson, DC (Lippincott, Williams and Wilkins, US\$175.00—to purchase and for shipping details, see *Dynamic Chiropractic's Preferred Reading and Viewing Desk*). Featuring:

- Videos of high technical quality (using patients, animations and fresh cadaver dissections to demonstrate functional anatomy) that are concise, logical and truly teach the principles and components of a comprehensive low-tech program.
- Accompanying booklets summarizing learning objectives and key information from the tapes.
- Rehab for the cervical, thoracic and lumbar spine—including step-by-step guides to treatment and exercise prescription.

This Report receives no financial benefit from this recommendation.