Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

We Get Letters

In Search of Chiropractic History Down Under

Dear Editor:

In New Zealand, the Hamblin Chiropractic Research Fund Trust is sponsoring research into the history of the chiropractic profession in this country.

The research is being done by Mr. Craig Wills. Craig has a master's of social science in history from the University of Waikato in Hamilton, New Zealand.

It is envisioned that the study will be done in three parts:

1895-1945 (end of World War II)

1945-1979 (registration in the 1960s and Commission of Inquiry)

1979-Onwards

If any practitioners or their families have information including letters and photographs of, and about New Zealanders in the United States and Canada, especially pre-1945, it would be most appreciated if it could be sent to New Zealand.

Would you please send this information or photocopies to:

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Justin Vodane, DC
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"Enuf Said"

Dear Editor:

I just wanted to say I enjoyed your "Report of My Findings" in the September 1, 1993 issue. I could not agree more with your commentary on the direction our profession is heading. It sounded like I was reading a Fred Barge article (that's good).

I look forward to reading more of your "reports" of this nature in the future.

Marc M. Tonti, DC
Huntington Beach, California

Forgotten Study?

Dear Editor:

I have just finished reading Dr. John Gantner's article, "Workers' Compensation, Our Golden Opportunity" (August 13, 1993 issue of "DC").

I have known Dr. Gantner for a number of years and always found his articles interesting and informative. In this particular article, however, I must correct a statement made by Dr. Gantner. He states: "An honest study should compare the effectiveness and overall cost of work done by different disciplines when treating a workers' compensation claimant. ...It has never been done in any state to my knowledge."

Actually, there has been such a study performed here in Florida in 1988. The study was funded by the Florida Chiropractic Association and performed by FCER. It was titled "Chiropractic v. Medical Care: A Cost Analysis of Disability and Treatment for Back-Related Workers' Compensation Cases." The purpose of the study was to do a comparative analysis that, among other things, included: "Cost of all physician services and physician-prescribed procedures (such as occupation and physical therapy, and radiological examinations and interpretations), cost of hospital services and procedures, both in and outpatient, drug and supply costs, transportation costs, and miscellaneous treatment costs." Page two of the study states: "The method used to select cases and collect treatment cost information was designed to show the total cost management of a claimant's treatment. ...An accurate estimate of the cost of care by a primary health care provider must consider the physician's services in addition to all prescribed adjunctive procedures and modalities that are an extension of the physician's treatment regime."

Interestingly enough, the results of this study are quite favorable to chiropractic. I would encourage anyone interested in this study to contact FCER.

John Gentile, DC
Miami, Florida

Thermography: "Some Have Lost Touch with Reality"

Dear Editor:

The current controversy over thermography appears absurd. It appears that some have lost touch with reality in terms of diagnostic testing.

Diagnostic testing is the utilization and extension of our senses for the purpose of understanding a patient's clinical problems, so as to be able to formulate an appropriate treatment regime. We use eyeglasses, ophthalmoscopes, and microscopes to augment our vision, hearing aids and stethoscopes to augment our hearing, and chemical analysis to augment our senses of smell and taste.

Vision relies on sensors within our eyes to detect reflected electromagnetic waves in the visible portion of the spectrum, commonly referred to as light. We use our eyes to inspect the patient, and make judgments regarding normal versus abnormal, in terms of color, apparent texture, lesions, etc.

MRI is an extension of our vision into the microwave and radio wave regions of the electromagnetic spectrum. X-ray is an extension of our vision into that part of the spectrum above the ultraviolet, called the x-ray region of the electromagnetic spectrum. CT scans are a form of x-ray.

Both MRI and x-ray are invasive, in that radiation is passed through the patient. (Invasive, may or may not relate to being harmful.)

Electronic thermography is an extension of our vision into the infrared region of the electromagnetic spectrum. Thermography is not invasive since what is viewed is the electromagnetic energy being given off by the patient.

Because thermography is merely an extension of our vision, it would follow that if one can't use diagnostic thermography, then one would not be permitted to use x-ray, MRI, eye glasses, or even one's eyes.

The first question to ask is whether one should consider using thermography. Putting aside economic questions for the moment, the answer is obvious. All safe testing should be used to assess the patient. The more information we have, the more appropriate will be our treatment decisions. Unfortunately, we live in a world governed by economics. So, the question is reduced to deciding when one would utilize thermography, which requires an answer to the question of why one would use thermography.

While MRI and CT scans provide morphological information about the internal structure of the spine, thermography provides physiological information about the function of the peripheral autonomic nervous system. Skill, knowledge, and experience are required to interpret thermographic patterns.

If there is a clinical question that thermography can help answer, such as whether an RSDS is present, then a thermographic study would be clinically relevant. If it is a question of getting "show and tell" pictures for court, or of "lets do a thermographic scan and see if we can find an excuse to treat the patient," then the thermography would not be considered clinically relevant, just as an MRI would not be clinically relevant for these purposes. A positive MRI does not mean that the patient needs treatment. A positive MRI is typically only clinically relevant if the patient is symptomatic and the symptoms might be related to the abnormalities found on the MRI.

It is interesting to note that since thermography provides a measure of physiological dysfunction, appropriately interpreted abnormal thermographic findings tend to be relevant for establishing medical necessity for chiropractic treatment in terms of measurable physiological dysfunction which would be associated with a subluxation complex, and which is also often interpretable in terms of a recognized clinical condition for which clinical intervention would be deemed appropriate. Conversely, since MRI findings demonstrate morphological changes, in the absence of pain, they tend to be more relevant for establishing a basis for assigning permanent impairment, especially when combined with measurements of the patient's mechanical capabilities. Both thermography and MRI findings can be relevant for establishing a foundation for the patient's reported symptomatology.

In terms of economics, which in today's world usually means third party reimbursement, it is not the fact that the patient has a subluxation which is important, but the clinical manifestation of the subluxation. One of the best ways of "seeing" the manifestations of a subluxation is through the use of thermographic equipment. However, the world is harsh. Insurance contracts, usually only provide reimbursement for tests which are needed to help formulate an accurate differential clinical diagnosis for a medically recognized condition, for the purpose of formulating or modifying

a treatment regime. It is not a question of what an insurance company "should" be paying for, but what they have contracted to pay for. Because a particular thermographic study may or may not be reimbursable by an insurance carrier does not mean that it has no value in terms of chiropractic. The dermathermograph is very valuable in skilled hands, but its use is not typically reimbursable by insurance carriers.

The other consideration involved with reimbursement is the level of service. Insurance carriers contract to reimburse patients for usual and customary procedures. Anything more than this is considered to be a higher level of service and would not be reimbursable unless extra documentation was available to indicate why this higher level of testing was required for a particular patient. The requirements are no different for MRI, CT scans, or other diagnostic tests. The days are passing quickly when the doctor only has to say that he wants a test performed and it is accepted that the test is "really" needed and, therefore, would be reimbursable by insurance companies. There have been too many tests ordered for reasons other than the immediate needs of the patient for this practice to continue without the need for medical necessity to be documented.

The arguments about thermography are usually disguised arguments about reimbursement. None of the tests, thermography, MRI, CT scans, etc. provide absolute, unequivocal findings. All formal tests are subject to misinterpretation. Just look at the number of your chiropractors who fail the x-ray practical for their state boards, as an example. All tests should be used judiciously and in combination with patient history, symptoms, and other examination and test finding, in order to formulate an appropriate treatment regime for a patient. To argue about the validity of thermography is ludicrous. It is a "red herring' to avoid having to face the issues of clinical utilization in the treatment of the patient, and whether the level of service was appropriate for a particular case. These issues apply to all forms of testing, and should be the only basis for decisions concerning reimbursement.

Just as no one questions whether a doctor should look at a patient with his eyes using visible light, no one should question whether a doctor should look at a patient with thermographic equipment, an infra-red conversion device. The questions should be concerned with how much that look is actually worth in terms of case management decisions. In terms of RSDS, the look may be worth a lot. In terms of documentation for building a legal case, the look may be worthless in terms of medical necessity from the viewpoint of the third party carrier responsible for treatment reimbursement.

Howard L. Silverman, PhD, DC
Board certified in thermography/ACA
Independent consultant for utilization review
Clayton, Georgia

The "Undesirable Patient," a Second Opinion

Dear Editor:

As a clinical psychologist who has taught and worked closely with many in chiropractic during my years of professional practice, I was somewhat disconcerted by Dr. Eisenberg's article "Coping with the Undesirable Patient" in the July 30, 1993 issue. Dr. Eisenberg's general attitude toward the hypothetical "universally undesirable patient" was decidedly negativistic and avoidant. He seemed to imply that "older" doctors who have been practicing for years get "fed up" with these type of patients and want nothing more than to rid themselves of having to deal with these "pain in

the neck (or back) people." He even goes so far as to recommend certain "ploys" for subtlety driving such nuisance patients out. He suggests a group practice to "reassign" such types. Finally, his best recommendation is that "such treatment be provided by doctors who are emotionally better equipped to cope with such individuals," whatever that means.

I found the article to be less than helpful. Not only does Dr. Eisenberg merely seem to "rag" on certain types of difficult patients, but he gives no useful information about how to deal with "les hommes douloureux" once they cross your office threshold.

Dr. Eisenberg begins by attempting to define what he means by undesirable patients. He suggests that they can be identified by the following behaviors: (1) They are constant complainers -- no matter what you say or do they find fault; (2) when it comes to keeping appointments, they are repeatedly late; (3) if they flatly miss an appointment, they give some lame or transparent excuse; and lastly (4) they often have a poor payment record. He also points out that this "universally undesirable patient" has made the rounds of an excessive number of doctors and they possess a profound fluency when it comes to describing their symptoms. They are attention seeking and they have made a career of being sick because being well would pose unwanted responsibilities in their lives. These are not the sort of identifying characteristics which are readily itemized on an intake form, nor are they symptoms which quickly come up in the history or review of systems. As Dr. Eisenberg suggests, they may vigorously complain that no other doctor has been able to help them, but this may be a true statement, because some patients are in fact more "difficult" than others. However, much more than identification and discharge "ASAP" is the appropriate prescription. I don't get much else from the article.

I agree that chiropractors (and even MDs) more often than they would perhaps like, whether they have been in practice one year or twenty years, run into patients who do not respond to "appropriate" treatments, because there is a "functional (i.e., psychological) overlay" to their symptomatology.

May I point out that Descartes was wrong, the mind and the body are not separate. Our physical condition and our psychological status are always intimately connected. Perhaps not so much so as Dr. Ward's stressology would imply, but as a psychologist I have learned over and over that adjustments and mental relaxation are highly compatible. Our mental status does affect our physical condition and vice versa. It is almost a cliche that 60 to 70 percent of medical office visits reveal normal tests and are actually related to psychological complaints. I do not feel it necessary to really argue this point further. The proportion of physical to psychological components in any given patient is idiosyncratic, but Dr. Eisenberg appears to be referring to those who are almost entirely entrenched in the latter.

I would refer both the interested reader and Dr. Eisenberg to the DSM III-R for a more precise definition of the psychological characteristics to which he refers.

Actually he has alluded to two distinct types of mental disorders from the DSM III-R: somatoform disorders, and variations on the personality (Axis II) disorders.

Dr. Eisenberg is referring specifically to hypochondriasis when he alludes to doctor shopping and assuming the "sick role." Hypochondriacs, as some of the rest of the somatoform disorders, including 1) conversion disorder, 2) somatization disorder and 3) somatoform pain disorder, do seek to satisfy some unconscious psychological need in the focus and manifestation of their presenting symptoms, especially pain. I agree with Dr. Eisenberg that chiropractic by the very nature of the "touching" involved often tend to elicit or satisfy these psychological needs in patients. That is, perhaps some chiropractors are prone to attract these types of patients, as Dr.

Eisenberg implies. These types of patients are best approached with a supportive, yet firm adherence to a regular regime of treatment, portioned out over a reasonable time.

The very criteria which diagnoses such individuals as "somatoform" recommends a psychological component to their complaints. Often, in the case of pain complaints these components can be identified as anxiety, mental tension or stress. These factors have been shown to be readily managed by such intervention techniques as biofeedback, relaxation training or stress management. Any health care provider who does not currently have access to these professional resources in his or her community should actively seek them out. If the pain complaints suggest "masked depression," cognitive techniques have shown excellent promise in recent years. Appropriate psychological interventions in "cooperation" with good chiropractic care can go a long way in helping these types of patients to not only cope with their pain but to satisfy psychological needs as well.

Hopefully, with the advent of a national managed care system, these types of patients will be more readily identifiable and case management will assist in the coordination and cooperation for the interdisciplinary treatment which is necessary in these cases.

There is an entirely different class of patients to which Dr. Eisenberg refers, but who must not be confused with the more "treatable" somatoform candidates. These are the types of patients with personality disorders. Personality disorders are defined by two cardinal characteristics. They are identified by alloplastic and egosyntonic behaviors. To use a more archaic term, individuals with somatoform problems can be said to be neurotic, i.e, their behaviors are autoplastic and egodystonic. Neurotic individuals report their symptoms to be discomforting and not their normal condition (egodystonic) and they are willing to change (autoplastic). They seek help and at least initially in the professional relationship attempt to cooperate with the doctor in their own treatment. However, individuals with personality disorders, as opposed to the somatoform (neurotic) type, find nothing unusual or wrong with their behaviors (egosyntonic) and want the world to change or adapt to them (alloplastic), not the other way around. Or put simply, neurotics drive themselves crazy, personality disorders drive everyone else crazy.

Dr. Eisenberg seems to be referring to these patients when he describes such passive aggressive acts as arriving late for an appointment, hubris, or intrusive behavior. I would agree with Dr. Eisenberg that patients with personality disorders are indeed very difficult to treat, even from a psychological perspective. They are recalcitrant to TLC, education or even insight oriented psychotherapy. Their treatment requires tenacity, strength, and consistency from their health providers, whether they be chiropractors or psychologists.

They are in fact undesirable patients. They can disrupt a practice, annoy staff and they can, as Dr. Eisenberg warns, cause "spill over" because of the negativistic and oppositional feelings they elicit in others.

However, again I am in disagreement with Dr. Eisenberg's passive recommendation that "someone else ... emotionally better equipped" should treat them. Our role as healers and care providers dictates that we do everything in our power and under our licensure to decrease suffering, physical and/or psychological.

Individuals with personality disorders are indeed draining, maddening, frustrating, and "a nuisance" as Dr. Eisenberg suggests, but the referral to a competent psychologist who is trained to treat such disorders is the most appropriate course of treatment. If not so much to change the person with personality disorder, but to give the chiropractor support and counsel, which would allow him or her to continue to provide the best care he or she is trained to give. To put it simply,

misery loves company. Share the load! These are truly difficult patients, but patients nonetheless and they deserve our best professional efforts no matter what "a pain" they are to us.

Sadly, Dr. Eisenberg's article reflects a somewhat passive and "burnt out" approach to the subject of the difficult patient. Appropriate and differential diagnosis within this subgroup is the best response to an otherwise vexing problem which affects all health care providers. If we work together, such difficulties are always minimized.

Dennis Lindsey, PhD
Licensed psychologist
Associate Professor, LACC

SEPTEMBER 1993