Dynamic Chiropractic

PHILOSOPHY

We Get Letters & E-Mail

Things Won't Change Until We Demand Meaningful Reform

Dear Editor:

I can't tell you how much I loved reading Dr. Andersen's article, "Who's to Blame for the Crisis in Health Care?" [April 22 *DC*, page 1] I think he hit on every important topic/point involved in this mess we call heath care. The insurance industry has sold the public and our elected officials - both in the states and the federal government - a twisted tale of lies and deception, and have gotten away with it. Things will not change until enough people become outraged and demand real and meaningful reform.

A copy of Dr. Andersen's article should be sent to every elected official, and if they still don't "get it," I believe a new political party called The Vote the Incumbent out of Office Party should be formed. You have one shot to get it right. If you get elected and things don't get better, you're out. Why are there career politicians totally out of touch with what is really going on still in office? It is time to take a stand. Send the article out; then vote the bums out.

Robert Reiss, DC
Yorktown Heights, N.Y.

Enough Is Enough

Dear Editor:

I read with dismay the article about the drug-free position of the ACA by Dr. Edwards ["ACA Reaffirms Drug-Free Position"] and the other (apparently staff-written) article on the scope of practice expansion opposition by the ICA ["ICA Weighs in on Scope Expansion in New Mexico"]. I do not belong to either of those organizations, nor will I as long as that attitude prevails.

Dr. Edward's credentials at the end of his article did not list his office with the ACA. I was curious to find out more about Dr. Edwards and to find out what rank he held in the ACA, so I went to the ACA Web site. It does not tell who the officers are. I really question his authority to speak for the ACA. He does not speak for me. [*Editor's note:* As stated in the bio at the end of his article, Dr. Edwards is a former ACA board chair and former chair of the ACC Political Action Committee (ACA-PAC). His long-standing column, "Insider's Insights," often addresses ACA activities and policies.]

He wants us to be drug free. Most of the nation is drug free [in terms of chiropractic scope], and look what a sorry mess our profession is in. Many chiropractors are starved out. Most don't make enough to pay dues to a national or state association. Where I practice, our right to "diagnose" is under siege. I am sure the straights are applauding that.

Well, I have had enough. Enough ACA. Enough ICA. Enough TCA ("T" for Texas). For all of their rhetoric for the last few decades, we still don't get paid by Medicare or most insurance like we

should. We don't have equal access ... the beat goes on and on. Wake up, chiropractors! Now is the time to rise up. The time will never be better. Drug prescription is the equalizer.

People in this country want drugs and if we are able to provide them, then we have a much greater opportunity to influence them into a non-drug health solution. If we want to be able to take them off of their drugs, then we need prescriptive authority to do so. I have always maintained that we will never get rid of discrimination against our profession until we achieve true prescriptive power. Think about it. Do you think Medicare would pay for our exams and X-rays if we could prescribe drugs? If that were the case, they would have to admit that we really are physicians.

Some of the brightest minds in our profession want prescriptive power. One of my neurology diplomate instructors, who is one of the most brilliant doctors I have ever seen, is going through a nurse practitioner program so he can do the procedures that are currently not in our scope. In a way, it does break my heart to see one of the brightest minds of our profession want to practice outside of our profession. Would it not be better if he practiced as an advanced-practice chiropractor, rather than an advanced-practice nurse? Master's-prepared nurses do not have half the training a DC has and do not have to do an internship. Yet they can legally perform any procedure a chiropractor can, and much more. And in most states, we cannot even recommend a single aspirin. With all of my training and lack of scope, I am very indignant of that.

The ICA is very "concerned" about public safety when it comes to chiropractors dispensing drugs, whereas I am more concerned about the abilities of a nurse practitioner, with their limited training, making diagnoses and dispensing drugs and even performing spinal manipulation if they so choose.

Doctors, we started tiering our profession long ago when our specialty boards evolved. I do not know about other board preparation programs, but we have to know a lot about drugs, neurotransmitters, and receptors in the neurology diplomate program. When you know all of that, all you need is a few additional hours in pharmacology and a prescription pad. In my state you cannot practice as a chiropractic neurologist unless you have that credential. Heck, it even looks like we won't be able to do an Epley's maneuver without advanced training here in Texas. How about your state?

Instead of pouring my money into the fight against the Texas Medical Association and the AMA, I am going to invest in myself. I will be training in New Mexico this fall for advanced-practice chiropractic so that I may bring it back to my beloved Texas. I hope to see a lot of my colleagues there.

Robert Walls, DC
Azle, Texas

Editor's note: The following two letters to the editor address Dr. Steven Eggleston's recent article, "Accurate Prognosis in Personal-Injury Cases Utilizing George's Line." The first letter, from Dr. Lawrence Nordhoff, critiques Dr. Eggleston's article, much like Dr. Arthur Croft did in the May 6 issue. The second letter is from Dr. Eggleston himself, clarifying several points regarding his original article while responding to Dr. Croft (and perhaps to Dr. Nordhoff).

"Unfounded Facts Were Not Necessary in This Article"

Dear Editor:

It is important for chiropractors to carefully analyze all articles that are published in both peer- and non-peer-reviewed articles to be certain that the data within the paper is valid and the conclusions have merit based on the evidence provided in the paper. After reading the article by Dr. Steven Eggleston (March 26, 2010), I felt a response was necessary to put whiplash prognosis and the use of the 5th edition of the AMA impairment guides for spinal instability in perspective.

Dr. Eggleston makes several claims: a) The DC can make astonishing accurate long-term prognosis at the first examination; b) Most DCs see small anterolisthesis and/or retrolisthesis on the films and ignore it or fail to appreciate its significance; and c) 35-45% of trauma patients have somewhere in-between ligament laxity injury or neural arch fractures. He recommends the use of the outdated 5th edition of AMA guidelines, and states that patients with no measurable translation instabilities will probably heal completely within a few months.

I have read many studies over the years that specifically address long-term prognosis for WAD patients[1] and have yet to see any large peer-reviewed paper conclude that any group of physicians can make astonishing accurate prognosis at the first examination from a single variable such as ligament laxity. Most prognostic studies list several factors that lead to either good or poor prognosis. Simply put, there is no consensus in the scientific community as to any single factor that leads to long-term prognosis, with the exception of fatalities.

I find in my review of chiropractic records, and in response to questions to groups that I provide WAD seminars to, that most chiropractors understand and appreciate the significance of disruptions in George's lines or when dynamic flexion-extension X-rays show spinal instability. Dr. Eggleston is implying that most DCs are not proficient in their analysis, and thus committing malpractice by improperly documenting instability. Instead of painting a picture of most DCs being on the borderline of committing malpractice in their analysis and having little if any biomechanical interest in spinal kinematics, it would be great if Dr. Eggleston could provide a large study showing real-world data that compare the male and female population.

I have yet to find any radiographic or biomechanical/kinematic study validating that 35-45% of trauma patients have somewhere in-between a translation ligament laxity injury to neural arch fractures. There is scant literature relating to WAD cases relating to measured instability. In a recent study by Centeno, et al., the authors specifically looked at rear-end impact cases using flexion-extension X-rays, noting a mean translation of 3.29 mm and 4.61 mm for males and females, respectively.[2] Generalized injury data from automobile crashes is available. For example, the Insurance Research Council reports that 5-7% of all claims involve fractures of all types in its analysis of 42,038 automobile injury claims in America.[3]

The 5th edition of the AMA guides has been updated to more accurately account for human anatomic/gender variations. The 6th edition's diagnosis using flexion-extension X-ray measurements for an Alteration of Motion Segments Integrity (AOSMI) of the cervical spine requires >20% of Anterior-Posterior relative translation of one vertebra on another or greater than 11 degrees of angular motion. For the L1-L5 lumbar spine it requires >8% anterior or >9% posterior relative translation of one vertebra on another. For L5-S1 >6% anterior and >9% posterior translation is needed. Angular motion >15 degrees for L1-L3, >20 degrees L4-L5, and >25 degrees at L5-S1 levels are needed. These guidelines also correlate instability on the presence or absence of radiculopathy and myelopathy findings.[4]

As far as WAD patients, with no measurable instability, having complete healing within a few months, there is simply no basis for this statement. Facet joint and capsule injuries, disc injury, and

subfailure soft-tissue injuries have been implicated in chronic pain studies.

As an attorney, Dr. Eggleston has his attention focused on litigation. However, the chiropractor needs to be professional and not use the outdated 3.5 mm as a means to exaggerate the impairment for a patient. Unfounded facts were not necessary in this article. I wonder what insurance carriers and adjusters feel about the chiropractic profession's expertise in reading X-rays after reading this article.

References

1. Initial and Long-Term Symptoms Following Traffic Accidents. In: Nordhoff LS. *Motor Vehicle Collision Injuries: Biomechanics, Diagnosis, and Management, 2nd Edition*. Jones and Bartlett, 2005.
2. Centeno CJ, Elkins W, Freeman M, Elliott J, Sterling M, Katz E. Total cervical translation as a function of impact vector as measured by flexion-extension radiography. *Pain Physician*, 2007;10:667-71.
3. Insurance Research Council. *Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation*. Malvern, PA, 2008.
4. Rondinelli RD, et al. *American Medical Association Guides to the Evaluation of Permanent Impairment, 6th Edition*, 2008.

Lawrence Nordhoff, DC
Pleasanton, Calif.

Clarifying the AMA Guides

Dear Editor:

I write to point out the errors and omissions in Arthur Croft's letter to the editor in your May 6, 2010 issue. In the *AMA Guides 5th Edition* errata sheet, March 2002, chapter 15, page 378, it states, "Measurements are obtained in flexion (as in Figure 15-3A) and extension, *and the difference is calculated*." (Emphasis added) To calculate the difference means to subtract.

The *Guides* method is to measure both films. One of these measurements will be represented by a positive integer and the other by a negative integer. For example, the C4-5 measurement might be stated: "C4 translates upon C5 during flexion by +2.0 mm and -2.5 mm during extension." The flexion measurement goes one direction from the plane of George's line and the extension measurement goes in the opposite direction (a negative number) from George's line. To "calculate the difference," as *The Guides* recommends, the formula would look like this: 2.0 mm minus (-2.5 mm) = 4.5 mm. I stated in my article to add the two numbers together for the sake of simplicity, rather than explain the process of subtracting negative numbers.

Dr. Croft's statement, "The 6th edition of the *AMA Guides* no longer uses the DRE system," is factually incorrect. First, DRE was never a "system," but rather, was called "The DRE Method" in the fifth edition. Second, in *The Guides, 6th Edition*, DRE was replaced with DBI, which *The Guides* calls "an expansion of the DRE method ... [which] resembles the DRE method described in the Fifth Edition, with some enhancements."

In Dr. Croft's Dec. 3, 2007 *DC* article on this subject, he stated, "I often have argued these issues with radiologists, orthopedic surgeons, and chiropractors." Now he is arguing with me and the 41 authors and 79 reviewers of the *AMA Guides*.

Steven Eggleston, DC, Esq.
Irvine, Calif.

What D.C. Means to Me

Dear Editor:

When we graduate from chiropractic college, we are given the title D.C., which means doctor of chiropractic. To me, it also means: Doctor of Courage: To stand up against a drug and medical monopoly for what we believe is good and true and right. Doctor of Character: To believe in Christian values and teachings, and not act like we ourselves are God. Doctor of Compassion: To listen to the patient and not just run him through like an assembly-line piece of machinery.

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