

The Physical Examination: Objective or Subjective?

Dear Doctor,

Our IME Doctor has examined your patient and found all physical exam findings within normal limits. He indicates this patient does not need any additional medical or chiropractic care. Future chiropractic care is not reasonable or necessary.

Sincerely,

The Insurance Company

Sound familiar? The standard orthopedic, neurological and chiropractic examination will frequently give little information on what is really happening with the patient. Unfortunately, insurance companies, HMOs, attorneys and even doctors rely solely upon this inaccurate, incomplete information to base treatment plans.

"Standard orthopedic and neurological tests are not sensitive to what produces pain in whiplash. These tests were designed to assess the ventral ramus of peripheral nerves and are not usually sensitive to structures innervated by the dorsal ramus which are among the most commonly injured in WAD ...," wrote Ron Eccles, DC, DABCN, in *Dynamic Chiropractic* 1995;13 (18) Sept. 1:42-43. He continues to explain the neurological origins of the myotomes, dermatomes and sclerotomes. The myotomes have to do with reflexes; the dermatomes with sensation (hypoesthesia and hyperesthesia).

Positive reflex tests and positive dermatome findings may indicate radicular involvement, but the sclerotomes may indicate referred pain, while the above tests appear normal. Radicular pain is produced in the distribution of a nerve root as a result of some sort of mechanical or irritation of that root. Referred pain is perceived in a region topographically displaced from the region of the source of pain. The patient will often complain of numbness or tingling in the arms and hands without abnormal reflexes and dermatome areas. It would seem apparent that the patient is not making up these symptoms, just that they can't be explained by the examining doctor.

The majority of the physical examination is subjective. A somewhat knowledgeable patient can fake many of these signs and symptoms. Such was the case of a Chicago man who in 1991 ran up a Medicaid bill of \$101,442 without ever being hospitalized. He saw 111 different doctors, had 559 blood and urine tests, was diagnosed with 28 different ailments, and received 65,505 pills. He sold the pills, syringes and inhalers on the street and claimed on a good day he could make nearly \$100. (Chicago Tribune, Nov. 6, 1993.)

Clark and Haldeman documented poor interexaminer reliability. (*Spine*, 1988, 13(3) pp:332-341.) They stated: "Present disability evaluation schedules (in California) for the low back are not scientifically based and produce very great interexaminer differences."

Too often the exam deals with anatomical and physiological losses rather than the functional factors. How many times have IME doctors found all exam findings within normal limits contradicting the primary treating doctor's consistent positive findings?

In a rare medical interexaminer reliability test on fundal height measurements, it concluded that "these findings indicate that, to ensure maximal reliability, fundal height measurements should be obtained by the same clinician throughout pregnancy." (Engstrom, et al. J Nurse Midwifery, Jan-Feb., 1993, pp17-22.)

Most examiners do not differentiate between age and sex. One study indicated: "Not only do passive ranges of motion change with age, but statistically significant differences were found between men and women." (JMPT, June 1996, 19(5):pp306-309.)

A different study indicates that another variable is the time of day that the exam is performed. "For the reliability of a measurement, it is important to investigate lumbar ranges of motion at the same time of day." (Ensink, et al., Spine, 21(11):pp1339-1343.)

"Conventional outcome measures, such as the presence or absence of abnormal physical signs, or the ability of the patient to go to work, are very crude. Their lack of sensitivity may lead to failure to detect genuine treatment effect." (Roland, Morris. Spine, 1983, 8(2):pp145-150.)

"Estimations of intrarater reliability can be inflated due to correlated error and the difficulty in blinding examiners." (Haas, Research Division Western States Chiropractic College. JMPT, Jan. 1995, pp10-15.)

Other studies support this lack of consistency:

"Little significant agreement between examiner was found for active and passive motion palpation, muscle tension palpation and misalignment palpation." This study suggests that "subjective findings (pain) may be amongst the most reliable of conservative spinal observations." (Keating, et al. JMPT, Oct. 1990, pp463-470.)

"Measurements of passive cervical ROM in six directions from neutral zero remains unreliable for use by different examiners" (Nilsson, et al. The interexaminer reliability of measuring passive cervical range of motion, revisited. JMPT, June 1996, 19(5), pp302-305.)

"Interexaminer reliability of the electromagnetic radiation receiver for determining lumbar spinal joint dysfunction in subjects with low back pain indicated poor to fair reliability" and concluded that "in subjects with low back pain the EMRR may not be a reliable indicator of spinal joint dysfunction." (Gemmell, et al. JMPT, March-April, 1990, pp134-137.)

In a study on the inclinometer it was concluded: "The procedure described in this study should not be used as a clinical outcome measurement." (Boline, et al. Spine, March 1992, pp335-338.)

In another study it was stated: "The use of the Electrical Conductor Scanner Instrument for evaluation putative spinal pathology through manifestations in skin resistance in relatively asymptomatic patients is not supported by the results of this experiment." (Plaughter, et al. JMPT, Sept. 1993, pp453-459.)

The patient's ability to function optimally must be considered. "The association between physical and lab measures and more relevant human activities is weak, so functional status should be assessed in

its own right." (Deyo. Chiropractic Technique, 1990, 2 (3):pp127-137.)

Functional status can be measured in a number of ways. One of these available is static and dynamic x-rays. These radiographs can indicate abnormal function as well as verifying soft tissue damage through uncompensated and abnormal spinal patterns.

Frequently, spinal segments will compensate for each other. A hypomobile segment will cause an adjacent hypermobile segment. The ranges of spinal motion will appear normal on global visualization, but dynamic x-rays or videofluoroscopy will reveal this is not the case.

The AMA Guidelines to Evaluation of Permanent Impairment, Vol. 4, pp3/98, indicates that a loss of vertebral motion segment integrity is a 20 percent impairment, without positive exam findings. The guidelines also indicate that pain with a loss of function is reason for impairment (Chapter 15).

Interexaminer reliability on x-ray has been proven to be very good. This was demonstrated in Jackson, et al. Reliability of x-ray marking. JMPT, Oct. 1987, pp157-163, and Troyanovich et al., JMPT, Oct. 1995, pp519-524.

The International Chiropractic Association X-Ray Policy (1990) states: "X-ray is a primary diagnostic/analytical tool in detection of subluxation, in determining segmental mobility/immobility and in ascertaining the reduction and/or correction of the subluxation(s) and spinal distortions."

The gold standard of the physical examination has turned to lead. It is frequently subjective based on the examiner's employer. Accurate objective findings must be acknowledged and utilized to provide the best available health care for the patient. The case history, x-ray findings, subjective complaints along with an honest, accurate physical exam are all necessary components for a proper treatment plan.

It is the doctor's responsibility to figure out what is wrong with each individual patient. By digging a little deeper, working and thinking a little harder, a proper treatment plan can be initiated and the patient won't have to be sent for an unnecessary psychiatric evaluation.

Dennis Woggon, BS, DC
St. Cloud, Minnesota

NOVEMBER 1996