Dynamic Chiropractic

BACK PAIN

Grand Rounds: Barometer of Professional Consciousness The Cinema-Verite of Back Pain

MEDICAL GRAND ROUNDS

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Grand rounds at the American Back Society (ABS) has charted an interesting evolution during more than the decade of its existence. In the early years, it was all about patients with unusual conditions or atypical presentations, and brilliantly intuitive doctors. After a bewildering case presentation, the participants (each representing a particular specialty, including chiropractic) would venture increasingly focused stabs in the dark, until one of two things happened: One of the doctors would successfully "Name That Disease," or the moderator would pull some expectedly unexpected diagnosis quite out of a hat. The audience would swoon, torn between a feeling of betrayal: "You mean now when I hear pounding hooves, I'm supposed to think of zebras?" and self-flagellation: "Oh man, I shouldda thought of that!" The diagnosis was of more intrinsic interest than the treatment, which followed more or less automatically from the diagnosis.

That's not the way it works nowadays, grand rounds at the ABS has become a fairly automatic affair, mostly featuring two types of patients: the first one is mechanically boring, while the other has a history of having been surgically abused. The mechanically boring patient is deconditioned, but the case history takes a surprising five minutes to present in spite of its evident banality. The patient has chronic low back pain, very few significant examination findings, and has not worked for a long time. The surgically abused patient has received two or three increasingly unsuccessful procedures for what may have started out as a fairly unimpressive industrial injury some 11 years ago. He is still out of work. He is depressed.

The mechanically boring patient serves as a vehicle to reiterate the point that pyschosocial factors represent an important, perhaps dominating, component of back pain, with the admonition that failure to identify such cases can result in expensive and totally unnecessary diagnostic and treatment procedures. The surgically abused patient is used to remind us that we should address the patient's functional status and not his CT scan or MRI; that most surgeries are unnecessary, and that the prognosis for salvage surgeries (second and third procedures) is especially grim.

Since the diagnosis is no longer of paramount interest in these cases, differences in the various treatment approaches occupy most of the discussion. The surgeons, on their best behavior, never recommend surgery. The manual therapists (chiropractors, osteopaths, physiatrists) also on their best behavior, bend over backwards to acknowledge this same pyschosocial bandwagon. They almost never recommend manipulation. (This is especially troubling to me since I usually can think of one real-world chiropractor who would not try a round of manual therapy on patients such as these, in the absence of any substantial physical contraindications). One of the medical doctors invariably comments that, based on the patient's fancy underwear as seen on the color slide, that counseling should be sought for the relief of what is probably psychosomatic back pain.

In short, grand rounds at the ABS have beat a hasty retreat from the dramatic heroism of a Robin Cook medical thriller to the stark melancholy of a docudrama about ordinary people with ordinary bad backs. In fact, grand rounds experience has become something of a cinema-verite of back pain. This transition reflects, of course, a parallel change in medical self-consciousness from the technology-inspired optimism of the 1980s to the great disappointments and attendant pessimism of the 1990s. The increasingly dominant managed care organization, not overly impressed with advanced imaging that only poorly discriminates normal from abnormal function, is unwilling to pay for costly diagnostic testing that is unlikely to change either the treatment or the ultimate outcome of care. By all accounts there is going to be a large scale shakeup and probable contraction of the medical profession in the near future. To its credit, the ABS, by having in recent years emphasized patients who are either victims of failed back surgery or who bear considerable pyschosocial baggage, did anticipate this attitudinal shift in thinking about back pain, including the relatively unfavorable view the recently published AHCPR guidelines take on most conventional, especially high-tech, medical procedures related to low back pain.

The change in the character of grand rounds at the ABS is very much like the difference between the classic English detective story and its pulp fiction American counterpart. Sherlock Holmes "is nothing but an attitude" (says Raymond Chandler in his essay "The Simple Art of Murder") who painstakingly assembles clues as an unrealistic and mechanical exercise in pure logic, only to solve the case in a manner that is so inaccessible to a mere human that a serious reader must inevitably feel a sense of betrayal. (Much of the interaction between Batman and Robin, as seen on the old TV show, is a parody of this type of wildly exaggerated deductive logic). Well, that's how the grand rounds at the ABS used to be. By comparison, American detectives like Raymond Chandler's Phillip Marlowe or Dashiel Hammet's Sam Spade don't so much assemble clues as stumble through the dirty alleys mean streets of the world, just as it is. They are common men with an uncommon sense of honor, experts in discerning the impurity and vagaries of human motivation, just like the doctors in contemporary medical grand rounds.

Chiropractic Grand Rounds

My first experience of an event billed as "chiropractic grand rounds" came at the Washington centennial, where a low back case with a simulated patient was presented to four doctors, each of whom represented a named technique: Mackenzie, Gonstead, Grostic upper cervical, and SOT. Given the fact that a named technique generally purports to treat any and all human complaints in a self-sufficient manner, resisting most suggestions that it mix its methods with those of other named techniques, I wasn't really expecting the proceedings to resemble very much (they didn't) ABS-style grand rounds, in which each participant functions like a specialist within a multidisiciplinary group practice.

Each doctor took about 15 minutes to demonstrate his diagnostic and, to a lesser extent, his treatment approach to the simulated patient. Partly due to time constraints, there was very little interaction either among them, with the moderator, or with the audience. Freely admitting my own preference for and bias toward eclectic, integrated chiropractic technique, I was pleasantly surprised to find that at least two of the four doctors showed at least some degree of awareness and respect for the procedures of the others. The Gonstead representative, for example, expressed his opinion that Mackenzie-style extension maneuvers may be indicated if that would centralize the sciatic symptoms. The Grostic practitioner, based on the details of the case at hand, felt that the low back and leg symptoms could not be entirely explained by an upper cervical subluxation, and that some type of treatment other than

a pure upper cervical approach was probably indicated for the low back regional complaint.

Nevertheless, this type of presentation in which the doctors are allowed to take large blocks of time to demonstrate their own very individualized and mostly mutually exclusive clinical approaches, does little to bring out any agreements or disagreements among them. Structuring an event in this manner more or less precludes any direct problem-based reassessment of any of the specific features of the different technique systems. Therefore, the spectators are most probably led to reject or imbibe chunks of analysis in an uncritical manner -- at least that's how I experienced the session. Certainly, if a spectator is interested in window shopping for a new technique system, this type of presentation amounts to providing easy access to a sample of each, but I have my doubts whether a doctor could easily come away from it with the greater clinical depth that is expected to result from a grand rounds experience. It will be up to the moderators to ensure that the doctors who participate in chiropractic grand rounds are forced to speak to rather than past each other's positions.

Almost from the beginning, the chiropractic profession fragmented into a series of competitive, often mutually exclusive proprietary techniques, each claiming to be largely self-sufficient for addressing either an expansive range or even the totality of human ailments. This fragmentation of the chiropractic armamentarium was always somewhat bizarre, but more recently has become particularly inconvenient now that society demands a more standardized chiropractic product than ever before. The implementation of a chiropractic grand rounds must be seen within this context, as an implicit rejection of the litany of worn out metaphysical homilies that continue to embarrass the profession: "It doesn't matter which technique you use ... All techniques work, just perfect the one that works best for you ... Patients tend to wind up with the doctor who uses just that technique that will work best for them." Nevertheless, the renunciation remains partial, incomplete. Chiropractic grand rounds at the Washington centennial, by pitting stand-alone systems against each other without really synthesizing them, wound up mirroring a profession that no longer believes that any of the technique systems can do it all, but is just beginning to rationally break down and combine their elements.

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SEPTEMBER 1995