Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

We Get Letters & E-Mail

Conservative Care Instead of Surgery? Not Always Possible

Dear Editor:

In the Dec. 2, 2011 issue of *Dynamic Chiropractic*, in your article, "The Case for Conservative Care for Seniors" [publisher's Report of My Findings, page 3], you make some good points. Certainly where conservative measures will work as well or even nearly as well as surgery, the risks and cost of surgery would argue for conservative care. But you cite the *Lancet* article, which demonstrates that 13.9 percent who died had surgery the prior year, 18 percent in the last month and 8 percent in the last week of life, as though these are shocking figures; and you question why the elderly would want that – and indeed why we as a society would want that. Yet you never made the leap with evidence that there was a conservative alternative for all these surgeries, let alone for even any of them.

Even if there were options most of the time (which I doubt), you offer no evidence of that or how often it would be the case. Frankly, I expect that when a conservative option was available, the elderly chose that in the majority of cases. In reality, there often is no conservative option.

It seems perfectly logical to me that if seniors see only a surgical option and choose it over a horrible quality of life (or certain death) in the future, many of them will die on the table or shortly thereafter due to complications. Of course the death toll is high for seniors after surgery; this should not be shocking. They are far more likely to stroke recovering from surgery for, say, a broken hip than a young person, but do you suggest they should just say no to the surgery to repair the broken hip?

Whether we as a society should say no at some point to seniors having surgery is quite another question; one that will not be easy to answer and is loaded with ethical dilemmas. But we are not there yet. Now, I am sure there are some surgeries that have no better outcomes than less invasive options, as Ken Thorpe is quoted as saying in your article, but his remark is vague at best, with no numbers at all or any evidence to suggest if this is a large or small percentage of all the surgeries performed on seniors.

You get the feeling reading your article that your point is that if seniors are going to die that year anyway, why do surgery on them – just let them die, as if they were already going to and as if the surgeries are all done just to enrich surgeons and hospitals. But that is clearly absurd and simply not the case.

I have to believe most of these seniors do not expect to die the year of their surgery, often see no other choice, agree to it and unfortunately die anyway due to either 1) the surgery itself; 2) complications of the surgery; or 3) for reasons totally unrelated like auto accidents – but they still show up in the 13.9 percent who died in the year following their surgery.

Now for a personal example: My father has congestive heart failure due to a congenital aortic heart

valve defect (murmur) that has recently become much worse. His heart will deteriorate quickly and he will die most assuredly within a year, if not sooner, if the valve is not fixed. This summer, at age 93, he was spry, climbing stairs, living independently, using his new iPhone, his old PalmPilot and his computer, and still driving. He even went roller skating on his 90th birthday. His mind was still sharp.

His quality of life has deteriorated quickly with loss of breath at almost any amount of just walking. He might live in a wheelchair with oxygen for a few more months, but his heart is overworking with extra heartbeats, growing thicker, and will soon fail. But a transcatheter heart valve, implanted through his femoral vein, has a good likelihood of restoring him to the health he had this summer, and surgery to do so is currently planned for next month.

There are some risks with this and he might become one of those in your statistics, dying within a year. Then again, he might get good blood flow back to his lungs and his body, and be able to climb stairs and live his life again for a number of years. There is no conservative option for him, despite what Ken Thorpe thinks. Maybe society should let him just die; maybe eventually we may ration care to the elderly and just let them die, but for now the option is open to him.

You questioned if the elderly want this – and yes, Dad does want it and from the informed consent most everyone should have to give, I would say all the elderly cited in the *Lancet* study wanted the surgery. They thought it would extend their lives for years or decades. Unfortunately, unforeseen by them, they would die the following year.

But my point is that this is not being done to simply enrich surgeons, nor is it being done when people can somehow magically predict the future and know they are going to die after the surgery anyway and still choose it. In my Dad's case, he knows he will likely die within the year without the surgery, so choosing it seems like a rational choice, despite the fact that he could add to those statistics and die from any cause in the following year.

If you want to make a case for conservative care, show the percentage *with* a conservative option that was not taken who would be alive still; I expect you would have to limit your case to one type of aliment. We have those sorts of figures for specific ailments like disc replacements for nonspecific low back pain (in the general, not senior population), and they clearly argue for conservative care like chiropractic. But for the elderly across *all* forms of surgery – the case you seemed to try to make – good luck finding any figures on that, let alone for finding that conservative care was as good or better than all forms of surgery in seniors.

John H. Harris, MA
Okemos, Mich.

Ditch the Philosophy Except for Its Historical Significance

Dear Editor:

The only thing that I agree with in Dr. Philip Lawrence's letter in the Dec. 16 issue is that "prescription rights will not give us integrity." Just as in every profession, there are those who have no integrity, MDs included. It's not about integrity (most DCs have integrity); it's about doing what's best for the patient and being able to make a decent living at the same time.

Dr. Lawrence talks about "your holistic practice being inundated with ‘dope heads' who have no interest whatsoever in natural health." Most patients do not perceive us as or even care that we are natural/holistic professionals, but as experts in back pain; and most are quite surprised when in acute pain, that we are unable to administer even the most minimal and basic analgesic to turn the tide of pain. As we all know, when we can't give them medication, they will go to their physician, who will prescribe it and then promptly dissuade the patient from further chiropractic care. It's happened hundreds of times to me.

I also think it is simplistic to suggest that we would "kill someone more quickly, or put them on dialysis." I think most chiropractors are interested in the short-term benefit of pain medications, not the use of prolonged lifetime medications such as cholesterol- and hypertension-regulation meds, etc.

Furthermore, he mentions 39 percent of the recent ChiroPoll respondents who want prescription rights. I suggest that the state boards do a real poll to include the more than 70 percent of the chiropractic profession who can't make a living at it. I think that it's ridiculous for our profession to maintain that we treat one of the most painful disorders known to man (back and neck pain), affecting upwards of 90 percent of the population and causing untold disability and unnecessary surgeries, without the benefit of medication. I believe a real poll would reveal that more like 80 percent want it when you consider the important issue of feeding your family and doing something you are trained to do: help people in pain.

Finally, I'd like to say something about philosophy. I bought into the philosophy for awhile when in chiropractic school. However, in my seventh semester I injured my right shoulder. For the next six months, my arm virtually hung at my right side. I was receiving cervical adjustments almost daily, including various techniques, to no avail. The interns were very good adjusters. Finally, a friend and clinic intern put an ultrasound with EMS on my shoulder and I responded almost overnight.

Although it was painful to have my shoulder hurt as it did, it was one of the best things that could have happened to me. It caused me to examine the "philosophy" that failed my shoulder. The six months of adjustments to my neck made no difference whatsoever.

Incidentally, the clinic intern who resolved my shoulder pain only lasted about one year in practice and recently retired from the police department. Sad, but true. How many others? Far too many, and frankly, I'm tired of it. We need to reset our focus and ditch the philosophy, except for its historical significance.

Michael Lynn, DC
Exeter, Calif.

Dynamic Chiropractic encourages letters to the editor to discuss issues relevant to the profession and/or to respond to a previously published article. Submission is acknowledgement that your letter may be published in print and/or online. Please submit your letter to editorial@mpamedia.com; include your full name, degree(s), as well as the city and state in which you practice.

FEBRUARY 2012