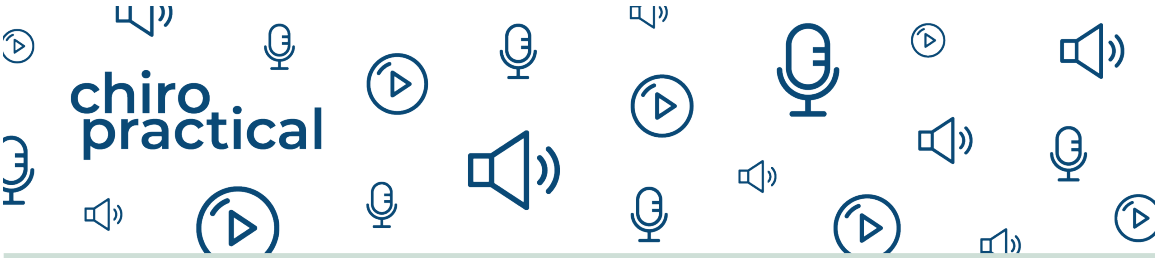


This is one of the top claims– and it's highly defensible. Why do DCs lose in court?

In this episode, we examine a disc degeneration case study.

[00:00:00] Chick Herbert: Hi everyone. This is Chick Herbert, and welcome to Chiropractical. Why are there so many disc herniation lawsuits? If you're ever going to be sued as a doctor of chiropractic, it is likely to be around this issue. Today we'll explore what you can do from a patient communication, documentation, informed consent perspective and how do you mitigate risk for your practice? This continues on from last month where we talked about the violation of doctor-patient boundaries and another area that people get themselves into trouble.

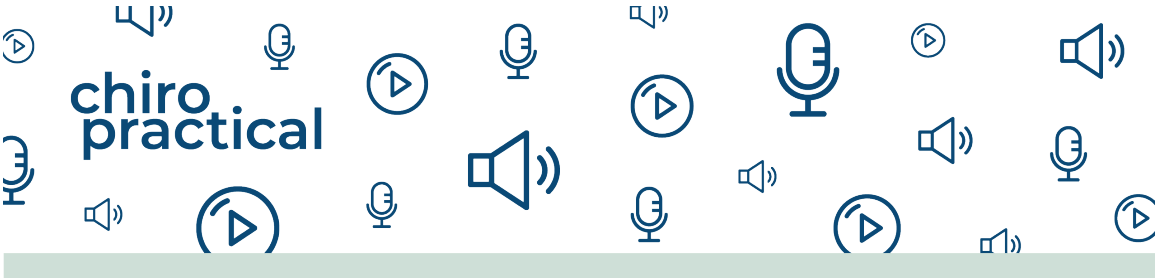
[00:00:31] Melissa Knutson: This is Melissa Knutson and we are joined today by Dr. James Demetrious. Dr. Demetrious has been a longstanding member of the NCMIC Speakers Bureau. He is also a clinician author, educator, and a board certified chiropractic orthopedist based in Wilmington, North Carolina. We have Mike Whitmer with us as well. Mike is the vice president of chiropractic insurance programs at NCMIC. So welcome Mike and Dr. Demetrious.

[00:00:58] Chick Herbert: So on today's episode, we will talk about a casestudy and use that as the basis for our conversation around disc herniations. And so Mike, if you could walk us through the setup of what that case involved.

[00:01:10] Mike Whitmer: Sure. The patient in this case was a 47 year old woman. She worked at a printing company. She had a lifetime history of back pain due to a gymnastics accident when she was a kid. She hurt her back when she was lifting a box of paper at work and reported to the clinic where she had been seen by a doctor for several years. Upon arrival at the clinic, she realized the doctor she had seen previously had retired and a new doctor had come in and purchase the clinic and that's the doctor that she saw that day.

[00:01:46] Mike Whitmer: The new doctor relied on the retired doctor's records plan of care, did not do a new examination, did not take a new history. Furthermore, the patient brought with her an MRI that was about a year old and the new doctor didn't review that MRI. So he adjusted her using a side posture adjustment and the patient immediately experienced an increased level of pain.

[00:02:15] Mike Whitmer: The doctor tried to alleviate the pain with ice for about 45 minutes. No benefit to the patient. The doctor had the patient referred to the local hospital for follow-up. Upon arrival at the hospital, the patient immediately underwent an MRI that showed a disc herniation and the patient actually underwent surgery about two days later. The surgery was successful. The patient embarked on a six week course of physical therapy and was released from care. About nine months following the patient filed suit against our doctor, alleging that he failed to meet the standard of care for treatment of this patient in this condition.



[00:03:03] Mike Whitmer: This case was difficult to defend because of the issues with the examination, lack of new history, reliance on the retired doctor's records, and didn't even read the MRI that the patient brought with her. We actually ended up settling the case to protect the doctor from the wrath of a jury if we took it to trial.

[00:03:26] Chick Herbert: So Dr. Demetrious, there's a lot here. Maybe we start at the beginning. Can you talk about why the history and examination is so vital to the patient care and as it relates to this herniation lawsuit?

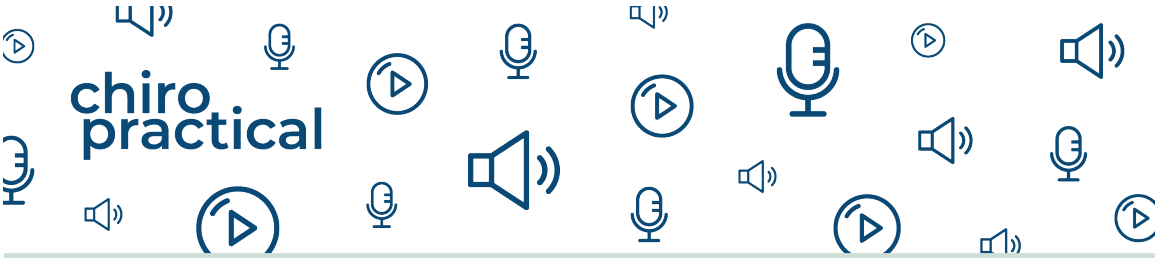
[00:03:38] Dr Demetrious: It's incumbent upon us to assess patients directly and while another doctor may have notes and information that are vital and important, including the MRI evaluation that was available, it's incredibly important to perform a proper history, review the documents that are available, review the images. I prefer to look at any available images prior to seeing the patient that helps me direct my care. And then evaluate the patient with a proper examination. Without those steps, without looking at the patient directly, you know, there may have been a change since the patient had seen that other doctor, there might've been a change since that MRI was performed. It's really just very important to make a new assessment to evaluate the patient, one, and two, to provide some comfort to the patient that you're caring and you're listening and you are to care now.

[00:04:37] Mike Whitmer: You know, I always say when I'm talking to students and doctors of chiropractic that good risk management is good risk management, but guess what? It's good patient care first.

[00:04:46] Mike Whitmer: And a really good risk management step is to get as much information as you possibly can about that patient before you embark on their care. Part of doing that, when that patient walks in the door, is doing the examination, doing the history, get to know that patient a little bit. And of course in this case, it kind of astounds me that the patient came in with imaging and the doctor didn't look at it. Well, that's a really good piece of information to look at and establish a baseline.

[00:05:15] Chick Herbert: And Dr. Demetrious, I assume that trust is a really important component of a doctor patient relationship. And from a patient experience perspective, I would think this would degrade that level of trust just because the doctor didn't take time to do a current assessment.

[00:05:31] Dr Demetrious: I would agree. And it's heartening to patients when I take the moment and time to take a look at that disc, take a look at that report, assess them directly and help them understand that I'm really interested in finding out what's happening. The difficulty with not listening and paying attention to the intervening time between the time she saw the doctor last and when she presented to the new doctors, there may be alteration in her clinical symptoms. There may be something that popped up that was not present when she saw the other doctor. She may have developed some weakness or bladder or bowel incontinence that wasn't present. That might be so not only for a new patient, but on recurring visits, it's important to modify and evaluate and assess the patient on our ongoing basis.



[00:06:22] Melissa Knutson: Dr. Demetrious, can you tell us a little bit more about how patient communication and patient education might play into this?

[00:06:28] Dr Demetrious: It's vital. In order to secure trust and understand what's occurring with the patient we need to have that really frank discussion and chiropractic practices are busy. If we don't have the time and take the effort to evaluate and review that image, which takes a little bit of time, you know, an MRIs, there's a lot of images on there if you're going to read the study yourself, it takes a few moments to read a report and it takes a little bit of time. It's difficult sometimes if you have a really busy practice. We need to do better. We need to improve our ability to listen and build that trust. And when patients see me looking at their images and I'm talking to them about the report and any additional findings that I see, it builds confidence.

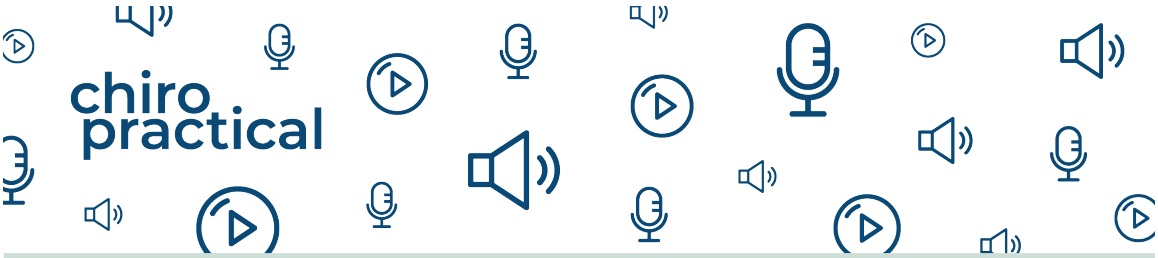
[00:07:11] Mike Whitmer: This case illustrates patient education can really have a positive impact on the relationship between the doctor and the patient, the trust level between the doctor and the patient and the perception of the care they're receiving and why they're receiving it. Particularly with disc herniations, I think that a lot of patients don't understand what's happening, don't understand what could be the case. And I think this sum preemptive communication and education on the part of the doctor can stem some misunderstandings, particularly about causation between the doctor and the patient down the road.

[00:07:58] Mike Whitmer: I'm a good case. You know, when I went to my chiropractor with some back pain, he said, you're of a certain age and you may have a disc herniation and he got the little model out and showed how disc herniations work and just did some really good basic education for me so that I understood what my plan of care was and how it hoped to help my condition.

[00:08:11] Chick Herbert: Dr. Demetrious, could you talk a little bit more about how common disc herniation is among the general population and how that might affect this case?

[00:08:20] Dr Demetrious: There's really good literature that's available. There was an article by Jensen in 1994 that looked at a hundred asymptomatic patients, never had pain before, and 52% of them had bulging and herniated discs. There's a beautiful Mayo clinic systematic review that was performed in 2015. It looked at the prevalence of disc herniation in our populations from 20 to 80 years of age. The prevalence of bulging discs in the asymptomatic never had pain category was anywhere from 30 to 84, lumbar protrusions, 30 to 43%. These are this carnations and protrusions and bulges that are common in the non-pain group. Nakashima and the cervical spine found in the asymptomatic population in the journal *Spine*, 88% of patients will have bulging discs in the neck. And Cassidy and their papers, remarkable papers, found no excess risk due to chiropractic care with lumbar disc herniation.

[00:09:19] Dr Demetrious: I like to talk about these papers and I talk about this information directly with my patients. If they have symptoms and signs, I want to advise them that, you know, the likelihood is you do have these problems and oftentimes they've been aggravated irritated because of activities of daily living because of their lifestyle, because their workouts because of whatever.



[00:09:40] Dr Demetrious: And then oftentimes these normal findings, these disc herniations are present and just become irritated. And we can evaluate that as well. Looking at the MRI, we can see the new edema and new inflammation, new irritation that leads us to believe that this is the new cause of pain. When actuality, these causes were already there, you flared it up. It's on you.

[00:10:00] Mike Whitmer: I think that's a great example of, yes, it's good risk management, but it's also good patient care because an educated patient is going to be more compliant. They're going to be more successful than the patient that does understand the why, doesn't understand the risks, and doesn't understand their responsibility in their own care.

[00:10:22] Melissa Knutson: Yeah. That's interesting to hear that 30 to 80% in that study already had this issue. So there's a good chance that as patients come into your office, that's something that's already present within that page. Dr. Demetrious, I'm curious to learn a little bit more about imaging and related to this issue specifically, but what types of imaging, what's the timing? What would you recommend here?

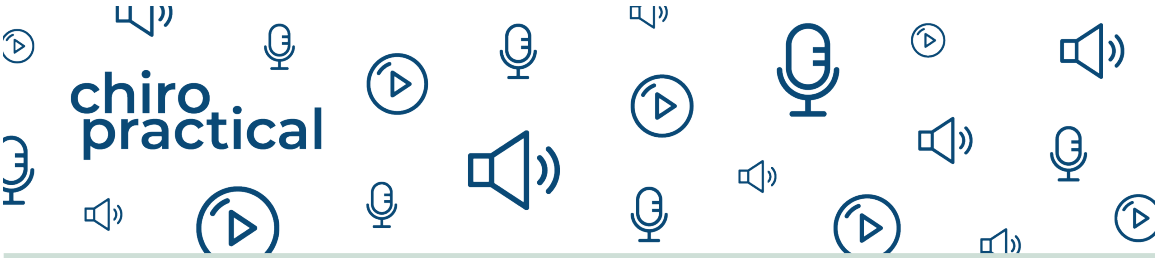
[00:10:44] Dr Demetrious: Well, first in the assessment on our patients, we have to make a determination whether it's appropriate decorum imaging, typical lower back pain, the appropriateness criteria that's utilized in chiropractic that's being taught at the CC accredited schools and as part of the American College of Radiology's criteria.

[00:11:04] Dr Demetrious: In order to determine whether we need imaging at a given point, we have to be aware of that historical and evaluation finding. That's why examination and history is so important. In order to obtain an MRI in my area, I have to follow the ACR criteria, which is patient has been in pain for a period of time; under care for a period of time; is demonstrating weakness, bladder, bowel, or saddle issues, or alter gain; and changes that are valuable through examination and history.

[00:11:29] Dr Demetrious: It's vitally important that we assess those studies that had been performed because sometimes our medical radiologists, while doing a great job, they won't include information from their own literature about periarticular edema, modic changes, annular tears, and those are causes of pain that need to be discussed with the patient directly to show how they're going to possibly progress under chiropractic care, if they're a good quality candidate for chiropractic care, it's really quite important.

[00:11:53] Dr Demetrious: I talk about the fact that I hope that more of our chiropractic candidates in doctors will read these images directly. I'm glad that they attend my coursework because I'm teaching them how to utilize, how to evaluate, how to order properly.

[00:12:10] Dr Demetrious: And there's a beautiful article in the Mayo clinic article by Kotsenas and Zirbianci talking about how we see the inflammation that occurs. We can see periarticular edema and inflammation that's not typical unless you do certain sequences. So it's vital upon the chiropractor to ask as the specialist that a general practitioner medical doctor may not be aware.



[00:12:30] Dr Demetrious: They may order the MRI, but they may not offer the fat suppressed imaging that's necessary. That's why good quality CES are important. It's vital. We have to evaluate just from the patient communication perspective, if that doctor had spent just a few minutes and talked to the patient, I see a disc herniation, there is no inflammation or there is inflammation, this is the means with which we have to address your condition, I think it may have been a better outcome.

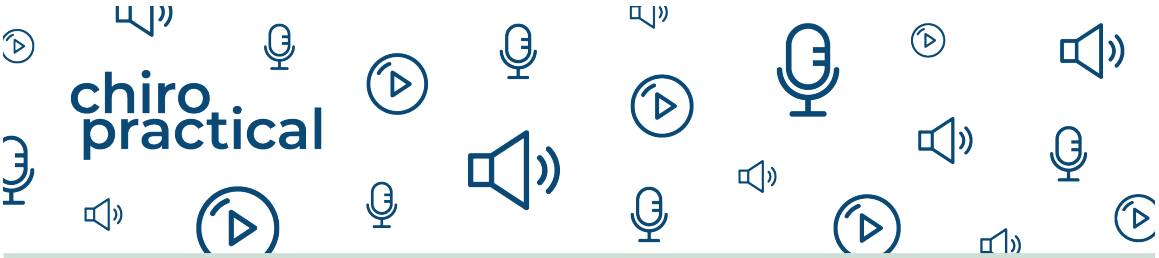
[00:12:56] Chick Herbert: Dr. Demetrious, we've talked about when you should order an MRI and what criteria need to be met. Can you talk about any care protocols in dealing with disc herniations or this situation?

[00:13:08] Dr Demetrious: Through our history, through our exam, which underscores again, the importance of those things, we can gain a great deal of information. If a patient has a cervical disc herniation, we have to define what postures can provoke that and help them with regard to one, care, and two, to their activities of daily living. If a patient has a lumbar spine disc herniation, we understand that certain groups have more or less narrowing or spinal stenosis in different areas.

[00:13:35] Dr Demetrious: So the younger population tend to do a little bit better with extension McKinsey protocols. Where the older population with periarticular Facet arthropathy, they may have more difficulty with extension. And we see that and we can hear that from them when we talk with them directly. It's really important to ask, are you comfortable while you're sitting while they're flexed in that position? And then we can get great information that there may be encumbrance in the spine in that posture. We may find that the patient has difficulty painting the ceiling or trimming hedges above his head because he's extending or she's extending her neck. And that could tell us that there is likely a compression of a spinal nerve root or irritation of the disc or a posterior joint and that would tell us, you know, maybe it's not a really good idea to adjust the patient in extension, and that can help us define how we can adjust the patient.

[00:14:33] Dr Demetrious: I had a herniated disc in my neck many years ago, and flection gave me a relief. One of my colleagues came to my office to adjust me and he didn't listen to me really well. And he extended my neck in a painful place and adjusted me in that posture and that was terrible. I had a whole very large herniation, but to be adjusted in a little bit of flexion where it took the pressure off the disc and the nerve gave me a great deal of relief. If I was a patient, I would have been really upset with him by extending my neck in a way that provoked it.

[00:14:50] Dr Demetrious: That's why it's so essential to know what's occurring from the history, what's occurring from the examination, what's occurring in their activities of daily living. And to this specific patient we're discussing, I think it's vital to listen to and pay attention to what that previous doctor did. And if you don't take the time to do that, you can miss great-great clues. It's really important to say, how did you do, and what did the doctor do that you liked and what didn't you like with what he did. If the patient says, well, I really liked side posture adjustment, but I hated that flection distraction, it's not rocket science, you know what that may be taking pressure off and he did a good job.



[00:15:29] Dr Demetrious: And if somebody saw the patient prior to seeing me, and they said, you know, I felt terrible when he saw him. Well, what did he do? He put me on that drop table and it killed me. You know, I'm never going to put that patient on that drop table. This all requires a little bit of time in daily discussion.

[00:15:43] Chick Herbert: Mike had commented about the importance of education and talking to patients about degeneration. At what level do you document that?

[00:15:50] Dr Demetrious: On every level, every time. I have a picture in my office and it's a picture of a attractor I took in upstate New York and it's an old rusty tractor. It's from the 1930s and forties.

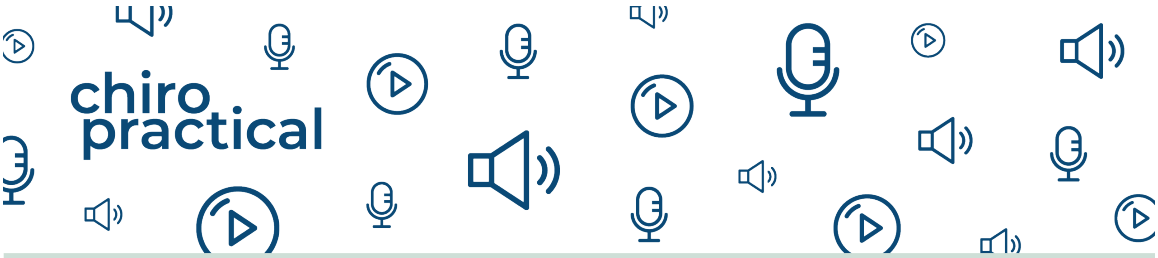
[00:16:02] Dr Demetrious: And it's just sitting in the field. It looks like an art. My wife said, why are you putting a rusty old tractor on the wall? And I said, well, that's what everybody comes to me with - different levels of degeneration wear and tear. Now patients are frightened oftentimes by their doctors. I try to alleviate that and say, you have degenerative disc disease.

[00:16:18] Dr Demetrious: That means you have rust. You have arthritic change of wear and tear. And these changes are common. For a 50 year old individual, you have an 80% chance of degenerative change in your spine. And that's just not disc herniations that is often blamed. It's the spurs. It's the arthritic change. It's the narrow disc. It's the annular tears. This is stuff that varies from patient to patient and has to be addressed. It's constant that I'm talking about degeneration, but more importantly, that's the norm. It's the inflammatory provocative effects of going to the gym and over-training doing too much work in the yard and having those discussions to help them help themselves.

[00:16:55] Mike Whitmer: Well, I'm never going to pass up an opportunity to say this: Documentation is absolutely key in the event of a malpractice claim. I've heard our defense attorneys say that we need to be able to look at your record, tell what you did, why you did it. When you did it, who did it, really tell the story of that patient's treatment. Documentation also is another great example of yes, it's good risk management, but it's also good for the patient.

[00:17:25] Mike Whitmer: If you don't see the patient for a while and need to refresh yourself on what's happened, your documentations do that. If you need to refer the patient for other care, documentation will help that patient get established with the provider that you're referring to. More is better with documentation. I never miss an opportunity to say it.

[00:17:46] Dr Demetrious: I totally agree. And that starts from the very big. It's about what brought them to me, their level of discomfort, quantifying them on an analog or numeric pain scale, going through the nuance of how is this symptom manifesting through activities. And this all has to be documented carefully. I personally dictate my notes and I try to make them as capacious and as much as time will provide.



[00:18:07] Dr Demetrious: It's vital and important that we talk about their progression, visit to visit. I have a form in my office. I use it while patients are seeking my care actively, the little pain men. It's a statement that says “I feel better, same or worse.” And “Since last week, my activities are better, same or worse since last week in a zero to 10 pain scale.”

[00:18:28] Dr Demetrious: And in that simple document, I just copy those questions onto an 8.5” by 11”, and it's cut it in half, put on pink paper. It's called my pink form and I use that regularly and it's in their hand. They are progressing. So it's just not my word in my documentation, in my notes, but it's supporting my care, but they are progressively improving, or they're not.

[00:18:49] Melissa Knutson: I also would want to pose the question to Dr. Demetrious at what point as you're working with a patient, should you refer them out?

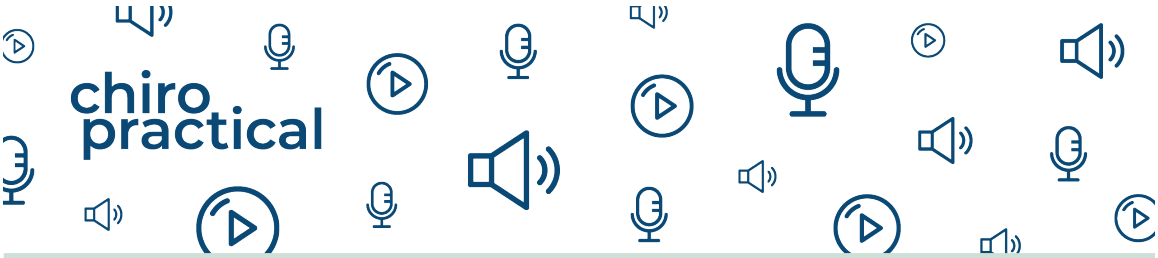
[00:18:56] Dr Demetrious: First and foremost, I want to make sure that there are no contraindications to my care. A red or yellow flag is your absolute or relative contra-indication. So that requires again, proper examination, proper history and evaluative procedures.

[00:19:09] Dr Demetrious: For these cases that have mechanical disc degenerative changes, ridiculous symptomatology, we have to monitor them. The most important aspects for me are those ideas and those that have been evaluated and reported by the different criteria. Is the pain progressing? Are you having any trouble with urinary or bowel incontinence?

[00:19:30] Dr Demetrious: Well, what does that mean? Are you having accidents? Are you peeing or pooping? Well, yeah, I am. Or are you having retention, that urgency that if you don't go, you may have a problem. The literature is really clear about this, that people often have from level of urinary or bowel incontinence, but they don't report it because it's embarrassing.

[00:19:49] Dr Demetrious: They don't want to talk about it. You have to have a frank conversation. You have to have trust. In order to decide whether I'm going to send a patient for imaging that hasn't been performed, or if it has been done and has to be done again, that requires again, further. We need to understand the protocols.

[00:20:04] Dr Demetrious: The American College of Radiology is ACR appropriateness criteria, and that means is their bladder or bowel weakness, disc peronea, data abnormalities and the abnormalities that are progressively and worsening. If we suspect any of those things, I'm writing the prescription for the MRI. And I'm going to also write a prescription to see, I give a list of the local neurosurgeons and orthopedic surgeons I know in my area for them to, for a consultation, not for surgery. And I make that clear that I'd like them to see somebody just to make sure that I'm on the ball. And that's difficult sometimes for chiropractors because they're afraid they're going to lose a patient. And if anything, it actually lends itself to more referrals back to you because patients love the fact that you're listening to them and you want them to get the best care.



[00:20:45] Melissa Knutson: Well, I think we unpacked a lot of information today. Thank you for joining us.

[00:20:49] Chick Herbert: I learned today that I'm a rusty old tractor in a field. I appreciate that analogy. Well, thank you again, Dr. Demetrious, it was a pleasure to have you on and thank you for the wealth of information that you provided. Lots of really good nuggets.

[00:21:03] Chick Herbert: I have to call out one that you just mentioned, which is having the patient state their response in terms of how their progression of pain or progression is improving and what a simple thing, but what a powerful way to have it be in the patient's words, not yours. So thank you for sharing that.

[00:21:22] Chick Herbert: Melissa and Mike, great episode. Let's take a minute to summarize. Before we close this herniation claims against doctors of chiropractic is all too common and they should be defensible. But in many cases, we find that the doctors are not adhering basic risk management and patient experience practices. And we can do better in that area.

[00:21:40] Melissa Knutson: Yeah, absolutely, Chick. So if you take anything away from this episode, I want you to remember to do your own exam and history of the patient, make sure you're doing a lot of great communication and education with that patient along the way. Read images if they're given to you from your patient and take your own imaging, if it makes sense, but then of course refer out.

[00:22:01] Chick Herbert: Dr. Demetrious did mention it everybody wants to be considered as an expert and knowledgeable. It may be an opportunity to establish relationships with others that help you bolster your knowledge and skills in some of the areas that we talked about.

[00:22:16] Mike Whitmer: I think for me, the big takeaway of this episode and this discussion is risk management basics rule. Don't forget your basics. Get as much information as you possibly can about the patient and that's not just on the first visit, but keep that up throughout their patient care. Educate your patient. Like you said, Melissa, and always very important: document it all.

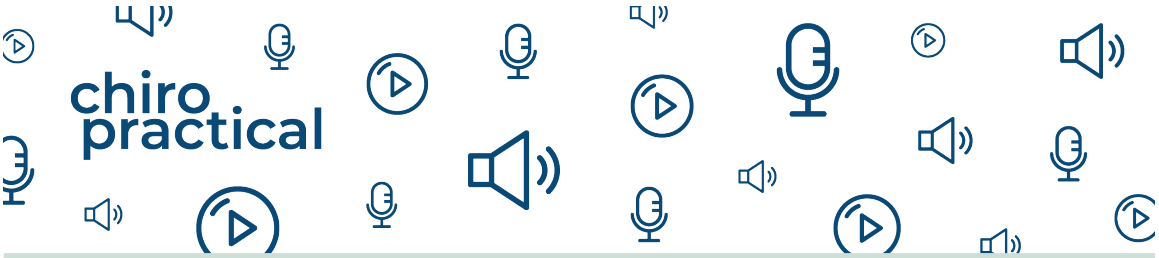
[00:22:40] Melissa Knutson: Absolutely, Mike, that was another key one: documentation, documentation.

[00:22:44] Chick Herbert: Sometimes urgency creates a lot of bad habits. I know our doctors have extremely successful in busy practices and they're going from patient to patient. It's easy to get hurried and not do some of the fundamentals. So how do you deliberately pause to make sure that you're hitting those foundational elements of patient care?

[00:23:04] Chick Herbert: If you're interested in learning more about the subject and the research that Dr. Demetrious referenced today, please check out our show notes at NCMIC.com/Chiropractical.

[00:23:15] Melissa Knutson: Thank you for joining us again and take care of be well.

Resources:



Cassidy, JD et al Lumbar intervertebral disc herniation: treatment by rotational manipulation

Jensen, MC Magnetic resonance imaging of the lumbar spine in people without back pain

Kotsenas, Amy Imaging of posterior element axial pain generators: facet joints, pedicles, spinous processes, sacroiliac joints, and transitional segments

Mayo Clinic 2015 Systematic literature review of imaging features of spinal degeneration in asymptomatic populations

Nakashima, H Abnormal findings on magnetic resonance images of the cervical spines in 1211 asymptomatic subjects