



# THE CHIROPRACTIC REPORT

An international review of professional and research issues, published bimonthly.

Editor: David Chapman-Smith, LL.B. (Hons.), FICC (Hon.)

January 1992 Vol. 6 No. 2

## Referral Letters and Written Reports

### A. Introduction

1. Consulting engineers, lawyers, chiropractors, medical specialists and all professionals face two common realities with respect to correspondence and written reports:

- Such communications are now of pivotal importance in building and maintaining a practice. (One skilful letter from a lawyer can solve a dispute, avert protracted and expensive litigation, and lead to referral of new clients. A timely and appropriate letter from a chiropractor can prevent arbitrary closure of a WCB claim or initiate a wealth of referrals over a period of years. Conversely failure to send a required letter can terminate professional cooperation after one case).
- Formal education leaves all these professionals ill prepared for effective communication on paper in their respective market places. (Opinions from young lawyers are generally far too technical, long, padded with irrelevant research and issues, and are confusing to the client. Letters and reports from newly graduated chiropractors often display the same faults).

2. Competence on paper has become particularly important for health professionals in recent years because:

- a) They work within an increasingly complex health team environment. Their patients are likely to be receiving care from more than one provider.
- b) Care is generally managed and/or funded by third parties such as employers, private insurers, workers compensation boards or the government. These third parties require written reports to justify continuing treatment.
- c) Written communications provide the most potent form of market visibility and advertisement of ability for professionals. And in the 1990s marketplace - featuring an over-supply of providers and new cost constraints - successful promotion of a practice has new urgency. As a child you may have been told by a wise parent that three things were essential to making your way in the world - good handwriting, speech and appearance. In 1992, when no one writes long-hand any more, professionals are too busy to meet in person, and most communication is on letterhead - your correspondence is all three of these attributes rolled into one.

3. For chiropractors, who once worked in relative isolation and could manage with less developed writing skills, there is still often misunderstanding of the new importance of written communication in the 1990s. This is that:

- a) Medical doctors, who have "a long history of negative feelings and frustration" for patients with back pain because "they have little to offer ... and believe they can do little to prevent patients with acute pain from developing chronic pain",<sup>1</sup> are now generally willing to refer these and other patients to chiropractors.
  - b) This represents by far the largest current source of new chiropractic patients. (In many parts of North America the quickest way to establish a new chiropractic practice is in a multidisciplinary setting, initially in reliance on medical referrals.)
  - c) Effective reporting and writing skills are the main pre-requisite for a referral practice.
4. Almost monthly there is fresh evidence of the medical profession's growing acceptance of the efficacy of skilled manipulation, and of increasing referral of patients to chiropractors as the best educated and most skilled specialists in this field. Thus:

a) The journal Spine (October 1991) has just published the North American Spine Society's new "guide to current diagnostic and therapeutic procedures for patients with lumbosacral spinal disorders". Relative value of procedures is defined according to six categories - Procedure Categories I ("generally accepted, well-established, and widely used") to VI ("of no proven value").

These guidelines, prepared by leading medical specialists, give "chiropractic adjustments" Procedure Category I rating.<sup>2</sup> (Treatment frequency and duration is given as 2-5 treatments per week for two weeks, decreasing to 1-2 per week over a period of up to four months, with optimum treatment duration of one month).

b) In the U.S. in July 1991 a RAND multi-disciplinary panel, the majority of which was medical, accepted that manipulation was an appropriate intervention for most patients presenting with back pain.<sup>3</sup>

c) In May 1991 Till reported a Canadian study finding that on average 22% of patients of chiropractors in the city of

### Professional Notes

#### Corticosteroid Injections for Back Pain - Another False Start

'Fads in the Treatment of Low Back Pain', editorial by Richard Deyo, N Engl J Med (October 3, 1991) 325:1039-1040.

'A Controlled Trial of Corticosteroid Injections into Facet Joints for Chronic Low Back Pain', Carette S, Marcoux S et al, N Engl J Med (October 3, 1991) 325:1002-7.

Injection of corticosteroids into the facet joints to relieve back pain:

- Was first used in the U.S. in 1976.
- Is now routinely performed in medical practice in North America.
- Remained "an expensive treatment of unproved efficacy" until the late 1980s. Developers claimed good success rates but no controlled trials were done.
- Has now been shown by trials in Europe (1989) and North America (1991) - see reference above - to be of no significant value.

The publication of the second trial in the New England Journal of Medicine in October was accompanied by a firm editorial by Richard Deyo, MD MPH of Seattle, criticizing medical fads such as this in the treatment of back pain. Deyo observes:

"Too much research on back problems consists of case series that serve the entrepreneurial purpose of legitimizing expensive new forms of technology, rehabilitative centers or surgical programs of uncertain effectiveness."

Saskatoon (population 150,000, chiropractic population 38) were referred by medical doctors.<sup>4</sup>

d) Last year another Canadian study, from Patel-Christopher at the Faculty of Medicine, University of Toronto, showed that the majority of Ontario family physicians (63%) were referring to chiropractors - and that 9% (1 in 10) of these MDs were patients themselves.<sup>5</sup>

e) In 1990 a trial published in the British Medical Journal and reporting that chiropractic management of acute and chronic mechanical low-back pain was twice as effective as medical care<sup>6</sup> led to a sudden increase of referrals. Prior to the referral rate, according to a 1987 survey of all general medical practitioners in Oxfordshire, was already at 50% - 1 out of 2 GPs had referred patients for manipulation by a chiropractor or osteopath during the past year.<sup>7</sup>

5. Correspondence and reports can become the bane of practice, a prime source of stress and a major limitation for an otherwise competent professional.

With the right approach, and a limited period of discipline and practice, skills can be learned that remove the stress and greatly enhance professional image and opportunity. This Report:

- Reviews the principles of effective professional writing.
- Provides samples of letters and reports.

## **B. When to Write**

### **Letters**

6. Letters should always be sent:

- a) When you refer a patient
- b) When a patient is referred to you
- c) When a referred patient completes his/her course of treatment.

There are good arguments for adopting a practice of generally writing to each new patient's family medical doctor. Many chiropractors now do this. Aims are to make the MD aware of chiropractic treatment being given which is clearly in the patient's best interests, to promote cooperation, to promote better understanding of chiropractic, and to encourage future referrals. Ensure that the patient knows and approves in advance of your intention to write.

7. If you are referring one of your patients to a specialist copy the letter to the patient's family MD, who may be

responsible for follow-up care (e.g. medication after spinal surgery by the specialist to whom you have referred). Often it will be wise to contact the family MD prior to referral. This earns respect and future cooperation. Procedure is:

- a) Call and explain who your mutual patient is, your intention to refer, and that you will forward a copy of the referral letter. You may even decide to seek approval - you do not need it, but a little humility goes a long way in all relationships.
- b) Make the appointment with the specialist.
- c) Write your letter of referral, seeing that the specialist receives it well prior to the patient, recording that it is copied to the family MD.

### **Reports**

8. Generally reports are written in response to:

- a) Mandatory requirements - e.g. terms of the insurance policy or legislation governing third party payment.
- b) Specific requests - e.g. from a lawyer for the purposes of litigation.

Experience often leads to preparation of brief letter reports in other circumstances. For example, you may have been treating a patient with whiplash injury for 4-5 months without request for a follow-up report from the insurance carrier. A brief report explaining the current rationale for treatment and commenting on prognosis and management plans may be the document on file that prevents an arbitrary administrative decision rejecting continued coverage at six months.

### **C. Principles**

9. The same few important principles apply to all written communications, whether by letter or more extended report. Keep them:

- a) Professional in appearance
- b) Short and concise
- c) Highly organized and accessible
- d) Free of jargon

#### **Professional in appearance**

10. Everyone who influences your practice and professional life, other than your patients and staff, will judge you more by your correspondence than your clinical skills, character and real professional competence. This includes third party payors and lawyers deciding what weight to give to your professional opinion,

medical doctors deciding whether to trust and refer, and everyone else. This means:

a) You should select and periodically review your letterhead with more care than your clothes, car or office furnishings.

When your letterhead lies in the in-tray at an insurance company, lawyer's office, government department, family physician's office, it is amongst letterhead from other professionals and corporations. Are you satisfied with the image it gives of you and your profession? In this competitive environment does the appearance enhance the substance of what you have written?

b) Quality word processing equipment is essential - printer, typeface and/or font must be state-of-the-art for professional offices in your community.

c) Strong secretarial support is vital. Your secretary must be the guarantor of professional format, accurate grammar and spelling, and be able to prepare from dictaphone and despatch correspondence in your absence. (Learn to use a dictaphone - it is the key to maximum efficiency).

If your correspondence is your market image - your dress, speech, handwriting and major professional presence in the world - the necessary investment is well worthwhile and of high priority in your practice.

#### **Short and Concise**

11. Brevity is a virtue. Everyone is rushed, has no time. You will only write the letters and reports, and others will only read them, if they are succinct and to the point. Be ruthless and fearless in being brief.

Understand the reason for each communication. It is never:

a) To give a full explanation of what you found and did with the patient.

b) Provide an introduction to chiropractic. It is to:

i) Illustrate, by the mere fact of the letter or report, that you understand your responsibilities and role, and can be trusted to operate within a professional and team approach.

ii) Give the essence of findings, management, prognosis, reason for referral, etc.

iii) In the case of a medico-legal report, to give a basis for negotiating settlement of a claim. This is:

*continued on page 3*

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- Express acknowledgement that history, exam and findings are consistent with an accidental injury as alleged by the patient.

- As specific an assessment of disabilities as possible.
- A summary outline of the basis for these two conclusions.

That's what the lawyer is paying you for, not an essay on all aspects of your management with multiple findings, opaque jargon and a valueless conclusion such as "prognosis is guarded". To the lawyer this means "I am unable to help you with a professional judgement in this case."

12. One excellent technique for keeping general correspondence short, if there is need to make various points or present detailed evidence on some issue, is to put the issue and conclusion in a brief letter and enclose a separate memorandum and/or other documents with the details.

### Organized and Accessible

13. Organization is crucial to readability, comprehension, appearance of competence, persuading the reader to accept your conclusions and expertise, and thus the whole exercise. This means:

a) Liberal use of sub-headings and paragraph numbers, especially in reports. However a letter that takes two or more sides will also need sub-headings and paragraphs.

b) Many short paragraphs. *Never write a paragraph over 10 lines.* Do you realize that most newspaper articles start a new paragraph for every sentence - if they didn't they wouldn't be read. The same principle applies to your writing.

14. The increasing volume of communication has brought major changes in organization of professional material in recent years. Accordingly:

a) Major research journals, such as the British Medical Journal, not only have an abstract summarizing research articles, but also now divide the abstract by sub-headings. For an example see Fig. 1.

continued on page 5

### Figure 1

#### Radiographic examination of the lumbar spine in a community hospital: an audit of current practice

Shawn F S Halpin, Lindsey Yeoman, Derek D Dundas

#### Abstract

*Objective:* To assess general practitioners' decisions to request lumbar spine radiographs according to the guidelines of the Royal College of Radiologists.

*Design:* Prospective questionnaire survey of outpatients attending for lumbar spine radiography.

*Setting:* London community hospital.

*Subjects:* 100 consecutive adult outpatients attending for lumbar spine radiography at their general practitioner's request.

*Main outcome measures:* Patient's history and clinical signs; radiological diagnosis; change in management of patients with significant radiological abnormality in response to the radiologist's report.

*Results:* 60 patients were aged between 18 and 45, 27 (45%) of whom were women. Five patients were fully examined by their doctor before radiographs were requested, 76 were partially examined, and 19 were not examined. In 37 patients the examinations showed radiologically normal findings; 30 had radiologically significant disc or degenerative disease. Pain score and radiological diagnosis was not correlated (6.43 (range 1-10) for patients with significant disease v 6.14 (range 1-10) for those without,  $p > 0.05$ ). There were no cases of malignancy or infection. One patient with radiologically significant disease was referred to a hospital specialist, and the management of only two such patients was altered by the report. 52 of the examinations should not have been requested if the guidelines had been strictly applied.

*Conclusions:* There is a need to inform doctors of the efficacy of radiological examinations. An awareness of the college's guidelines among general practitioners should be actively promoted by radiologists.

BMJ 1991; 303:813-5

### Figure 2

#### A. Referring a patient

Dear Dr. Brown:

Re: John Jones W.C.B. #946384, Accident Date: June 5, 1990

Thank you for seeing Mr. Jones. He is a 30-year old truck driver with a 2-year history of unremitting low-back pain which came on after lifting a large steel pipe off a loading dock. The pain radiates down the right posterolateral thigh and leg to the dorsum of the foot and big toe. He has been off work since this accident and is presently on compensation. He is unable to sit for long periods of time and, as a result, unable to return to work. He has had a course of physical therapy, various medications for pain, two weeks of bed rest under traction, and now three weeks of chiropractic care with little relief. He has no bowel or bladder dysfunction and is otherwise healthy.

On examination, he is unable to flex his spine and stands with an analgesic list to the left. There is marked paraspinal muscle spasm and tenderness at the L4-L5 level. The right ankle jerk is depressed, but other deep tendon reflexes are active and symmetrical. He has decreased sensation over the right L5 dermatome and weakness of the ankle dorsiflexors graded at 4/5. His straight leg raising is only 20 degrees on the right.

X-ray examination of the lumbar spine shows a loss of disc height at the L4-5 level with marginal osteophytes.

I think Mr. Jones has L5 radiculopathy from a small disc herniation at L4-5. Since he has not improved with conservative measures, I consider he should be assessed by an orthopedic surgeon. You will be seeing him on Tuesday August 12 and I will look forward to your opinion.

Yours sincerely,

cc: G.P., W.C.B.

#### B. Receiving a Referral

Dear Dr. Brown:

Re: Janine Jones, Accident Date: August 19, 1990

Thank you for asking me to see Ms Jones, an 18-year old student involved in a motor vehicle accident one month ago. She was the driver of a car which was hit from behind unexpectedly. She was not wearing her seat belt and was thrown forward, hitting her chest against the steering wheel. She did not lose consciousness, but experienced immediate chest and neck pain. She was taken to and kept in hospital for one week after the accident. X-rays and other investigations were negative and she was discharged with a cervical collar for whiplash injury to the neck. Neck pain is now predominantly left-sided with referral to the left periorbital region of the face. Past history includes a similar injury to the neck three years ago, and she is presently on medication for epilepsy.

On examination, she appears fit but somewhat depressed. The range of motion of her cervical spine is reduced by 50 percent on extension, 25 percent on forward flexion, and 50 percent on left rotation. Reflexes, sensations, and motor power are all intact in the upper extremities. The cranial nerves are normal. There is marked tenderness and muscle spasm over the atlantoaxial joint on the left and digital pressure at this level reproduces her symptoms.

Thank you for sending her x-ray report which states that her cervical spine is normal.

I think that this woman, following a hyperextension-hyperflexion injury to her cervical spine, is now suffering from upper cervical joint dysfunction, particularly at C1-2 on the left. We have arranged to give her a regimen of manipulations to her cervical spine over the next two weeks, and we shall keep you informed on her progress.

Thank you for this referral.

Yours sincerely,

#### C. The Follow-Up Letter

Dear Dr. Smith:

Re: Janine Jones, Accident Date: August 19, 1990

Ms. Jones has now completed her regimen of manipulations for upper cervical joint dysfunction secondary to a whiplash injury. I am pleased to report that her progress has been good, and she is 75 percent improved. She still suffers occasional back pain, but has returned to school and her daily activities.

On examination she has a full, pain-free range of motion in her cervical spine. There is only slight tenderness over the para-spinal muscles and articular pillars.

I have arranged to see her periodically over the next three months to ensure her full recovery. Such problems are often recurrent, but settle quickly with prompt treatment. If she develops similar trouble in the future, I would be happy to see her again for you.

Yours sincerely,

Dear Mr. D:

**Re: Mr. L.L.**

At your request I forward the following report on your client.

### History

Mr. L., a 44 year old mechanic, consulted me on May 7, 1990 as the result of an injury suffered in a motor vehicle accident on March 21, 1990.

At the time of consultation Mr. L. informed me<sup>1</sup> that he had developed left hip and leg pain one day after his vehicle had been rear-ended by another vehicle. He stated<sup>1</sup> that at the time of the accident he could see the impending collision coming in his rear view mirror. He braced himself with his left foot but was thrown forward and backward within the constraint of his lap-shoulder- harness seat belt.<sup>2</sup> He felt no ill effects immediately after the accident, denied any cuts or bruises, could walk and move all parts of his body and was conscious at all times.

Mr. L. was first examined by Dr. R. of Bramalea on March 22, 1990. X-rays were taken and he was prescribed medication. He subsequently saw Dr. H. (March 26, 1990) for additional clinical evaluation and was referred for physical therapy.<sup>3</sup>

The first evening after the accident Mr. L. experienced stiffness in his left leg, but did not relate this to the accident at the time. He was able to sleep that first night. The following day, however, his left leg became sore and stiff and the pain increased in intensity over a two to three week period to the point where he spent four days in bed. Subsequent to this he developed some numbness in his left leg and foot and experienced difficulty standing on his left leg. He had trouble sleeping and felt that the medication and physical therapy was of limited help.<sup>4</sup>

On May 7, 1990, Mr. L. presented himself to our office for evaluation. He related an intense uncomfortable ache in his left posterior buttock and leg. His pain was aggravated by prolonged sitting and not appreciably relieved by rest. There were neither bowel nor bladder disturbances accompanying the pain.<sup>5</sup> He had no history of lower back, hip or left pain prior to the date of the accident.<sup>6</sup>

### Examination

On physical examination Mr. L. did not appear to be in acute distress. However, it was evident that he was uncomfortable and he had difficulty getting up from a chair. General trunk motions were painfully limited in flexion, left lateral bending and extension. Specific motion palpation of the lower back revealed blockage<sup>7</sup> of the right lumbosacral joint to articular challenge. The left piriformis and gluteal muscles were moderately hypertonic and painful near their medial insertions adjacent to the left sacroiliac joint.

Passive straight leg raising was painful over his left hip bilaterally to about 40-45 degrees. Dorsiflexion of the left foot intensified his left buttock pain with the left leg raised to 40 degrees. He noticed a sharper sensation (hyperaesthesia) over the posterior aspect of his left leg to about the ankle.

Dorsiflexion of the left great toe was about 20 percent weaker than the right.

The left sacroiliac joint and gluteal muscle insertion were extremely tender and on provocation produced scleratonegous pain referral down the posterior aspect of his left leg to the ankle. Lower limb reflexes were difficult to elicit bilaterally and were not helpful in isolating specific nerve root involvement. Neck flexion was mildly painful at the lumbosacral junction. Peripheral pulses were equal in

character, rate and intensity. Abdominal palpation was negative.<sup>8</sup>

Radiographs of the left hip and lumbar spine were taken on April 19, 1990 at Finchgate Medical Centre in Bramalea. Mineralization was adequate for the patient's stated age. Slight spondylitic spurring was evident at the L4 to L5 interspace although this and all discal spacings are reasonably well maintained. Slight roughening of the iliolumbar ligament insertion was evident. The sacroiliac and hip joints were unremarkable.

The above findings on examination are consistent with and suggest an accidental injury such as that described by Mr.L.<sup>9</sup>

### Clinical Impression<sup>10</sup>

1. Left L5 disc protrusion producing S1 nerve root compression (discogenic sciatica).
2. Left sacroiliac strain producing scleratogenous pain referral.

### Management<sup>11</sup>

Management of the patient's condition included:

1. Restoration of spinal mobility by various techniques of joint manipulation. Adjustments employing traction forces were given in the direction of pain-free motion in order to reduce discoradicular irritation.
2. Soft tissue mobilization and massage to relieve hypertonic musculature.
3. Ultrasound and electrotherapy to reduce inflammation, pain and spasm.
4. The patient was instructed to take hot showers, restrict certain stressful movements and positions and shown how to mobilize (exercise) the lower back in order to reduce muscle tension once correction and healing was evident.

### Prognosis

At the time of Mr. L.'s last visit on July 19, 1990, he had shown remarkable improvement. His lower back and pelvic mobility was painless and essentially full in all planes of motion. The muscles were not tender and were free of tension and spasm. All tests of provocation were unremarkable including straight leg raise, foot dorsiflexion and neck flexion. Injuries such as those sustained by Mr. L are likely to have permanent effects. Every moderate to major traumatic episode has a mechanical wear-and-tear effect on the discal and posterior joint structures. The frequency and severity of future symptoms depend upon a number of factors.

Based on Mr. L.'s progress I feel that he has undergone the worst of his disorder, but I cannot exclude the possibility of relapse considering all aspects of the case including his quite prolonged convalescence. Given his employment as an auto mechanic, even if he is careful of certain work postures and does not experience any setback or symptoms over the next six months, it is likely that his spine will be subject to postural and mechanical disadvantage. I expect that there is a 30% probability of recurrent lower back and leg pain given his signs and symptoms.<sup>12</sup>

### Disabilities<sup>13</sup>

Mr. L. has noted the following disabilities or changes in lifestyle:

1. He is more limited in his work as a mechanic in terms of agility, confidence and endurance. He manages well at present but only through careful compliance with various exercise, rest and postural procedures.
2. He was involved in competitive motorcross cycle racing prior to the accident. Two attempts to resume this activity

have produced severe discomfort. I have advised him to abandon off-road racing permanently.

3. He is a skilled carpenter and has enjoyed home and cottage renovations over the years. He had to cancel plans to build a cottage extension this summer.

4. He states that he has always led a very physically active lifestyle but feels he must be more limited and cautious in everything now.

If I can be of any further assistance to you or Mr. L. in this matter, please contact this office. Yours truly,

James Smith, D.C.

#### Notes to Report

See text of the Report (Paras 8-15) for general principles of report writing - importance of brevity, organization, avoiding jargon and remembering who is reading report and why. Specific comments on this report are:

1. With respect to the circumstances of the accident and all matters arising outside your office, you are reporting the patient's evidence, not verifying the facts yourself. Make that clear as you commence the history.

2. Give good detail here because it is relevant to the precise biomechanical forces, and thus injuries, symptoms, management and your prognosis. If the patient has his/her head slightly turned in anticipation that is highly relevant biomechanically - include it.

3. No detail here - for example we don't need to know what sort of medication - because this is not fundamental to your management and report. You are merely recording economically that these things happened.

4. The tone of your report, and your credibility, will be much better if you do not openly criticize treatment by others.

5. This sort of comment indicates thoroughness and that various screening was done. However don't lengthen and burden the report with details, or all tests and negative findings.

6. Of vital relevance on whether or not all pain and disability arose from the accident - always indicate presence or absence of relevant past history.

7. 'Blockage' not 'subluxation'. Avoid all unnecessary use of terms of art, chiropractic or medical, especially ones like subluxation which have more than one meaning and thus confuse.

8. You may have performed many more tests during physical exam. This is enough - there are already three paragraphs. These have given the necessary, clear, overall picture and sense of competent examination. Will more detail help resolution of this matter by the insurance company or attorney? No - it only obstructs the flow of the report and detracts from overall impression.

9. This conclusion, if correct, must be set forth expressly in your report. It is crucial to the legal issue of 'causation', the link between accident and injury and thus the patient's claim.

10. Select the few major findings, itemize them by number, keep the language simple for the lay reader, and ignore the detailed findings.

11. 'Management' is preferred to the narrower concept of 'treatment'. Read this section as a lay person - that is who is using the report. Do not list treatment dates. If these details are specifically requested list them on a separate page appended to the report.

12. You are being asked for a concrete opinion that will help settle a claim - that is the whole point of the exercise. 'Prognosis guarded' is entirely valueless. Provide something firm - this is within your area of expertise and no one can do it better than you. Different jurisdictions develop different approaches towards disability rating and compensation. None of the many different disability scales has been accepted as correct. Use a method accepted where you practice. If in doubt call the lawyer who requested the report for guidance - the most knowledgeable people get that way by being prepared to seek guidance all the time, and the lawyer will appreciate the call. See next note.

13. Courts and compensation tribunals in many North American jurisdictions now prefer expression of disability in terms of concrete activities the patient cannot now perform - this section of the sample report gives examples.

This is in recognition of the fast pace and short attention span in modern life. If the BMJ needs to pander readers in this way to keep them reading, so do you.

b) Legal judgements, once pages of uninterrupted text, are now carefully indexed, sub-divided and paragraphed. Each issue being discussed has its own heading, and every line is numbered.

See sample letters (Figure 2) and report (Figure 3) for examples.

#### Free of Jargon

15. Perhaps the major fault of professional writing generally, and chiropractic writing, is inappropriate use of jargon. In the words of David Cassidy DC and colleagues, who have long experience:

"The problem with most letters that we see written by chiropractors is that they are too long and full of jargon ... (other professionals) are very busy and receive many letters each day regarding patients ... if the letter is too long and unintelligible they simply won't read it.

They are not interested in, nor understand, subluxation listings or motion palpations findings ... they are interested in history, disability, range of motion, sensory, reflex and motor deficit, straight-leg raising, tenderness, xray findings and diagnosis ...

Contrary to popular belief a short, concise and to-the point letter is more impressive than a complex essay full of jargon."<sup>8</sup>

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#### Spain

The European Chiropractors' Union and the Asociacion Española de Quiropractica invite you to the 1992 ECU Annual Conference to be held in early summer in beautiful Marbella:

**Dates:** May 27-31, 1992

**Place:** Hotel Don Carlos, Marbella, Malaga, Spain

**Theme:** Chiropractic and Postural Defects

**Speakers:** Nancy Abrams, DC MD - Canada

Alan Breen, DC PhD - U.K.

Joao Carlos Costa, MD - Portugal

El Dars MD FRCP - UK

Tammy DeKoekkoek, DC DABCO - U.S.A.

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Thus in a letter to a medical doctor your chiropractic finding of 'L4-L5 subluxation', necessarily confusing since the word has more than one meaning in this context, becomes 'marked muscle spasm and tenderness and joint restriction at the L4-L5 level'.

In a report to a lawyer or other lay person, who you must assume may not understand 'L4-L5' refer to 'restricted movement in the lower lumbar spine principally at the L4-L5 joint level (left lateral and rotation)'.

16. Assume for a moment that you are a lawyer or an insurance claims adjuster. Which of the following two descriptions, both extracts from actual reports, is more helpful and convincing?

**A.**

Segmental examination of the spine brought out pain and asymmetry and apparent restricted movement at C1-C2, C4-C5, T1-T2, T3-T4 and L4-L5 which I would describe all as flexed rotated and sidebent left. There was also dysfunction of the right sacroiliac joint which I would describe as left on left-axis. These are simply terms to describe the position of the vertebra in space; the barrier to joint movement must be palpated, but the positional diagnosis allows one to derive the direction in which manipulation should take place in order to free the joint, and restore physiological movement.

**B.**

Digital palpation of the patient's cervical, thoracic and lumbar spinal regions revealed spasticity as well as tenderness involving the following muscles: bilateral suboccipital, right paracervical, right levator scapula, bilateral trapezius, bilateral rhomboid and the right erector spinae group. Multiple rotatory fixations and subluxations were noted throughout the cervical, thoracic and lumbar spinal regions. Ranges of motion testing of the cervical spine revealed limitation in neutral extension at approximately thirty degrees, forward flexion at forty degrees,

left rotation at forty degrees, and right rotation at forty-five degrees. Neutral foraminal compression as well as both right and left Kemp's (extension, rotation and compression) exacerbated the patient's cervicothoracic and right suprascapular symptomatology.

Without knowing anything of their respective clinical competence, the adjuster 'knows' that the first chiropractor is more skilled, will gossip about this to colleagues, will allow the claim more readily, and will refer himself/herself and friends when they need chiropractic care.

**D. Samples**

17. Sample letters appear in Fig. 2. These contain a format recommended by Cassidy and colleagues of a four paragraph structure:

- i) History
- ii) Exam findings
- iii) X-ray findings
- iv) Diagnosis, prognosis, course of action/outcome

You may have a preferred system. The point is to adopt a standard format, then practice until you have the skills to draft a steady volume of correspondence efficiently. An annotated sample report appears in Figure 3 - see notes appearing there.

18. Quite simply individual chiropractors who hope to fulfil their potential in an era when the medical profession and wider world has a new level of acceptance of chiropractic, must be skilled in written communication. As Cassidy DC concludes:

"Letter writing is a skill that must be developed by practice. In our clinic, over 25 letters are dictated each day. We have an exceptional secretarial staff that can handle the typing load. It may seem like a lot of work, but our dictations help to build our practice. By keeping our medical colleagues in touch with what we do, they learn to trust us with their patients and are educated about chiropractic."

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9. Ref 8 supra, 31.

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