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Original Articles

BILATERAL ULNAR TUNNEL SYNDROME WITH AN UNUSUAL ONSET OF A DOUBLE CRUSH

By James R. Brandt DC, FACO

Ulnar tunnel syndrome (tunnel of Guyon) is an entrapment neuropathy of the ulnar nerve that is characterized by pain, numbness and paresthesia of the wrist that radiates into the ulnar aspect of the palm and dorsum of the hand. It includes the little finger as well as the ulnar half of the ring finger. These symptoms may radiate proximally to the area of nerve entrapment. The syndrome is often described as an aching or burning in nature with associated "pins and needles" type of paresthesia. (1)

Most authors consider the ulnar nerve as the principal and constant terminal branch of the medial cord. Therefore, it contains only fibers from C8 and T1. The nerve does not supply any structures above the elbow. It distributes fibers at the elbow and below. (2,5)

At the wrist the ulnar nerve passes deep to the palmar carpal ligament and superficial to the flexor retinaculum. The nerve then divides into superficial and deep branches. The deep ulnar nerve is motor to the hypothenar, interosseous, 3rd and 4th lumbricales and adductor pollicis muscles. The nerve passes through the tunnel or canal of Guyon to get to the hand. The tunnel is formed by the pisiform and hamate bones. (3)

Understanding the differential diagnosis for ulnar distribution symptoms, as with any condition, is important to expedite the recovery of the problem and enhance patient satisfaction.

The case study presented included the typical symptoms of ulnar nerve involvement, but had been unresponsive to prior medical care.

CASE STUDY:

Kevin S. presented to the office with bilateral numbness in the ring and small fingers. This began about 6 weeks prior to admittance to the office. It had been progressively getting worse. He felt this came on after playing some "aggressive volleyball for a couple of hours". "It feels like its hit my funny bone". He

commented that it is mostly from the wrists down, but on the right it goes up towards the elbow. He doesn't notice much radiation in the left arm. He drives a Bobcat loader at work and also drives a garbage truck daily. This activity aggravates his symptoms. He has been taking OTC pain medication without much success. He saw his primary care physician, who provided him with medications that upset his stomach and was not able to take after a week. He did not recall the names of the medications. He was provided with a 6" cock-up canvas splint for each wrist. These aggravated his symptoms and he discontinued wearing them. His work requires him to pull levers and his hands have been feeling progressively weaker. He cannot bowl as he is unable to control the bowling ball. Comments were given that he has trouble gripping objects. "My handwriting is getting worse." His elbows are sore as they rest on 2 metal bars that are used as a rest for the arms on the Bobcat. "I get some numbness in my hands when the pipe bumps my elbow". He has similar levers in the truck that he uses to control the lift of the garbage cans. He has not had prior chiropractic care for any condition. There is a family history of type II diabetes. System review is unremarkable and he has no allergies. He drinks between 2-3 cans of Mountain Dew soda per day. He does not abuse tobacco or alcohol. He sleeps on a Select Comfort air bed. His Epworth sleepiness scale is 6, this is within normal limits.

Kevin is a 35 year old Caucasian male with a height of 70 inches and a weight of 227 lbs. He is afebrile with a pulse rate of 82 per minute and a respiration rate of 16 per minute. The blood pressure on the left is 128/76, and on the right is 122/78 at 1645 hours. His pain severity scale is 3/10. The pain, numbness and tingling has been constant for the last 2 weeks. It has started to affect his activities of daily living. A review of the HEENT is unremarkable. Auscultation of the lungs and thorax is unremarkable. Normal heart sounds are present and no friction rubs or rales are present. His cervical range of motion is full and complete without complaints. No appreciable spasm is present. Cervical distraction is negative as well as foramina compression. No thyromegaly is present. Auscultation of the carotids did not reveal any bruits. Circumduction is adequately accomplished with mild crepitation. Muscle stretch reflexes are +2/+2 in the upper extremity. Hypoesthesia was noted over the C8 dermatome bilaterally. Grip strength is 110/110/100 lbs. on the right, and 90/85/90 lbs. on the left; he is right side dominant. Circumduction of the wrists is uncomfortable and this activity aggravates his symptoms. Tinel's is positive at the wrists over the Guyon Tunnel. It was also positive at the right cubital tunnel. Palpation reveals 0/+1 tenderness (0/+4 scale) at this level. There is +1 pain on palpation at the hook of the hamate and over the ulnar tunnel. The pulses are firm and equal bilaterally. He has good nail bed color. Froment sign is negative. Phalen's is positive into the 4th and 5th digits of the right hand and to a lesser extent the left. Thoracic outlet testing is negative.

The working diagnosis is bilateral ulnar tunnel syndrome, and right cubital tunnel entrapment, (double crush, right side)

The treatment plan included the description and explanation of the proposed treatment (informed consent), indications and contraindications to the process. Alternative treatments were reviewed. ADLs were reviewed and recommendations for work were given. His responsibilities were also discussed. Care consisted of active manipulation of the wrist and right elbow. A trial period of 8 visits was recommended. He accepted the treatment plan. Work recommendations included using foam cushion for the pipes on the Bobcat. His grip was discussed and he is to hold the handles further down on the grip to keep the wrist straight when pulling the levers. He was given a green Flex-bar by Theraband. This is designed for rehabilitation of the wrist and elbow. Underwater ultrasound was applied 1.25 W pulsed 50% for 6 minutes per wrist. He read and signed the Graston Technique informed consent. These tools were used for the myofascial release at the elbow and wrists. He was encouraged to continue working. He received a total of 6 visits over 3 weeks. It has been three months since the treatment was completed and he has remained symptom free.

Discussion:

History taking can lead the clinician quickly to a preliminary diagnosis. An examiner can form an idea of the extent and magnitude simply from the patient's history. (5)

Diagnostic imaging was not considered in this case because the clinical findings and the history were unambiguous. If there had been some question or there was a failure to respond in a timely matter imaging would be considered. Plain films of the area would be the first series to consider. If fracture is suspected CT scanning is recommended. The best imaging tool is the MRI. T1 scan for diffuse swelling or enlargement of the ulnar nerve. T2 may identify a mass or fracture. (3)

The differential diagnosis of ulnar entrapment may encompass many conditions. It is important to remember that the nerve can be entrapped anywhere along its course from the neck, through the shoulder, upper thorax, elbow and wrist. If more than one area is entrapped it is called a "double crush" or "multiple crush" entrapment. Here are some conditions to consider (1,3,4):

1. Cervical radiculopathy
2. Thoracic outlet syndrome
3. Cubital tunnel syndrome
4. Pancoast tumor
5. Hamate fracture
6. Diabetic neuropathy
7. Aneurysm or thrombosis ulnar artery
8. Ganglion cysts
9. Lipoma

To differentiate the cubital tunnel entrapment from "golfer's elbow" (medial epicondylitis) there is a point of maximal tenderness 1" below the medial epicondyle, whereas with a true golfer's elbow, it is *directly* over the medial epicondyle.

Complications from prolonged or untreated ulnar tunnel problems may include permanent damage to the nerve and muscular atrophy, particularly of the intrinsic muscles of the hand. Weakness and disability will be present.

Entrapment conditions of the upper extremity can be treated effectively with conservative management. Goals should be to improve biomechanical function of the joint with manipulation, soft tissue therapy and to re-educate the soft tissue with exercises and training. This will help prevent weakness and development of a chronic condition. Supports may be used to assist the clinician in the recovery of these conditions. Many of the nutraceutical companies have soft tissue support supplements and products to recommend. Ergonomic changes may need to take place. In this case adding padding to the bars used for his elbows and teaching him to hold the levers to avoid stressing the wrists were helpful. Maintaining good patient cooperation in self care and communication will help provide a satisfactory conclusion to the entrapment condition.

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Reprints & Abstracts

Iron Supplementation May Help Children With ADHD

Arch Pediatr Adolesc Med. 2004;158:1113-1115

Iron deficiency may contribute to the physiopathology of attention deficit-hyperactivity disorder (ADHD) in children, according to the results of a controlled group comparison study published in the December 6, 2004 issue of the *Archives of Pediatric & Adolescent Medicine*. Iron supplementation may benefit this population.

"Iron deficiency has been previously considered a potent cause of poor cognitive impairment, learning disability, and psychomotor instability," writes Eric Konofal, MD, PhD, from Robert Debré Hospital in Paris, France, and colleagues. "Iron deficiency could lead to ADHD symptoms in relationship with central dopaminergic dysfunction."

In the study, the investigators found that serum ferritin levels were significantly lower in children with ADHD ($n = 53$; mean age, 9.2 ± 2.2 years) compared with age- and sex-matched control subjects ($n = 27$; mean age, 9.5 ± 2.8 years) with mild reading disabilities (serum ferritin levels, 23 ± 13 ng/mL vs 44 ± 22 ng/mL, respectively; $P < .001$).

Serum ferritin levels were also abnormally low (< 30 ng/mL) in a significantly greater proportion of children with ADHD compared with control subjects (84% vs 18%; $P < .001$).

In children with ADHD, low serum ferritin levels were correlated with more severe general symptom scores on the Conners' Parent Rating Scale. A trend toward a correlation with greater hyperactivity was also observed but did not achieve significance.

"Only the cognitive subscore correlated significantly with low ferritin levels," the authors note. "This correlation suggests that the iron-deficient children are mainly inattentive and distractable and suffer from learning disabilities, a finding consistent with the role of iron deficiency in cognitive defects and mental retardation." "Iron supplementation could be considered a first-line treatment for children with ADHD and iron deficiency," the authors conclude, adding that such therapy may improve central dopaminergic activity and decrease the need for psychostimulants.

Discussion:

This ferritin research may not seem Olympian, but it really is important. Any non-pharmacologic agent that can be used in the control of attention deficit and/or hyperactivity disorder is very significant, for the medications currently in require very delicate management and health review. I have included a brief overview of ADD/ADHD here in the USA and how it has been traditionally been approached for management. (From the American Journal of Health-System Pharmacy, 12/20/2004)

Attention-deficit/hyperactivity disorder (ADHD) affects an estimated 4-12% of school-aged children in the United States. ADHD is diagnosed by the presence, in two or more settings, of at least 6 of 18 characteristics indicating hyperactivity, impulsivity, and inattention. In addition, these characteristics must be evident by age seven, persist for at least six months, and significantly impair academic, social, or occupational function. Up to 65% of children with ADHD also have co-morbid psychiatric disorders, including mood disorders, depression, anxiety, and oppositional defiant disorder. Functional problems, such as academic underachievement and difficulty with social and family interactions, are also likely in these patients. Persistence of ADHD into

adulthood has been reported in 4-60% of patients, and adults with ADHD are more likely to exhibit occupational, financial, and social deficiencies.

ADHD is caused by a deficit in response inhibition, an executive function in the prefrontal cortex. As a result, those with this disorder are unable to control responses to external stimuli. Patients with ADHD also display a dysregulation of arousal wherein they are inappropriately stimulated during exciting activities and inattentive in the completion of more routine tasks. This condition may be attributed to dysregulation of norepinephrine, as noradrenergic activation is associated with the attention span.

Medications that balance the dysregulation of dopamine and norepinephrine improve response inhibition and regulate arousal, leading to improved performance, which supports the hypothesis that modification of monoamine transmission in critical brain areas may be the basis for pharmacotherapy of ADHD. Historically, only stimulants have been approved for use in children to treat ADHD. Noradrenergic agents, such as tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), bupropion, and clonidine, have been used in ADHD therapy. While these agents have shown efficacy, there are potential limitations to their use, including an approximately 30% failure rate, intolerance, adverse effects including potential worsening of comorbid anxiety, dosage regimens typically consisting of multiple doses of short- or long-acting agents throughout the day, and concerns about potential abuse.

A new medication for ADD/ADHD has just emerged on the market, called Strattera (Eli Lilly, Indianapolis, IN). It is Atomoxetine hydrochloride. This is a selective norepinephrine-reuptake inhibitor (SNRI), and is the first nonstimulant indicated for the management of ADHD in children over six years of age, adolescents, and adults.

If you have patients who are or have family diagnosed as either ADD or ADHD, you might want to run serum ferritin levels to see if there may be low levels. You might also suggest that the next time they see their medical provider who is prescribing their medications, to ask that physician about Strattera. Getting away from stimulants would be well worth the inquiry.

ABSTRACT 2:

Authors

Farrar JT; Young JP Jr; LaMoreaux L; Werth JL; Poole RM. Clinical importance of changes in chronic pain intensity measured on an 11-point numerical pain rating scale. *Pain.* 94(2):149-58, 2001 Nov. See comment in: *Pain.* 2001 Nov;94(2):131-2. & *Pain.* 2002 Apr;96(3):410-1.

Institution

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Abstract

Pain intensity is frequently measured on an 11-point pain intensity numerical rating scale (PI-NRS), where 0=no pain and 10=worst possible pain. However, it is difficult to interpret the clinical importance of changes from baseline on this scale (such as a 1- or 2-point change). To date, there are no data driven estimates for clinically important differences in pain intensity scales used for chronic pain studies. We have estimated a clinically important difference on this scale by relating it to global assessments of change in multiple studies of chronic pain. Data on 2724 subjects from 10 recently completed placebo-controlled clinical trials of pregabalin in diabetic neuropathy, postherpetic neuralgia, chronic low back pain, fibromyalgia, and osteoarthritis were used. The studies had similar designs and measurement instruments, including the PI-NRS, collected in a daily diary, and the standard seven-point patient global impression of change (PGIC), collected at the endpoint. The changes in the PI-NRS from baseline to the endpoint were compared to the PGIC for each subject. Categories of "much improved" and "very much improved" were used as determinants of a clinically important difference and

the relationship to the PI-NRS was explored using graphs, box plots, and sensitivity/specificity analyses. A consistent relationship between the change in PI-NRS and the PGIC was demonstrated regardless of study, disease type, age, sex, study result, or treatment group. On average, a reduction of approximately two points or a reduction of approximately 30% in the PI-NRS represented a clinically important difference. The relationship between percent change and the PGIC was also consistent regardless of baseline pain, while higher baseline scores required larger raw changes to represent a clinically important difference. The application of these results to future studies may provide a standard definition of clinically important improvement in clinical trials of chronic pain therapies. Use of a standard outcome across chronic pain studies would greatly enhance the comparability, validity, and clinical applicability of these studies.

ABSTRACT 3:

JMPT: January 2004 * Volume 27 * Number 1

Prize-winning paper from the World Federation of Chiropractic 7th Biennial Congress

Assessing the clinical significance of change scores recorded on subjective outcome measures

Hugh Hurst, DC^a [\[MEDLINE LOOKUP\]](#)

Jennifer Bolton, PhD^{* b} [\[MEDLINE LOOKUP\]](#)

Abstract

Background To date, clinical trials have relied almost exclusively on the statistical significance of changes in scores from outcome measures in interpreting the effectiveness of treatment interventions. It is becoming increasingly important, however, to determine the clinical rather than statistical significance of these change scores.

Objective To determine cutoff values for change scores that distinguish patients who have clinically improved from those who have not.

Method Data were obtained from 165 back and 100 neck patients undergoing chiropractic treatment. Patients completed the Bournemouth Questionnaire (BQ) before treatment and the BQ and Patient's Global Impression of Change (PGIC) scale after treatment. Three statistical methods were applied to individual change scores on the BQ. These were (1) the Reliable Change Index (RCI); (2) the effect size (ES); and (3) the raw and percentage change scores. The PGIC scale was used as the "gold standard" of clinically significant change.

Results The RCI, using the cutoff value of >1.96, appropriately identified clinical improvement in back patients but not in neck patients. An individual ES of approximately 0.5 had the highest sensitivity and specificity in distinguishing back and neck patients who had undergone clinically significant improvement from those who had not. In terms of raw score changes, percentage BQ change scores [(raw change score/baseline score) x 100] of 47% and 34% were identified as having the highest sensitivity and specificity in distinguishing clinically significant improvement from nonimprovement in back and neck patients, respectively.

Conclusion This study provides a methodological framework for identifying clinically significant change in patients. This approach has important implications in providing clinically relevant information about the effect of a treatment intervention in an individual patient.

ABSTRACT 4:

Quick scan for depression

Screening for depression in primary care with two verbally asked questions: cross sectional study
Bruce Arroll, associate professor¹, Natalie Khin, PhD student², Ngaire Kerse, senior lecturer¹

BMJ 2003;327:1144-1146 (15 November), doi:10.1136/bmj.327.7424.1144

ABSTRACT

Objective To determine the diagnostic accuracy of two verbally asked questions for screening for depression.

Design Cross sectional criterion standard validation study.

Setting 15 general practices in New Zealand.

Participants 421 consecutive patients not taking psychotropic drugs.

Main outcome measures Sensitivity, specificity, and likelihood ratios of the two questions compared with the computerised composite international diagnostic interview.

Results The two screening questions showed a sensitivity and specificity of 97% (95% confidence interval, 83% to 99%) and 67% (62% to 72%), respectively. The likelihood ratio for a positive test was 2.9 (2.5 to 3.4) and the likelihood ratio for a negative test was 0.05 (0.01 to 0.35). Overall, 37% (157/421) of the patients screened positive for depression.

Conclusion Two verbally asked questions for screening for depression would detect most cases of depression in general practice. The questions have the advantage of brevity. As treatment is more likely when doctors make the diagnosis, these questions may have even greater utility.

The questions asked were...

1. During the past month have you often been bothered by feeling down, depressed, or hopeless?
2. During the past month have you often been bothered by little interest or pleasure in doing things?

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Case History

Clinical Pearl

Review of the Literature

Current Events

Council on Chiropractic Guidelines and Practice Parameters:
“Best Practice Initiative.....How valid is this document/process?”

By Jeffrey R. Cates, DC, MS, DABCO, DABCC

As you may or may not know, a new initiative is currently underway that has the potential to impact your practice in a positive and significant manner. But how do we know the resultant guideline will be any more or less credible than any other guideline? This article will help illuminate the difference between a “best practice (BP) initiative” and a “guideline”, as well as explain how the process insures that the current initiative is above reproach.

Most doctors have neither the time nor the scientific expertise to extensively assess the research literature on any given health topic. Fortunately, both guidelines and best practice documents are available to summarize the scientific literature for busy doctors. Guidelines and best practice documents are wonderful tools which allow a physician to quickly review the best evidence for various diagnostic and treatment procedures.

The Council on Chiropractic Guidelines and Practice Parameters (CCGPP) is currently working on a new best practice document for the chiropractic profession, and it will be available to you in the near future. So, how can DC's use the new CCGPP Best Practice document to their advantage? Read it! Understand it! Some of the best minds in our profession toiled tirelessly to provide you with a useful summary of what is most likely to work best for your patients. It tells you how to document the necessity of supportive care, how to document exacerbations and so much more. If we as a profession don't adopt the CCGPP's fair and valid best practice guide, the insurance companies will use their own guidelines to assess our work, and it is very unlikely that they will be as balanced and fair as those put forth by our own scholars. In fact, chiropractors in California are fighting with their legislature, which mandates that they follow restrictive guidelines that are reported to be very stringent and used by carriers to deny care.

The CCGPP has applied the principles of good best practice construction and has employed the process recommended by the AGREE collaboration (Appraisal of Guidelines for Research and Evaluation). With a clear, well written best practice document, chiropractors can feel secure in knowing that health care decisions can be held to the standards we chiropractors have set and not arbitrary or unfair rules they have established.

The difference between a guideline and best practice document is primarily in the way the recommendations are handled. While both review the available evidence, “guidelines” generally provide treatment recommendations and numbers of visits, whereas, a best practice initiative is based on three important elements: research, clinical decision making, and patient values. The best practice document allows the physician to weigh the evidence, consider the clinical situation, and then select the treatment or diagnostic procedure that is best for that patient.

Many organizations produce guidelines, and often there are several guidelines on the same topic. Often, the recommendations are quite similar, but not always. The questions then arise: “Which one do we use? How do I know this ‘guideline or BP document’ will be any more or less valid than any other guideline?” Indeed, not all guidelines or best practice documents are created equal, and the quality of construction can vary considerably. Attempts have been made in the last decade to construct an instrument that can assist in the evaluation of the quality of a documents construction process. Two early instruments include Cluzeau's “Appraisal Instrument for Clinical Guidelines” (Cluzeau instrument) and the methodological appraisal instrument by Shaneyfelt et al.

In 2000, Ian Graham et al. evaluated 13 guideline appraisal instruments for validity and reliability. Graham et al evaluated assessment instruments according to their ability to assess 10 attributes put forth by the Institute of Medicine (IOM) as desirable guideline attributes. [1] Graham et al. concluded that the Cluzeau instrument was the most well developed followed by Shaneyfelt's. Additional reliability testing of the Cluzeau instrument by Cates et al served to support its validity. [2] Many medical and chiropractic guidelines were assessed with the Cluzeau instrument. Assessment scores for various chiropractic guidelines can be seen reading the following paper: Cates JR, Young DN, Guerriero DJ, Jahn WT, Armine JP, Korbett AB, et al. Evaluating the quality of clinical practice guidelines. *Journal of Manipulative and Physiological Therapeutics* 2001;24(3):170-6.

Additional improvements and modifications were made to the Cluzeau instrument and the resulting AGREE instrument was recently introduced. [3] The final version of the AGREE instrument contains 23 items grouped into six quality domains (scope and purpose, stakeholder involvement, rigor of development, clarity and presentation, applicability, editorial independence) with a 4 point scale to score each item. Guideline domain scores are calculated by summing all the scores of individual items in a domain and standardizing the total as a percentage of the maximum possible score for that domain. A global assessment is also rendered. This instrument has been internationally tested for reliability and validity and is widely used across Europe and in Canada. Currently, the AGREE instrument is arguably the world standard for guideline evaluation. [4]

Guidelines that lack quality construction and/or credible content have been and will continue to be rejected by the legal system and third party payers. The AGREE instrument is useful in identifying where the flaws are in a guideline so that they might be addressed and rewritten or revised. The Council on Chiropractic Guidelines and Practice Parameters (CCGPP) best practice document is being constructed by an impressive team of scientists and academicians within our profession. The CCGPP team has employed recommendations in keeping with good guideline / best practice attributes as put forth by the IOM and measured by the AGREE instrument. These measures will help insure that the new best practices document will be valid and acceptable to all stakeholders.

I encourage you to go to the CCGPP website at <http://www.ccgpp.org> and learn more about the CCGPP and the new best practice document and how you can support and donate to this project. A CCGPP representative will gladly travel to your state to present information and answer questions. Call CCGPP at 803.808.0640 if you are interested in a presentation. Since funds are limited, all we ask is for your organization to pay the travel expense. Our time is donated to your association.

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AMA Sets Standards for Expert Witnesses in Medical Malpractice Cases

By Peggy Peck

ATLANTA (Reuters Health) Dec 07 -Expert witnesses are a crucial aspect of medical liability litigation and now the American Medical Association has ruled that expert witnesses should be board certified as well as recent practitioners in the same field as defendant physicians.

The new AMA policy was adopted after a long and often tedious House of Delegates debate over appropriate word choices including, at one point, a debate over the merits of "and" versus "or" that came a day after a reference committee heard more than 2 hours of testimony on the same issue.

The new policy, which was finally approved by a vote of 284 to 196, states that the requirements for expert witnesses include: comparable education, training, and occupational experience in the same field as the defendant within 5 years of the date of the incident that gave rise to the malpractice claim and board certification.

The board certification issue was the sticking point for many delegates that contended the AMA has a long tradition of not requiring board certification for membership or as proof of expertise. Dr. Michael Williams, a neurologist at Johns Hopkins University and a delegate from the American Academy of Neurology said he has reviewed many transcripts of so-called expert testimony and "I can assure you that certification in no way guarantees expertise."

But proponents of the certification requirement such as Florida delegate Dr. Troy Tippet, a neurosurgeon from Pensacola, told Reuters Health that "we support certification because I think we need to make sure that we are selecting the most qualified witnesses. Certification is part of that qualification."

Former AMA president Donald Palmisano, MD, JD, at a press conference following the vote said the AMA is most interested in "the truth...fixing the expert witness problem is one way to help us get at the truth." But while Dr. Palmisano agreed that problems with expert witness testimony, for example, testimony of "experts who have no clinical experience even though they may have authored hundreds of papers," is only one part of the "broken medical liability system."

Dr. Palmisano said that the attention given to the expert witness issue does not signal an AMA retreat from its main priority -- a federal tort reform bill similar to California's Medical Injury Compensation Reform Act (MICRA), which caps noneconomic damages at \$250,000 and puts limits on plaintiff attorney contingency fees.

In a related action, the AMA House is again asking the AMA board to develop and maintain an electronic registry of expert witnesses in malpractice cases. The request for an online registry came from the Florida delegation, which maintains that establishing and maintaining such a registry would cost about \$3000. The AMA board said in a report that such a registry would cost closer to \$100,000 and would be onerous to maintain. As a result the board concluded that the AMA should not pursue an online registry.

Following the vote the Chairman of the Board of Trustees J. James Rohack, MD, a cardiologist from Temple, Texas said, the Board will "look at it again and try to determine if there is a less costly way to maintain a site that will be useful to our members."

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Attribution

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