J. Michael Burke, D.C.

Clinical and Forensic Chiropractor
Board Certified Chiropractic Orthopedist
Member, International Society of Clinical Rehabilitation Specialists

CURRICULUM VITAE

Professional Licenses and Board Certification

Licensed Oregon chiropractic physician, 1981-present
Formerly licensed in Washington, California, and Hawaii (no longer active in these states)
Diplomate, American Board of Chiropractic Orthopedists, 1988

Education

B.A. with honors, University of California Santa Cruz, 1974
Doctor of Chiropractic, Western States Chiropractic College, Portland, Oregon, 1980
Postdoctoral study in Radiology, WSCC, 1982-83
Postdoctoral study in Chiropractic Orthopedics, WSCC, 1985-87
Postdoctoral study in Spine Rehabilitation, Los Angeles College of Chiropractic, 1997-98, 2004-05

Professional Experience

Attending Physician, Gresham Integrated Care, a University of Western States clinic, 2010-2011
Private practice of chiropractic, 1981-2008
Cofounder, President, and CEO, ChiroNet, Inc. (now The CHP Group), 1989-96
Independent Medical Examiner, physician consultant, and impairment evaluator for insurers and attorneys in workers' compensation, personal injury, and malpractice claims in Oregon, California, Washington, and Hawaii, 1986-present
Peer Review Committee member, Oregon Board of Chiropractic Examiners, 2004-07
Peer review panelist, Washington Department of Labor and Industries, 1990-92
Consultant to Medical Director, Oregon Workers' Compensation Department, 1991-92

Academic Appointments

Associate Professor, University of Western States, 2010-2011
Clinic Faculty, Western States Chiropractic College, 2006-2010
- Physical Rehabilitation Supervisor, Outpatient Clinic
- OSCE examinations evaluator
- Co-instructor, Evidence-based Practice III/IV, 2009-2010

Postgraduate Faculty, Western States Chiropractic College, 2008-2011
- *The Independent Medical Examination: Training for Chiropractors*, 2008-2011 (cosponsored by the American Board of Forensic Professionals)
- *Physical Rehabilitation*, Certified Chiropractic Sports Physician program, 2009

Associate Faculty, Western States Chiropractic College, 2001-2009
- Intern supervisor at on-site sports events

Recent Presentations

Southwest Brain and Spine Center/Pain Society of Oregon, Second Annual Spine Symposium, 2011

American College of Chiropractic Consultants, 2008, presentation: *A Critical Look at Non-evidence Based Resources and Guidelines in Common Use for Whiplash Associated Disorders*

American College of Chiropractic Consultants, 2007, presentation: *Bringing Evidence-based Medicine into the Independent Medical Examination Process*

Western States Chiropractic College Northwest Symposium, 2007, presentation: *Rehab Strategies for Acute/Severe Back and Neck Pain*

Evidence-based Outcomes Measures, 2006; presentation provided attendees with continuing education in this subject required by Oregon Board of Chiropractic Examiners

Presentations to new licensees on medical record keeping and functions of Peer Review Committee, 2004-06, sponsored by Oregon Board of Chiropractic Examiners

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2011 Annual meeting
Oregon Board of Chiropractic Examiners (OBCE)

www.oregon.gov/obce

Submitted by:
Ann Goldeen DC, Oregon Delegate
Daniel Cote DC, Oregon Alternate Delegate

WHAT IS THE MOST PRESSING CONCERN YOU HAVE?

The OBCE has a growing concern that the current system of IME reviews is biased against the patients in that the insurance companies and the review entities they contract with seem gravitate to those reviewers who consistently cut off payment for care. The OBCE adopted a rule on clinical justification several years ago to ensure that examining doctors were held to the same standards as treating doctors. The OBCE has a current case alleging an examining doctor's exam findings do not support his final conclusions. This may illuminate the Board's concerns in this area.

from Federation of Chiropractic Licensing Boards website,
http://www.fclb.org/LinkClick.aspx?fileticket=UTb31KWwsvU%3D&tabid=737
accessed February 21, 2012

Previously posted at http://www.obce.state.or.us/OBCE/pdfs/pub4.pdf (no longer available)

Mon Aug 22, 2011
Re: [From OregonDCs] IME Counterpoint

Thank you to all who contributed to this discussion.
The latest issue of The American Chiropractor magazine has a nice article on how to end IME abuse once and for all.
M_____

Dr. M_____
Chiropractic Physician
_____, Oregon

Sat Aug 13, 2011
Re: [From OregonDCs] IME Counterpoint
IME physicians DC/MD/DO whatever who retrospectively opine that an auto crash that happened months earlier wherein (this is an actual case) the target vehicle's bumper was indeed crushed in 2" to 3" etc from the unexpected impact that absolutely no treatment was clinically necessary for the woman passenger and very little for the husband driver are a travesty and the recent complaint to the OBCE justified. ***I performed a second opinion medical records review, consultation, examination, and report of this couple which provided some of the basis for the complaint which the IME DC is contesting and I hope he loses as the OBCE and the profession need to send a message.*** ...

Sat Feb 18, 2012
[From OregonDCs] House Health Committee Hearing Wednesday regarding IME's [1 Attachment]
From: b_____.
To: _____
Sent: Saturday, February 18, 2012 1:26:06 PM
Subject: Re: [From OregonDCs] House Health Committee Hearing Wednesday regarding IME's [1 Attachment]

It occurs to me that the "3%" IME complaint statistic suggests that too many of us or our patients don't submit formal complaints to the OBCE after a clearly unreasonable IME outcome. Based on my own experience and ListServe posts from other docs about IME's, it makes me wonder about that. I will admit that I have never submitted a formal complaint even after the most egregious IME outcomes.

Perhaps someone (_____?) could post under what circumstances such a complaint should be submitted and how to do so.
A_____ DC

To: oregondcs@yahoogroups.com
From: d_____
Date: Tue, 7 Feb 2012 09:22:00 -0800
Subject: [From OregonDCs] C_____, D.C. HACK IME'S FOR USAA

(out of Medford) In my opinion, of course... ;) I'm certainly hoping the OCA can work this year within the profession and ***directly with the OBCE to PROTECT THE PUBLIC from these "paper review" docs who have sold their souls, our profession, and the citizens of this state down the river for their own shameless, gutless greed*** (again, in my opinion).

It's too bad they have to make their living on the underbelly of chiropractic, rather than experience the joy of HELPING people.

To all you shameless IME'ers... I hope your time has come.

R_____, D.C.

Tue Jan 31, 2012
RE: [From OregonDCs] Re: FL PIP law
The system will force the issue of proper charting and the utilization of evidence based outcome assessments...***not more hiding behind the "evil IME doctors"***.....V_____

From: R_____
Date: Mon Jan 9, 2012 5:54 pm
Subject: Re: [From OregonDCs] Auto Injury solutions
C_____, ***I have a patient in the office right now who was raped by this guy***, and USAA who uses Auto Injury Solutions. [*chiropractor who does IMEs*] practices in _____, OR. So, if anyone there knows him they might be able to shed light on why he is doing this BS. It is my understanding that things are ongoing to correct this through a particularly supportive group of chiropractic friendly attorneys. Hopefully they can clean this mess up.
I would also think the OBCE could take care of this as well.

R_____

This complaint concerns three patients seen by Dr. X. The patients are Mr. PD, Mrs. SD, and Ms. KC.

PD (DOB ##/##/1941) saw Dr. X on 6/22/2009 for complaints arising from a motor vehicle collision that occurred the same day. Dr. X's report of the encounter is dated 6/23/2009. Although not mentioned by Dr. X in his report, it is known that Mr. D was already an established patient at the time of the 6/22/2009 visit. Dr. X's bill for that date included an evaluation and management code for an established patient, 99212. Dr. X documented "head and neck symptoms," which the patient reportedly described as tightness and stiffness. Dr. X also reported "stiffness" in the "spine, ribs and pelvic region" as a result of the auto accident. The location of this symptom was also described as "upper back region; mid back region; low back region," and the symptoms were additionally described as "tightness/stiffness." The specific locations of the patient's complaints were not described in any greater detail than this. Dr. X did not quantify the patient's pain grade on a visual analogue or numeric pain rating scale. However, he reported that Mr. D's functional impairment at rest was 2/10, and during activity it was 4/10 (on an 11-point numeric scale).

There is a list of daily activities which were reportedly limited "as of 06/22/2009." Most of the activities on the list are qualified as either being "limited due to symptoms associated with the current condition" or "not limited but performance exacerbates symptoms." The limited activities consisted of household chores, lifting, sleep, static standing, walking, and golf. Activities that were not limited but reportedly exacerbated symptoms consisted of bending, carrying groceries, changing positions from sitting to standing, climbing stairs, driving, extended computer use, feeding, and static sitting.

It is very unlikely that Mr. D could have been aware of all these activity limitations and their effects on his symptoms on the same day the accident occurred. Mr. D likely presented to Dr. X within a few hours of the accident. Dr. X's report essentially states that the patient had attempted to sleep, play golf, and use a computer for an extended period of time, in addition to all of the other problematic activities listed. Even if Mr. D had erroneously reported these limitations, Dr. X apparently did not question the veracity of the patient's report but reiterated these specious claims as if they were fact.

This 6/22/2009 report, which is apparently the only documentation of this patient encounter, does not include a past and concurrent medical history. Even though the patient was apparently known to Dr. X prior to this encounter, the duty to keep complete and accurate records obligates the doctor to provide an interim history from the time of the most recent visit prior to 6/22/2009, describe the condition(s) for which Mr. D had been receiving chiropractic care prior to the MVC, and state how the new problems differed from and/or affected those previously treated. Furthermore, Dr. X should have reported information regarding the patient's concurrent health problems, comorbidities, and medications, if any. Dr. X's failure to keep complete and accurate records would have compromised another chiropractic physician's ability to understand the nature of this patient's case and follow-up with care.

The physical examination included inspection, palpation, orthopedic tests, and a minimal neurologic evaluation limited to reflex testing. Spinal ranges of motion were not evaluated, either visually or by measurement. Dr. X's interpretations of the examination findings are disturbing. For example, palpation reportedly demonstrated "moderate to severe thoracic tenderness...." The doctor stated this finding indicated "a possible fractured spinous process" and opined that thoracic x-rays were necessary to rule out fracture. Additional clinical evaluations could have been performed to help confirm or rule out this diagnosis, but they were not. Instead, Dr. X chose to defer further evaluation, including imaging, and proceed with chiropractic treatment.

On palpation of the thoracic and lumbar paraspinal muscles, Dr. X noted "palpable bands and/or taut fibers" which he interpreted as "chronic spasm." As Mr. D's condition was acute at the time, having allegedly been injured only hours before this examination, Dr. X's interpretation of this finding as chronic is either erroneous or else the chronicity would have to be attributed to a pre-existing condition.

During the examination the patient performed a Valsalva maneuver which reportedly elicited "localized thoracic pain," although Dr. X did not state the exact location. He opined that the results of this test indicated "a space occupying lesion in the thoracic canal or foramen." He then recommended "radiographs to confirm/rule out the presence of an osteophyte" as well as a MRI for evaluation "of a tumor or disc involvement...." However, as with

the possible spinous process fracture, Dr. X deferred the imaging studies he himself recommended pending the patient's response to treatment.

Dr. X also performed a cervical foraminal compression test which reportedly produced localized pain. Dr. X thought the results indicated "possible foraminal encroachment without nerve root pressure or apophyseal capsulitis." He thought cervical radiographs would be necessary to determine if foraminal encroachment was present but, again, the recommended study was not performed.

Following the examination findings, the report lists a number of diagnostic tests to be ordered. The reasons given for ordering the imaging studies are contradictory and senseless. Dr. X stated that thoracic and lumbar radiographs "are deferred pending results of treatment," but he also stated that "TThoraco-lumbar [*sic*; this spelling error is repeated in other parts of the notes] radiographs *to confirm/rule out the presence of a congenital anomaly are ordered* [emphasis added] as indicated." He stated that thoracic x-rays for evaluation of a fracture and for evaluation of an osteophyte encroaching upon the vertebral canal or foramen "are deferred pending results of treatment." Likewise, cervical radiographs "to confirm/rule out foraminal encroachment" were deferred. The aforementioned thoracic MRI "to confirm/rule out the presence of a tumor ... encroaching the vertebral canal or foramen" was also deferred "pending results of treatment." Then, contrary to most of the previous statements, Dr. X ordered cervical, thoracic, and lumbar x-rays, but the records do not indicate that the imaging studies were actually performed. There is no report of any imaging findings, and the billing statements do not list fees for radiographic services. The list also contains an incomplete sentence, "Cervical radiographs to confirm/rule out the presence of a congenital anomaly are [*sic*]," leaving the remainder of the sentence to the imagination of the reader.

Dr. X's diagnoses included segmental dysfunctions and strains of the cervical, thoracic, lumbar, and sacroiliac areas. Also listed are "late effect" strains of the pectoralis major muscle, parathoracic and paralumbar musculature, and the cervical intrinsic musculature. Dr. X again appears to be confused about the acuity of his patient's injuries. Obviously, late effects of an injury would not appear on the same day the injury was sustained. Alternatively, the late effects could have pertained to conditions that predate the motor vehicle collision, but this was not considered.

Treatment plans and outcome goals are listed in the report. Each previously cited diagnosis has its own treatment plan and outcome goal. Most of the diagnoses state a frequency and period of time for the treatment, usually three times per week for one month "or until patient reaches MMI." Treatment for the diagnosis of cervical segmental dysfunction, however, would be rendered only "when the patient feels treatment to be necessary." Treatment for the cervical strain was "deferred at this time." Dr. X offered no rationale for these treatment decisions. Treatment for the "space occupying lesion" was also deferred. The "possible thoracic fracture" noted on the physical examination was not listed in the diagnosis or treatment sections of the report.

The treatment goals for each treated diagnosis were described in terms of the 11 point functional impairment scale described earlier. However, in this portion of the report they are referred to as visual analog scale ("VAS") measures. The same values are given for each diagnosis: "Rest = 2" and "Active = 4." Functional impairments are usually not measured using a VAS. Furthermore, VAS results are measured in millimeters, not whole integers.

The last paragraph of this report states that the patient was counseled regarding "diagnostic impressions, the importance of compliance with the ordered treatment schedule and risk factor reductions to preclude additional injury." This does not constitute documentation of informed consent. Without such documentation it is apparent that Dr. X has not complied with the requirement to obtain informed consent. Only what is documented can be said to have occurred.

Twelve additional dates of service are documented subsequent to the 6/22/2009 encounter. Each chart entry spans three pages. The patient's name and date of service appear on each page, but only the first page of each note identifies the clinic of origin by name and address. Each chart entry is almost an exact copy of the previous one. The subjective findings consist of the list of limited activities copied from page 3 of the 6/22/2009 report. They remain unchanged throughout the course of care. An "analysis" follows this list. With the exception of the 7/15 and 7/28/2009 chart entries, this analysis never changes: "The patient reported no significant change in

their [*sic*] level of symptoms or their [*sic*] capacity for noted daily, recreational and/or occupational activities." The 7/15/2009 note says, "eye surgery tomorrow." The 7/28/2009 note says "able to ambulate after eye surgery. Spine and neck are really sore." These statements are the only explanation for the nearly two-week gap in care between the two visits.

In the Objective section of each chart note the aforementioned list of diagnoses is repeated. There is no documentation of any examination findings in any of the treatment notes. At the least, palpatory findings concerning pain, muscle tone, and static or motion segmental function should be documented. Following the reiteration of the diagnoses is this statement: "Examination revealed findings consistent with those noted in the current treatment plan. The current objective problem list is unchanged."

The Assessment portion of each note is blank. The treatment plan from the 6/22/2009 report is reprinted in each note. The treatment goals continue to be described using the alleged VAS scale with the original values unchanged. Then there is a list of therapies, labeled as "Ordered Procedures," which consist of manipulation, massage therapy, supervised electric stimulation, and ultrasound.

Finally, each note details the treatment rendered that day. The treatments consisted of manipulation of the cervical, thoracic, and lumbar regions and, infrequently, at the sacrum. Electric stimulation was also administered. There is no documentation that the remaining "ordered procedures" of massage therapy and ultrasound were ever administered. There is minimal variation in the vertebral levels reportedly adjusted at each visit. The notes are otherwise identical. Each note concludes, "The patient responded well to treatment noting improvement following therapy," and each subsequent note always reports no significant change, as was mentioned above.

The final chart entry is dated 7/31/2009. There is no appreciable difference in the patient's condition documented in that note compared to his condition at the outset of care.

SD (DOB ##/##/1945) is the wife of PD. She also was allegedly injured in the motor vehicle collision of 6/22/2009 and was first seen by Dr. X for the effects of that accident on the same date. Dr. X's report of that encounter is dated 6/23/2009. Mrs. D was also an established patient, having received treatment from Dr. X prior to 6/22/2009, although Dr. X did not mention a history of care prior to that date. Nonetheless, his bill lists an established patient evaluation and management service, 99212.

Complaints attributed to the MVC consisted of "head and neck symptoms" in the "neck region," the quality of which were described as "localized and tightness [*sic*]." There were also complaints in the "spine, ribs and pelvic region" which were described as "numbness and stiffness." The symptoms in the spine, ribs, and pelvis were also stated to be in the "upper back region; mid back region; low back region." The quality was additionally described as "localized and tightness and numbness [*sic*]." The subjective complaints are not described in any greater detail. However, Dr. X provided a fairly detailed description of the accident. With respect to the extent of damage to the patient's vehicle he stated, "The patient's vehicle was lightly to significant damage [*sic*]."

The patient's "functional impairment" was reported on an 11-point scale. Functional impairment at rest was 4/10; during activity functional impairment was 7/10. Then there is a list of daily activities. As with Mr. D, some of the listed activities were not limited, "but performance exacerbates symptoms." These activities were reading, sexual activity, sleep, and feeding. Other activities were "limited due to symptoms associated with the current condition." These were static sitting, static standing, walking, yard work, bending, carrying groceries, changing position from sitting to standing, climbing stairs, driving, extended computer use, household chores, and kneeling. The patient was "unable to perform" the remainder of the listed activities which were "lifting children" and "lifting."

As in Mr. D's case, the credibility of the reported activity limitations is doubtful. It is very unlikely that Mrs. D attempted most of these activities in the few hours between the MVC and her presentation to Dr. X's office, and Dr. X's report of these alleged limitations seems specious.

The report makes no mention of past or concurrent medical history, even though Mrs. D was a patient prior to this encounter.

The doctor's report of examination findings is as confusing and disturbing as that of Mr. D. The finding of a "high left shoulder with palpable scoliosis" led Dr. X to suspect a congenital anomaly and recommend radiographs. (Mr. D reportedly had a "high left shoulder with palpable scoliosis" as well, and Dr. X also suspected a congenital anomaly in his case, recommending an x-ray study which was never actually performed.) Palpatory pain in the thoracic spine suggested "a possible fractured spinous process" for which radiographs were thought to be indicated. A similar finding in the lumbar spine led Dr. X to the same conclusion. Findings of "chronic spasm" in the paraspinal musculature were noted, contrary to the patient's allegedly acute presentation. Valsalva maneuver produced "localized low back pain" and indicated "a space occupying lesion in the lumbar canal or foramen." Dr. X recommended thoracic x-rays and an MRI for further evaluation. The cervical foraminal compression test produced localized pain which indicated to Dr. X "possible foraminal encroachment," and he thought cervical radiographs would be necessary to evaluate this. Some but not all cervical motions were assessed, but they were not quantified (i.e., measured). "Cervical right rotation" demonstrated "moderate limitation due to pain" and, in addition, "severe limitation due to stiffness." (There is no explanation of how the same motion could be both moderately limited for one reason AND severely limited for another.) There was "mild limitation" of right lateral flexion and "mild limitation" of left rotation. The remaining cervical motions were not mentioned. Thoracic and lumbar ranges of motion were not reported.

There is a list detailing "Diagnostic Test Orders," but the eight items in the list, all imaging studies, were "deferred pending results of treatment." Included in the list were thoracolumbar radiographs to confirm or rule out the presence of a congenital anomaly, thoracic and lumbar radiographs to evaluate the presence of fractures, lumbar x-rays to confirm or rule out an osteophyte encroaching the vertebral canal or foramen, and a lumbar MRI "to confirm/rule out the presence of a tumor."

There is a long list of diagnoses, many of which are more appropriately described as examination findings such as "loss of cervical flexibility." Overall, the diagnoses are essentially the same as Mr. D, that is, cervical, thoracic, lumbar, and sacroiliac segmental dysfunctions and strains (although there are separate diagnoses of strain and sprain/strain of the neck). Also listed are "late effect strain" diagnoses for various muscles, again contrary to the reportedly acute injuries for which the patient was seen.

"Treatment Orders" are listed according to the diagnoses. As with other portions of the documentation, the doctor's clinical reasoning is inscrutable. For example, "cervical segmental dysfunction" was to be treated with Activator instrument manipulation, but treatment of cervical strain, cervical sprain/strain, cervical neuritis/ radiculitis (a diagnosis for which no subjective or objective findings were documented), and loss of cervical flexibility were "deferred at this time." Two of the treatment recommendations, those pertaining to lumbar and sacroiliac segmental dysfunction, are incomplete. They are to be "treated with manipulation utilizing [*sic*]," after which the next item begins.

Informed consent was not documented. Without such documentation, Dr. X has not complied with the requirement to obtain informed consent. Only what is documented can be said to have occurred.

Mrs. D received treatment from Dr. X on an additional 13 occasions. The treatment notes are largely verbatim reiterations of portions of the original report, essentially copy-and-paste duplications. Several of the daily chart entries offer a minimal description of subjective complaints and examination findings, in addition to the lists of activity limitations in the subjective section of the notes and diagnoses in the objective section. The assessment of the patient's condition was never updated. The "treatment orders" appear to have been copied from the original report including the "VAS" values for activity limitations. These outcome measures do not change throughout the entire documented course of care. The 6/30/2009 note contains the statement, "Discuss concern re disc," but there is no clue as to what this concern is, who has the concern, or what actions would be considered to address the concern. In the objective findings section of the 7/1/2009 entry, Dr. X noted, "swelling limber para left and right shoulder girdle [*sic*]." No further explanation of this obtuse statement was given. This "finding" does not appear to have caused any of the diagnoses or the treatment plan to be modified.

The name and address of Dr. X's clinic is identified only on the first page of each 3-page chart entry.

The record of Mrs. D's chiropractic treatments does not document any favorable response to care either by patient-driven or doctor-driven outcomes measures. The only evidence-based outcomes assessment documented is the grading of functional impairment which, as discussed previously, was applied erroneously.

KC (DOB ##/##/1987) was reportedly injured in a motor vehicle collision on 5/21/2009. She presented to Dr. X on 2/9/2010, almost nine months after the accident. She had not seen Dr. X as a patient prior to that date, but she had received care from other healthcare providers. Dr. X's report of the first visit is dated 2/9/2010. He stated she presented with "a new condition in the head and neck region *which is acute based on onset of less than 6 weeks ago* ... [emphasis added]." Dr. X noted "head and neck symptoms" which were located in the "neck region," and were characterized as "localized and tightness [*sic*]." Additionally, there were "spine, ribs and pelvic region" complaints, also erroneously reported as acute, which were characterized as "pain, stiffness." After providing a detailed narrative of the accident, Dr. X reported the entire nine-month interim history from the time of the accident to presentation in his office as follows: "The patient was hospitalized. The patient was x-rayed." Although Ms. C had seen other providers for evaluation and treatment of the injuries reportedly arising from the MVC, Dr. X was apparently unaware or unconcerned about this history as he did not document it. Dr. X also did not report an intervening accident that occurred on 8/21/2009. Dr. X did not report the severity of the symptoms, but he did provide a rating of "functional impairment" on a numeric pain scale. At rest, functional impairment was 4/10; with activity, 8/10. There is a long list of activity limitations, and after this the limited functions are again graded as 4 at rest and 8 with activity, but this time they are stated to be visual analog scale ("VAS") results.

The patient's past medical history was not documented. Concurrent medical problems, comorbidities, and medications were not mentioned.

Reported physical examination findings, as with the other two patients, are confusing. Furthermore, Dr. X's interpretation of some of the findings and his recommendations for further evaluation strongly suggest an inability to properly interpret the results of physical examination procedures. For example, a finding of "forward cervical flexion" was noted on visual inspection, which he interpreted to indicate a hypolordosis which, he believed, necessitated radiographs to "confirm/rule out the presence of a congenital anomaly. ..." Furthermore, he thought physical performance testing was necessary "to evaluate the existence of a structural defect...." Dr. X did not explain why physical performance testing would be the evaluation of choice to detect a structural defect.

Right-sided foraminal compression testing reportedly produced radiating pain into the lower back. Dr. X opined that this finding indicated "pressure on the nerve root due to entrapment or disc involvement." The distribution of the pain further suggested long tract involvement ("cionsider [*sic*] long tract sx").

Ms. C is the third of the three patients on which Dr. X found a "high left shoulder with palpable scoliosis" and, as with the others, he suspected a "congenital anomaly" which necessitated radiographic evaluation.

On palpation of the thoracic spine Dr. X found "tenderness at spinous or facet joint." He apparently is not able to distinguish between the two structures. He then stated there was a "recent history" of trauma, again demonstrating his ignorance of the patient's history. The "recent history" phrase is repeated several times in the examination portion of the report.

The straight leg raise test caused low back pain when each hip was flexed to more than 70 degrees. Dr. X opined that this finding indicated "lumbar joint dysfunction," but in fact this is a nonspecific finding from which no precise cause can be inferred. He then went on to perform Braggard's test, which was reported to reproduce pain at "65+ degrees. ..." Dr. X thought this had caused "intervertebral joint pain due to possible joint dysfunction," but since the normal range of ankle dorsiflexion is about 20 degrees one might be more concerned about the stability of the patient's ankle. More likely, Dr. X does not understand how to perform this test. Perhaps he does not know the normal range of ankle motion. Alternatively, he could have meant that dorsiflexion reproduced pain at 65 degrees of straight leg raise. Unfortunately, the notes are too confusing to derive meaning from them.

Dr. X also reported findings for "Bechterew's test/seated SLR." He stated, "The patient arched low back due to increased symptoms." He interpreted the results as indicating "sciatic neuritis," again showing his inability to

competently interpret common orthopedic tests. A similar error was made with the Nachlas test. Dr. X interpreted lumbosacral pain as indicative of "lumbosacral neuritis/radiculitis."

The patient then performed a Valsalva maneuver which caused "localized thoracic pain," which Dr. X interpreted as indicating "a space occupying lesion" in the thoracic spine. The Valsalva maneuver also caused low back pain which was interpreted to indicate the presence of a space occupying lesion in the lumbar spine. Thoracic x-rays and an MRI (the latter to "confirm/rule out the presence of a tumor or disc involvement") were recommended for evaluation of the thoracic spine pain produced by Valsalva maneuver. Thoracic x-rays and MRI were also recommended for evaluation of the lumbar pain produced by Valsalva maneuver.

Dr. X did not evaluate spinal ranges of motion. Any standard spinal evaluation would normally include an examination of spinal motion. He performed reflex testing in the upper and lower extremities, all of which were described as "normal," but were not reported on the appropriate 0-4 scale. He did not perform a motor or sensory evaluation of the extremities, did not test for abnormal long tract signs, or perform any other neurological testing (aside from testing for unspecified "pathological" reflexes). Given the doctor's stated concerns for tumors, injuries to intervertebral discs, neuritis, and radiculitis, a more thorough neurological examination should have been performed.

Dr. X's report contains "Diagnostic Test Orders" for several spinal imaging studies, some of which were both ordered and deferred at the same time. Cervical radiographs, for example, were ordered "to confirm/rule out the presence of a congenital anomaly," but the same radiographs were "deferred pending results of treatment" when they were considered "to confirm/rule out osseous entrapment of the nerve root. ..." Cervical and lumbar MRI studies for the evaluation of a tumor or disc encroachment on the vertebral canal or foramen were "deferred pending results of treatment." (In the physical examination portion of the report, Dr. X had considered ordering a thoracic MRI, not a cervical MRI.)

Dr. X reported taking cervical, thoracic, and lumbopelvic x-rays on 2/9/2010. His interpretation included a "thoracic Levo/Dextroscoliosis with apex at: L4, T10 and T7." He also found a "thoracic compression fracture at T7 and T8" and disc degeneration at T6-7 and T7-8. (Dr. X's bills for services rendered to this patient do not include fees for either technical or professional radiographic services.) Dr. X was aware that x-ray studies following the 5/21/2009 MVC had been obtained and could have requested them before determining if additional patient exposure was justified.

The reported diagnoses included sprains and strains of various muscles and spinal regions segmental dysfunctions, sciatic neuritis, lumbosacral neuritis/radiculitis, and "space occupying lesion." The imaging finding of a thoracic compression fracture or fractures did not make it to the list of diagnoses.

The report lists "complicating conditions" and their "anticipated effect on treatment outcome." Included are "acquired postural defects," scoliosis, thoracic degenerative joint disease, and thoracic compression fracture, all of which led Dr. X to conclude that "full recovery is not anticipated." However, the "Dextro/Levoscoliosis" also on the list was "not expected to complicate either the patient's response to treatment or outcome potential," unlike the aforementioned scoliosis.

The treatment plan included manipulation, massage therapy, ultrasound, and electric stimulation. Various combinations of these therapies were to be administered for the diagnoses of cervical segmental dysfunction, "late effect strain" of the suboccipital, scalene, and cervical paraspinal muscles, thoracic segmental dysfunction, and thoracic strain. However, treatment for some of the diagnosed conditions – cervical strain, cervical sprain, cervical sprain/strain, cervical neuritis/radiculitis, lumbar strain, sciatic neuritis, lumbosacral neuritis/radiculitis, and space occupying lesion – was "deferred at this time." The thoracic compression fractures were not addressed in the treatment plan. The frequency and length of treatment for some of the diagnoses was described. However, for the thoracic strain treatment would be administered "when the patient feels treatment to be necessary."

There is no documentation that informed consent was given. Dr. X's records of the other two patients described counseling regarding the diagnostic impressions, treatment compliance, and reducing risk factors to avoid

further injury. These statements are not found in the records of Ms. C, not that they would amount to documentation of informed consent had they been there. The mandate that chiropractors obtain informed consent does not require it to be written, but if informed consent was given in these cases, it was not documented and thus cannot be claimed to have occurred.

Including the first visit, 15 patient encounters are documented through 3/12/2010. A re-evaluation was reported on 3/10/2010, which is discussed below. The daily treatment notes include subjective complaints, primarily a repeat of the functional difficulties noted at the first appointment, although some of these appear to have been updated to some degree. On only four occasions do the notes reflect any real change in reported symptoms. For example, the 2/19/2010 note states that the pain level was decreased. On 2/24/2010 pain levels in the neck and low back had increased. The 2/26/2010 chart entry describes a small oval area of numbness at L3-S1. The 3/2/2010 note states that numbness in the "thoraco lumbar [*sic*]" area had decreased. Most of the treatment notes contain the statement, "The patient reported no significant change in their [*sic*] level of symptoms or their [*sic*] capacity for noted daily, recreational and or occupational activities."

The two examination reports, 2/9/2010 and 3/10/2010, as well as the 13 additional treatment notes identify the name and address of the clinic of origin only on the first page, although the patient's name and date of service appear on each page.

None of the treatment notes, or for that matter the re-evaluation report, document any examination (objective) findings. At the very least, one would expect to find a palpatory examination concerning segmental dysfunction, muscle tone, and pain elicited by palpation. This would constitute the minimal evaluative service necessary to justify the administration of chiropractic manipulative therapy. Thus, CMT was administered without adequate justification. Furthermore, charges for CMT services (98941 on most dates of service) would appear to be fraudulent given that all services included in the fee were not delivered.

Dr. X's documentation of the 3/10/2010 re-evaluation indicates that his patient received virtually no benefit from the treatment. The "VAS" for "Active" function had changed (improved, presumably) from 8 to 7, and the "Rest" VAS has changed from 4 to 6. The patient's ability to perform most of the activities listed was "unchanged." However, there are several incongruities in this list. For example, pet care "can now be performed without limitation." This activity was on the original list of 2/9/2010, but there was no statement regarding whether it could be performed normally, with limits, or not at all. The activity, "care for infirm family member," was originally noted to have "no effect." In the re-evaluation report it was also stated to have no effect but, additionally, Dr. X noted, "The patient reports this can now be performed without limitation," implying that a previously normal activity had improved.

There is no indication that any physical examination procedures were performed on 3/10/2010. In fact, the findings were copied from the initial examination of 2/9/2010. At several places in this report Dr. X stated the reported findings were "Results of the 02/09/2010 Exam." Thus, Dr. X did not perform a re-evaluation and therefore was ill-prepared to assess how his patient was responding to care, aside from the spurious evaluation of activity limitations. Nonetheless, his updated assessment for nearly all of the original diagnoses was stated as follows: "Today's examination reveals improvement in this condition." This assessment applied not only to conditions which were to be treated but also to those for which treatment was deferred such as the three cervical strain or sprain diagnoses, cervical neuritis/radiculitis, and the space occupying lesion. On the list of diagnoses in the re-evaluation report, lumbosacral neuritis/radiculitis is listed three times. The statement, "Today's examination revealed no change in the status of this condition," appears after the first two entries. Following the third entry there is the following statement: "Today's examination reveals improvement in this condition." The obvious contradiction here typifies the overall senselessness of Dr. X's documentation.

The updated treatment plan on 3/10/2010 was very similar to the original one. Treatment was again deferred for all the same conditions except for the lumbar and cervical strains which were to be treated with ultrasound. Treatment for some of the "late effect strain" diagnoses was changed from ultrasound to massage therapy, although the scalene strain would continue to be treated with ultrasound. Dr. X did not offer any rationale for the treatment modifications.

One additional treatment was documented following the 3/10/2010 re-evaluation. This was on 3/12/2010. No changes in subjective or objective findings were reported. Given that this chart entry is, again, a nearly complete duplication of previous treatment notes, it is doubtful that any subjective or objective data was gathered. As with the other chart notes, this one ends with the statement, "The patient responded well to treatment noting improvement following therapy." Presumably, the plan was to continue treating Ms. C, but this is the final patient encounter in the record, and there is no further information in Dr. X's records regarding her status after this date.

The remainder of this complaint summarizes the violations found in Dr. X's records.

811-015-0005 (1): It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.

Dr. X's records of these three patients are far from complete, and their accuracy is doubtful. The past medical history and a review of concurrent health problems and comorbidities are absent from these records. Information regarding subjective complaints falls below minimal standards on almost every chart entry. In the cases of Mr. and Mrs. D, Dr. X's report of their activity limitations must certainly be inaccurate. **Given the very short period of time between the motor vehicle collision and their presentation to Dr. X on the same day, his report of their physical limitations, implicitly attributed to the effects of the accident, is specious. The only alternative is to believe Dr. X's claim that Mrs. D, for example, was injured in an automobile accident after which she participated in a sexual activity, slept, performed yard work, carried groceries, worked on the computer for an extended period of time, performed household chores, lifted children, discovered that each of these activities was limited and/or painful, and then presented to Dr. X for chiropractic treatment, all on the same day.**

The Oregon chiropractic practice and utilization guidelines, in the section titled GOALS AND OBJECTIVES FOR CLINICAL PRACTICE, states that an Oregon chiropractic physician must "elicit a thorough case history" and include within each case history, chief complaint, present health pattern and relevant past health, injury or disability factors." In the section on CHIROPRACTIC DIAGNOSTIC AND TREATMENT PROCEDURES, the chiropractic physician is required to perform an intake interview which includes a history of the presenting illness and the past health history. In the RECORD KEEPING AND REPORT WRITING section, the doctor is required to document the "patient's complaints ... at each visit ... indicating improvement, worsening or no change." Additionally, objective findings are to include "changes in the clinical signs of the condition ... at each visit. ..."

Dr. X's records indicate that none of these requirements were met consistently, and most were never satisfied. None of the reported case histories comes anywhere close to being thorough. The presenting complaints of the three patients were not documented in sufficient detail. (Complaint documentation routinely includes information about the specific location and distribution of the symptoms, their onset, provocative and palliative factors, the quality and severity of the symptoms, radiation of symptoms, and times of day when symptoms are better or worse.) The present health pattern of each patient, i.e., concurrent health problems, possible comorbidities, and medications, was not reported. The past health history, relevant or otherwise, was omitted in all three cases. **The past health history of Mr. and Mrs. D was especially relevant as they were established patients of Dr. X prior to the 6/22/2009 MVC. At the very least, he should have stated reasons for their prior chiropractic care and differentiated their conditions subsequent to the MVC from those treated previously. In the case of Ms. C, her medical history prior to the MVC of 5/21/2009 was entirely ignored, concurrent health problems, comorbidities, and medications were not documented, and, most importantly, her interim history of nearly nine months between the time of the auto accident and her presentation to Dr. X was documented in two brief sentences, omitting highly relevant information regarding diagnostic and treatment procedures, course of care, and her response up to that time.** Dr. X rarely documented any of these patients' complaints at each visit, except to copy some of the information from the initial report and paste it into each subsequent chart note. His notes rarely documented improvement, worsening, or lack of change. He likewise did not document changes in the clinical signs of the condition at each visit. He did not even duplicate the physical examination findings from the first visit; rather, he copied the diagnoses and asserted that the examination findings at each visit were "consistent with those noted in the current treatment plan." In Ms. C's case, he did not perform a re-examination on 3/10/2010 but claimed

that duplicating the original examination findings was tantamount to performing a re-examination. The billing statement for that date of service is not contained in the record I reviewed, but if Dr. X in fact charged for the reevaluation, the charge could be seen as fraudulent.

811-015-0005 (1)(a): Each patient shall have exclusive records which shall be sufficiently detailed and legible as to allow any other Chiropractic physician to understand the nature of that patient's case and to be able to follow up with the care of that patient if necessary.

As should be apparent from the review of each patient's records, above, **Dr. X's documentation is befuddling and confounding. His clinical reasoning often appears deranged. How can a region of the spine be treated with manipulation for one condition, e.g., segmental dysfunction, but treatment of the same region be deferred because of the alleged presence of a different condition, e.g., a space occupying lesion? Further confounding this bizarre reasoning are Dr. X's decisions to defer treatment for benign conditions such as cervical strains and to allow patients to determine when they need treatment for one condition but not for the others. These senseless treatment plans, together with the very poor documentation of the patient's histories and spurious reports of their functional limitations, make it virtually impossible for another chiropractor to understand these cases and assume care of the patients.**

811-015-0005 (1)(b): Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record.

The details have been described above for each of the three patients. Only the first page of each chart entry complies with this requirement.

811-015-0010 (1): Clinical rationale, within accepted standards and understood by a group of peers, must be shown for all opinions, diagnostic and therapeutic procedures.

Dr. X's failure to comply with this administrative rule was partially addressed above with respect to his violation of OAR 811-015-0005 (1)(a). His failure to obtain a complete and accurate history of each patient compromises his ability to provide understandable rationale for his opinions and the recommended diagnostic and therapeutic procedures. **Dr. X's interpretation of certain physical examination findings led him to diagnose conditions that were probably not present and which were not likely indicated by the examination findings.** For example, the presence of palpatory pain, no matter how severe, would not in and of itself indicate the likelihood of a fracture. Even with a history of trauma, this would not be likely in the absence of positive confirmatory tests. Spinous percussion, for example, would be necessary to lead the examiner toward such a conclusion. Information from an active spinal range of motion evaluation would have helped to further assess the likelihood of a fracture, but Dr. X did not perform this routine examination procedure except in isolated instances and in an incomplete manner. In addition, the mechanism of the accident might further inform the clinician of the likelihood of this diagnosis, but Dr. X did not provide a rationale for how the accidents might have resulted in spinal fractures. Dr. X's interpretation of pain with the Valsalva maneuver as indicative of a space occupying lesions, again in the absence of corroborative findings, is another example of his clinical irrationality.

811-015-0010 (2): Accepted standards mean skills and treatment which are recognized as being reasonable, prudent and acceptable under similar conditions and circumstances.

The most obvious violation of this rule is Dr. X's decision to treat these patients with spinal manipulation even though he suspected fractures and tumors or other "space occupying lesions." Even though the presence of these conditions was highly unlikely, Dr. X obviously considered their presence likely enough to have documented them in his records and considered ordering imaging for further evaluation. Thus, **chiropractic manipulation, which would clearly be contraindicated should any of these conditions actually be present, was not a reasonable, prudent, or acceptable treatment. It is also not possible to justify any of the treatment rendered to any of these patients as reasonable, prudent, and acceptable when the**

subjective and objective evaluations were so notably deficient and the doctor's clinical reasoning so muddled.

811-015-0010 (3): All initial examinations and subsequent re-examinations performed by a chiropractor to determine the need for chiropractic treatment of neuro-musculoskeletal conditions shall include a functional chiropractic analysis. Some combination of the ... PARTS exam constitutes a functional chiropractic analysis.

The reevaluation of Ms. C reported by Dr. X to have been performed on 3/10/2010 was apparently not done at all. Dr. X merely copied the results of the 2/9/2010 examination. Thus, a functional chiropractic analysis was not performed when the patient was reevaluated. None of the chart records for any of the patients document a functional chiropractic analysis at any of the visits except for the initial evaluations. Although this rule does not specifically state that such an analysis must be performed prior to every treatment in which spinal adjustments are administered, this same chiropractic functional analysis would have constituted the evaluation and management portion of the service missing from the CMT procedures, as noted in the summary of Ms. C's case.

811-015-0010 (4): Evidence based outcomes management shall determine whether the frequency and duration of curative chiropractic treatment is, has been, or continues to be necessary. Outcomes management shall include both subjective or patient-driven information as well as objective provider-driven information.

The only subjective (patient-driven) outcome measure reported was the rating of functional limitations by inappropriately and erroneously utilizing a visual analog scale. None of the records actually show a visual analog scale or provide a patient-completed form indicating the patient's response. A visual analog scale (VAS) is a 100 millimeters line on which the patient marks a short perpendicular line indicating the degree to which a symptom is perceived. Then the patient's mark is measured and reported in millimeters. Even if Dr. X's numerical method of determining his patients' activity limitations is valid, they did not change at all in the D's cases. In Ms. C's case, there was no significant change. One value increased while the other value decreased. Lack of change in this one and only measure does not justify the continuation of curative chiropractic treatment. No other subjective or objective outcomes, evidence-based or otherwise, were reported.

811-030-0030 (1)(d): Every exposure, including post-treatment exposures, and scanograms, shall have clinical justification with adequate documentation consistent with the patient's case history.

Dr. X's justification for ordering x-ray studies is not apparent. It is not clear why x-ray studies were ordered for Mr. D and Ms. C but not for Mrs. D. The physical examination findings were not so distinctly different to suggest that Mr. D and Ms. C required radiographic evaluations but Mrs. D did not. Furthermore, the (apparently spurious) findings which suggested fractures and space occupying lesions to Dr. X were not sufficient justification to order radiographic imaging ("deferred pending treatment results"), but imaging studies were performed for more obscure reasons. In Ms. C's case, there appears to have been no reason whatsoever to order imaging, at least until Dr. X had obtained the results of prior imaging studies, but there is no indication that he even considered doing this.

811-035-0005 (1): The health and welfare of the patient shall always be the first priority of Chiropractic physicians. ...

The incomplete evaluations and the nearly complete absence of clinical reasoning, the erroneous and far-fetched interpretations of some of the examination findings, together with Dr. X's senseless clinical decisions concerning imaging studies and treatment clearly put the health and welfare of his patients in jeopardy. These patients are fortunate that they did not actually have serious or life-threatening conditions, or the outcomes of Dr. X's treatments could have been quite grave.

811-035-0005 (2): The patient has the right to informed consent regarding examination, therapy and treatment procedures, risks and alternatives, and answers to questions with respect to the examination, therapy and treatment procedures, in terms that they can be reasonably expected to understand.

Violations of this rule have been identified in the discussions of each patient's records, above. There is no documentation that Dr. X obtained informed consent from any of these patients.

684.100 (1)(f)(A) Any conduct or practice contrary to recognized standard of ethics of the chiropractic profession or any conduct or practice that does or might constitute a danger to the health or safety of a patient or the public. ...

811-035-0015: Unprofessional conduct means any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established.

This complaint has highlighted repeated instances which demonstrate that Dr. X's conduct and professional practice patterns fail to conform to minimal standards of acceptable chiropractic practice. His records document willful or careless disregard for the health, welfare, and safety of his patients. His conduct and practice behaviors hold great potential for harm to the public.

811-035-0015 (5): Charging a patient for services not rendered.

811-035-0015 (12): Perpetuating fraud upon patients or third party payors, relating to the practice of chiropractic.

Billing for services not rendered constitutes fraud. Every time Dr. X charged for CMT services, with the exception of the first visits for each of the three patients, he charged for services not rendered, i.e., the evaluation and management (or functional chiropractic analysis) portion of the CMT service. Assuming a fee was charged for Ms. C's re-evaluation on 3/10/2010, the fee would be fraudulent because a re-evaluation was not performed.

684.100 (1)(q): Gross incompetency or gross negligence.

I submit that **Dr. X's records constitute clear documentation of gross incompetency** in the practice of chiropractic. His failure to obtain an appropriate medical history, report relevant prior medical history, and perform timely and appropriate evaluations to update his assessments of these patients are egregious in and of themselves. However, his **misinterpretation of physical examination findings resulting in specious recommendations and follow-up procedures based on the mistaken interpretations are errors that would not be tolerated even in the training of chiropractic interns, much less in a doctor who has practiced for as many decades as Dr. X.**

Additional comments:

1. Many of Dr. X's mistakes may have resulted from his record-keeping software. It seems likely that the software is programmed to make certain diagnoses and recommend further diagnostic procedures in response to specific conditions determined by history and physical examination findings. One might be tempted to excuse Dr. X's apparent errors of judgment, attributing them instead to programming errors and poorly functioning software. However, Dr. X is himself responsible for all inaccuracies and mistakes generated by the software. The records are entirely his product and he is responsible for their content, erroneous or otherwise. Dr. X affixed his electronic signature to them. We must therefore assume that he read these records and, whether or not he recognized their inherent errors, endorsed them as the immutable record of his clinical procedures and judgments.

2. Dr. X's records do not accompany this complaint because the Board SI [is - *jmb, February 20, 2012*] already in possession of those records. They were reviewed as part of the investigation of OBCE case numbers 2010-1008, 2010-1009, and 2010-1027.

3. I find it shameful that **five chiropractic members of the Oregon Board of Chiropractic Examiners reviewed these records and were either unconcerned about the radical deviations from the standard of care documented therein or failed entirely to notice them.**

IME Abuse: A Plan for an End

from The American Chiropractor, http://www.theamericanchiropractor.com/articles-special-feature/5830-ime-abuse-a-plan-for-an-end.html

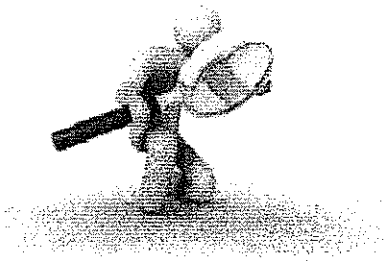
Special Feature

Written by Mark Studin, D.C., F.A.S.B.E.(C), D.A.A.P.M., D.A.A.P.L.M.

Tuesday, 23 August 2011 22:57

This magazine is mailed to more than 50,000 chiropractors. The author of this article makes erroneous statements about IMEs which reinforce misconceptions held by many chiropractors. He advocates filing complaints with state regulatory boards when the treating chiropractor disagrees with the IME doctor's opinions.

An independent medical examination (IME) is performed by a doctor that has not previously been involved in the treatment of a given patient. Historically, they become involved in the case because of a request by an insurance company and are provided by an independent company retained by the insurance carrier. This allows for a level of insulation between the carrier and the IME doctor, as the carrier can now claim they did not perform any evaluations.



Upon receipt of the complaint, the state is [illegible] and [illegible] on the offending doctor.

In a perfect world, the IME doctor renders a second opinion that allows for necessary care of covered issues of injured patients. However, in the real world, an IME doctor rarely gives an opinion that is in the best interest of the patient. In my 30 years of experience as a practicing doctor, a medical consultant, a medical-legal consultant that speaks to doctors in 46 different states and a former IME doctor, I have witnessed that the truth is usually not told by the IME doctor. The IME opinion usually sides with who writes the paycheck and, as the adage goes, it's always about the money!

IME abuse has gone mostly unchecked, because both the patient and the treating doctor have allowed it to for too many unacceptable reasons. Regardless of the past, the time to correct the problem is now and the following is one person's opinion.

When your patient has an IME, suggest that he/she bring a friend who goes into the examination room during the examination. Filming is fine, but a witness will ensure a less hostile environment and, in my experience, will never be denied access upon your request. After the IME, either you, as assignee of benefits, or the patient must request a copy of the IME report. Upon receipt of the IME report, sit with the patient and review everything the IME doctor documented having done.

Explain how a Foraminal Compression test or a Lasegue's test is performed and ask, "Did the doctor perform this test?" Should the doctor have documented doing so, but not performed the test, a VERY common occurrence, the IME doctor lied. In legal terms, the IME perjured him/herself and needs to be brought to justice. You have to remember that the only reason the doctor did this was to make money with complete disregard for the welfare of your patient.

Inform your patient of his/her right to render a complaint against the doctor's license and direct him/her to the website of your state professional conduct board. On that site is a complaint form against the doctor's license. I have previously informed the patient that if he/she chooses to render a complaint, he/she should also state that a witness was in the room, so that it is not the doctor's word against his/hers. (Note: This wasn't done against the treating doctor, so you have no complaint.) In my experience, almost 100% of patients chose to render a complaint.

Upon receipt of the complaint, the state is obligated to investigate and create a file on the offending doctor. Simultaneously, if your patient has a personal injury or workers compensation case and he/she has legal representation, the patient should send a copy of the complaint to his/her lawyer. This is critical in leveling the playing field in his/her third party case so that the lawyer can present to the carrier and, eventually, the jury to cast doubt on the integrity of the fraudulent IME examination and examiner.

The carriers will not be pleased and, should they receive enough complaints against a doctor, they will eventually fire that independent IME company or request that doctor not be used any further. It's always about the money and the best way to ensure removing bad doctors is to hurt their employers financially; losing in court will be a big financial loss.

Another tactic IME doctors utilize is not commenting on testing performed. In every instance, the carrier has copies of all tests performed and, commonly, those tests are not referred to in the report. Part of the time, the IME doctor has a copy of the report or the actual test results and, the balance of the time, the carrier has not forwarded the report to the IME doctor because they realize it will significantly influence the results of the examination. In absence of having all of the results, a doctor cannot accurately report on a condition of a patient and, in many states, licensure boards would consider that misconduct. To do it purposely for personal gain should be criminal. The way to show intent is for numerous complaints to be filed against the same doctor or carrier showing a pattern

of abuse.

Another improper tactic is to retrospectively have an IME performed well after care has ended (6-12 months) with the conclusion that the previous care wasn't necessary. Although I would probably lose my license for treating without a timely history and physical, as I would need a clinical basis for my diagnosis, prognosis and treatment plan, so does any doctor rendering an opinion. Crystal balls were banned from medicine a century ago and only "charlatans" can look far into the past to determine the necessity for care. This is an opinion well after the care was rendered and the patient has healed or the wound has been repaired in the interim. A doctor can render an opinion for the "right now" and even for the recent past (a few weeks ago) to determine if either more care is necessary or if the recent care was necessary, as the current clinical picture is applicable. However, to render an opinion 4, 8 or 12 months into the future is grossly irresponsible and cannot be accurate in the musculoskeletal arena.

I am of the belief that many of these complaints will go without disciplinary action. However, they will begin to create a profile on the offending IME doctor and put the carriers and courts on notice about the integrity of the report, the independent IME contractor and the IME doctor. There are many ways to counteract fraudulent IME examination, but the only way to put an end to it is to remove the funding source for continued abuse. A very real parallel is that, if we removed the funding source for terrorism, we wouldn't have any.

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Dr. Mark Studin is just one voice, a chiropractor seeking to attain 95% of the entire population under chiropractic care in his lifetime. He can be reached at DrMark@TeachDoctors.com or 631-786-4253.

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