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X-ray evaluation: A Clinical Huddle.

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Abstract: Practice Wisdom suggests that the quality of care we provide is enhanced when the intentions of both the doctor and the patient are aligned.

Indexing Terms: chiropractic; intention; patient communication.

Introduction

As a student, intention begins with '*just being able to move a vertebra with a minimal amount of discomfort and distress to the patient.*' The next progression of intention is when the student/doctor is able to FIND the subluxation with a heat sensing device like a Nervo-scope, Delta-T, or similar device and confirming it with their chiropractic examination, EMG and thermal scanning, visualization, static and motion palpation and full spine x-rays. I fully believe that the subluxation MUST be found on the patient with the Nervo-scope/Delta-T and the level of the nerve pressure marked with a BB prior to taking of the full spine x-rays.

> *... chiropractic clinical decision making is complex, however our intentions must be explained in terms the patient understands to encourage an alignment of their intentions for an outcome with our intention of providing care.'*

Then determine the location of the subluxation and the Gonstead listing for correction of the subluxation. This progresses to the student/doctor's intention to move the vertebra, sacrum or ilium in a specific direction determined by the Gonstead listing for correction of the subluxation.

This further progresses as the student/doctor determines which part of the subluxation is the major and which is the minor, thereby making the adjustment more specific for correction of the subluxation. Is the subluxation's worst component the posteriority, determined from the lateral full spine x-ray,

static and motion palpation? Is the worst component the inferiority determined from the lateral full spine x-ray? Does the amount of inferiority of the L5 vertebra preclude adjusting that vertebra (i.e. is the L5 disc angle greater than 20 degrees?)

In that case does the chiropractor have to adjust the base posterior, sacral tubercle, PI, EX, or PIEX to change Ferguson's angle and then the L5 disc angle so the inferiority of the vertebra becomes more manageable? Is the worst component the amount of rotation of the vertebra as seen on the A-P full spine x-ray and confirmed by static and motion palpation? Or finally, is the major component the amount of lateral wedging of the vertebra as visualized on the A-P full spine x-ray and confirmed by visualization, static and motion palpation?

One must then determine which type of adjusting table is best for correcting that particular subluxation listing on that patient given the student/doctor's expertise: Should it be the pelvic bench, hi-lo table, slot table, knee chest table or cervical chair. Remember, you will NOT become proficient in adjusting unless you learn how to use each piece of equipment and that is only accomplished by actually using each one. Body size of the doctor has NO bearing on which table used.

The next phase is to determine which type of adjustment is best for the correction of the subluxation given the patient's age, spinal condition and flexibility and again the student/doctor's level of expertise. Should you use a finger push, thenar contact, pisiform contact, pisiform over thumb, or cervical chair adjustment with the index finger or thumb?

Finally, what is the doctor attempting to accomplish with the adjustment? Are they trying to affect the autonomic nervous system? (i.e. clinically, the sympathetic nervous system C7 to L5 or the parasympathetic nervous system occiput to C6 and sacrum or ilia?) Or is the doctor trying to affect the musculoskeletal system to improve spinal biomechanics (i.e. trying to change the hypo or hyper lordosis of the lumbar spine, change the L5 disc angle or Ferguson's angle, increase or decrease the thoracic kyphosis, or influence the cervical hyperlordosis, straight cervical spine, cervical hypolordosis or cervical kyphosis?) Improving the lateral spinal curves will do a lot to slow down the degenerative/ageing process that is accelerated in the subluxated spine.

Ideally the doctor can find only one bone that is the cause of the major subluxation. Sometimes that is not easy due to the patient having had multiple traumas over their life span or there may be chiropractor caused subluxations.

If the doctor has progressed through all of the above stages of learning, the patient may respond favorably or unfavorably to Gonstead chiropractic care - usually they respond favorably. Maybe the patient has a life style that precludes correction of the subluxation. (i.e. smoking tobacco, vaping, poor diet, over use of alcohol, etc.) Regardless of the outcome of the care, the patient deserves to be monitored by progress re-examinations and re-x-ray.

I find that re-examinations should be done every 10 - 12 adjustments if the patient is on a treatment schedule to determine the progress of the correction of the subluxation. I have found that retaking the A-P and Lateral full spine x-rays after the initial 10 or 12 adjustments is very beneficial. By this time the patient is improving and is not as acute/antalgic as they typically were when chiropractic care was initiated. The chiropractor can see what the patient looks like on the x-ray when they are subacute.

Depending on the findings of the re-examinations the doctor can determine if further care is necessary. I believe the patient should be informed of the outcome of the examination and x-rays so they can make an informed decision as to how they want to live. Contrary to most patients' thinking, HEALTH is not determined by an absence of PAIN.

Lastly what is the goal of the treatment plan? Is it pain relief, improved body function, spinal changes seen on X-ray, or improved health of the patient? I always end my initial consultation

with the patient by asking them what are THEIR goals for care: pain relief, improved body function or improved health and body function? This way the doctor and patient are on the same page regarding what is trying to be accomplished.

When I give my report-of-findings, I preface it by saying '*I understand and respect your goals for care. However, I am obligated to give you my best recommendations for care to get you out of pain as quickly as possible and with as few adjustments as possible. I am also obligated to base my recommendations on how long I anticipate it will take to get the most improvement in your spinal health as quickly as possible*'.

Then I give them their report-of-findings. After I review the results of their examination, the EMG scans and their full spine x-rays, I make my recommendations and we begin adjusting if the patient wants to be adjusted. Remember, the patient decides what they want to accomplish from their care. Too often, the doctor cares more about the patient's health than does the patient.

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In July 24 2021, the Gonstead Clinical Studies Society and Gonstead Methodology presented Dr. Rick Elbert the C.S. Gonstead Lifetime Achievement award for his work promoting Chiropractic and the Gonstead method of Chiropractic adjusting. Dr. Elbert has been in Chiropractic practice for 44 years, the last 10 in Ogden.

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