

DISABILITY MEDICINE

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GUEST EDITORIAL: Our Professional Quest for Certainty

David ButleRitchie, J.D., LL.M., Ph.D.

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Professionals in every field of human concern share what we might call a “domain specific” appreciation of the level of certainty possible within that particular profession. This appreciation is generally shared amongst professionals within each domain. Physicians (perhaps within specialty area) share a sense of certainty, engineers share a different sense of certainty, and lawyers share yet another sense of certainty. These different senses are not universal and absolute in the sense that they can be clearly demarcated and mapped, but are cultural and linguistic artifacts that help define and determine professional coherence within each domain.

These domain specific notions of certainty are characterized in different ways. In some domains, for instance, certainty is delimited by “margin of error.” In others, certainty is proscribed by statistically significant deviations from a predetermined mean. Physicians often evaluate the treatment of patients in relation to the “standard of care within the community.” The domain that I am most knowledgeable about, the law, has its own tolerance for a diminished sense of certainty.

There are two things that all these senses of certainty share. First, they are all embedded into the fabric of the professions of which they are part. The sense of certainty within each domain is passed on as a professional trait through the culture and training within the domain. Second, each of these distinct notions of certainty is defined by their variance from a universal and absolute sense of certainty. That is to say, every domain of human activity allows for, and indeed is defined by, the fact that absolute certainty is not possible. This state of

affairs is widely acknowledged by professionals within each domain, but is infrequently admitted-especially to those outside the domain. Physicians, for example, want to make their treatment decisions seem more certain than they really are to non-physicians. The same can be said for lawyers and other actors in the legal system. These attempts are not problematic if we remind ourselves that terms and characterizations do not cross domains easily.

One really important aid to understanding this fact is a cross-discipline discourse designed to inform and educate professionals about the use of “terms of art” within other domains. In fact, medical professionals (especially those in public health sectors) have long tried to instigate such a dialogue with the public at large and other professionals. Sadly, legal professionals have lagged behind in this respect. Perhaps even sadder still, professionals within the domain of law actively conceal the meanings behind certain conceptual constructs and terms of art. The causes of this are many and varied, but if there is to be a new movement in law-one designed to make it more accessible to the public and to other professionals-such activities must be revealed and discussed. An example of this obfuscation in the context of the law is the use of the term “objectivity” by legal professionals. In my discussion of this, I maintain that the sort of certainty that the term connotes is neither possible, nor expected by professionals in the legal domain. It is my hope that this discussion will spark a more honest and forthright discourse amongst professionals inside the domain of the law, and those who interact with that domain from outside its arcane halls.



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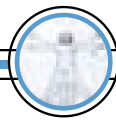
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“ Objectively speaking...” There is no such thing in the law!

David T. ButleRitchie, J.D., LL.M., Ph.D.¹

Introduction

Objectivity is something that is frequently invoked in discussions about the law. This strikes me as odd, however, especially given the nature of law and legal decision-making. In fact, I frequently tell my law students that when an actor in the legal system (a judge, lawyer or witness) drops “objectivity” into a discussion about a legal concept or decision that actor is either trying to slip something by someone, or he simply does not know what he is talking about. This position will seem stark to many, and indeed my first-year students are frequently dismayed at the suggestion that law lacks the sort of objective basis that they presumed before joining the profession. The fear that is frequently expressed relates to the assumption that if there is no objectivity in the law then there can be no reliable basis for legal standards or decisions. In essence, this fear is driven by the belief that law requires a sort of transcendental or absolute certainty that is simply not possible. In what follows I will discuss the proposition that “objectivity” in the law is a chimera (at least in its prevailing usage), and the idea that the lack of objectivity is necessarily problematic. In the end I continue to maintain that objectivity and law are infrequent bedfellows, but suggest that this does not pose any real problem because discourse about law and legal decisions can be sophisticated enough to capture

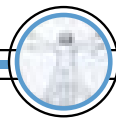
a sense of certainty that is both useful and reliable.

Several things need to be said before I fully address this agenda, however. First, I want to make clear that I do not intend to engage (except to identify in passing) the age-old philosophical quandary of whether there is such a thing as “objectivity” in any sense, and if there is, how human beings- using their faculties of reasoning- can access that objectivity. These are complex questions of epistemology that have plagued the best minds of nearly all philosophical traditions throughout the ages. The various answers to these questions are intriguing, but are not really necessary to accomplish what I hope to do here. I simply intend to discuss the frequent attempts to use objectivity in legal discourse.

Next, I should make clear that in what follows I do not intend to cast aspersions upon those who use “objectivity” (the word, the concept, or both) in discussions about the law. Many, perhaps most, actors within the legal system who attempt to draw on a widely acknowledged notion of objectivity do so out of a good faith desire to capture a sense of certainty that can be universally embraced. A good faith desire is not enough to salvage flawed and misguided assumptions, however. If legal concepts and decisions are not philosophically objective, as I suspect, calling them

“objective” - even if the claim is made with ardent good faith- will not make them so. The implications of this criticism need not be too damning, though. If the position I adopt below is sound it simply follows that actors in the legal system should be more precise about their use of terminology.

Finally, the conclusion that law is not the sort of domain that is amenable to a sense of transcendental objectivity does not lead me to endorse a view that legal standards and decisions are either useless or indefensible. In other words, this is not an argument for legal anarchy. The American legal system works quite well, and the lack of “objectivity” within that system simply does not bother me much. Law is a discursive enterprise, not a science. Tolerance for a sense of certainty that jettisons any hope of transcendental absoluteness, then, is simply par for the course. Indeed, there are some very persuasive arguments in favor of adopting a more pragmatic notion of certainty that does not aspire to a false sense of “objectivity.” One such notion is found in the work of the American philosopher John Dewey. While I will not attempt to give a full treatment of his concept of certainty (for this is not the place for such a treatment), I will discuss how his alternative obviates the need for objectivity in law. A legal system can operate perfectly well without a sense of objectivity. In fact, ours has for centuries. If it is not



necessary for legal concepts and decisions to be objective, then why make the attempt?

Notions of Objectivity

In virtually every area of human concern we seek some sense of certainty. It is, at base, a protective mechanism that allows us to have some confidence in the things we do. The psychology behind this is very complex, but as the history of our intellectual traditions attest, the quest for certainty has been a constant and enduring part of the human condition. In fact, in a real and important way this quest has formed our very notion of being. For most of us, the quest to understand our relationship with the world around us gives us (and perhaps our universe as well) purpose and context. This impulse led to the development of the scientific method, and continues to propel scientists and philosophers, among others, to profound discoveries.

The desire to frame knowledge claims in objective terms is a direct result of this tradition. For us to make wide-sweeping claims about the things we know seems to depend on the ability to objectify those claims or at least that is what we have always been taught. In this section I briefly trace the major philosophical positions on the concept of objectivity. In so doing I will frame these positions in the context of abstract knowledge claims. I do this with a decided sense of resignation, as I believe the discipline of philosophy has frequently been dismissed by those in the scientific community (especially in the practical sciences like medicine) as

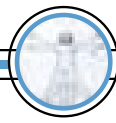
being overly abstract.² Nonetheless, these positions are frequently embedded in the statements of non-philosophers when they make assertions about the objectivity of their knowledge claims.

There are at least three senses in which one can use the term objective,³ although in normal discourse it is often the case that the person making the claim of objectivity would be hard pressed to identify exactly which meaning she is attaching. These three senses of objectivity are: (1) semantic; (2) metaphysical; and (3) logical. Semantic objectivity relates to kinds of statements about objects, and is basically a matter about grammar and usage. When one ascribes a trait to an object in a speech-act he is attempting to assert an objective claim about that object (“the desk is green” or the “cat is black”).⁴ These sorts of claims do not depend on there actually being such an object in the world (i.e., there need be no green desk, etc.), or on our ability to confirm or deny the existence of such an object. These claims are merely language artifacts that carry meaning in the context of conversation. Metaphysical objectivity refers to claims that ascribe some trait to actually existing objects.⁵ If there is such an object in the world, and the traits ascribed to it can be confirmed, then the assertion made is objectively true. This notion of objectivity depends on what is known as a “correspondence theory” of truth. If the traits made in the assertion can be confirmed to correspond to the existential facts, then we can accept the claim as being objective.⁶ Finally, logical objectivism refers to the notion that certain claims can be truth tested

independent of either their semantic construction or their metaphysical correspondence.⁷ These are the sorts of claims to objectivity that logicians and mathematicians make. Collectively, I will refer to these three notions of objectivity as “rigorous epistemic objectivity.”

Much has been written on each of these notions of objectivity. The arguments proffered are, by and large, persuasive and powerful. From a philosophical perspective, then, there are undeniably attractive reasons for embracing some notion of objectivity.⁸ This is particularly the case if one accepts (either tacitly or explicitly) a foundationalist notion of reality. Briefly put, foundationalism refers to the theory of knowledge that maintains that there are indisputable characteristics about the universe from which we can derive objectively true or valid claims. As one can see, each of the above notions of objectivity assumes such a position.

If one rejects the foundationalist assumption (that is, if one were to adopt an anti-foundationalist position, as many so-called postmodern theorists have done), however, then the notions of objectivity mentioned are likewise called into question. Many domains of human endeavor accept the foundationalist presumption. This is especially true of the hard sciences, formal logic, and mathematics. Indeed, there are many fine discussions of the appropriateness of the foundationalist enterprise to domains like science and mathematics.⁹ For my purposes, however, I find such an assumption troubling in the context of law and legal



reasoning. As I mentioned at the outset, I am not entirely certain why the term (the concept, or both) is bandied around so haphazardly in legal discourse.

Objectivity and Law?

Law does not seem much like an “objective” enterprise, and the way in which actors in the legal system make decisions is radically different than the way logicians and mathematicians make decisions. In fact, law is more like the domains of art and literature than the hard sciences. Law is, at base, an interpretative endeavor; one that relies on the standpoint of the individual(s) engaged in the inquiry. It is no wonder, then, that the attempt made by many legal theorists in the nineteenth century to characterize law as a science have fallen into widespread disrepute. Contemporary legal philosophy is populated more by the ideas of literary theorists and cultural critics like Jacques Derrida and Stanley Fish than by epistemologists like Hilary Putnam and Daniel Dennett; and properly so. As a discursive enterprise, law maintains an uneasy association with both foundation- alism and the related concept of objectivity. So why is there still an un-reflective impulse to characterize legal arguments and decisions as objective?

This almost certainly is related to the fact that we have been conditioned to accept a certain amount of subjectivity and indeterminacy in some domains and not in others. At first blush this dichotomy appears reasonable. We might not wish to argue someone’s subjective opinion in the realm of art, say, whereas we might in the domain of

law. The job of judges and legislators does, after all, have a more profound impact on people’s lives than does the typical literary critic; right? That is to say, we might wish to extract subjectivity from areas of human concern such as law because the decisions made there are more important. But this answer seems unsatisfying. Many people believe (perhaps rightfully so) that politics and religion are profoundly important, but we normally accept a good deal of subjectivity and indeterminacy in those domains. Why should we allow subjectivity and indeterminacy in religion and politics and not in law?

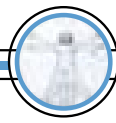
I suspect that the answer is really embedded in the fact that for most laypeople, regardless of their sophistication and mental agility, the law is a mysterious domain that has direct and often immediate existential impact. Indeed, the first assumption that law students have dashed during their first year of law school is the idea that law is simply a set of black letter rules that can be memorized and used in deductive fashion in order to arrive at a conclusion in any particular set of facts. This is disconcerting to them, especially given the divergent range of arguments and opinions they see concerning any one of these so-called rules. Over time, though, they (like others indoctrinated in the legal domain) become more comfortable with the subjectivity and indeterminacy of the law and legal reasoning. The problem, then, is not so much the fact that law is inherently subjective and indeterminant, but that it is popularly

seen as objective and determinant (by non-lawyers).¹⁰

It has been said that all lawyers (but perhaps not all legal theorists) are now legal realists.¹¹ This assertion is meant to convey the idea that experts in the domain of law all recognize that the reasoning process employed by those in the American legal system- and hence, the decisions arrived at by those actors- is not characterized by neutrality and objectivity at all, but is by its very nature informal, evolving and indeterminate. This might be called our “dirty little secret.” In fact, Richard Rorty has rightfully said that this position has been defended by such legal luminaries as Ronald Dworkin, Richard Posner and Roberto Unger,¹² leave a group as ideologically diverse as they are universally recognizable in legal theory circles.

The thread that ties experts in the domain of the law (including such a diverse group of legal theorists) together is their rejection of foundationalism in law and legal reasoning.¹³ This is the heritage of eminent personalities in the law such as Oliver Wendell Holmes, Jr. and Jerome Frank. Holmes, in particular, radically recentered legal discourse from the “scientific” to the “realist,” jettisoning transcendental objectivity and formal logic along the way. In his most famous work, for instance, Holmes said that:

The life of the law has not been logic: it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions or public policy, avowed or unconscious, even the prejudices which judges share with their fellow-men, have had a good deal more to do than the syllogism in determining



the rules by which men should be governed.¹⁴

What relationship does experience, necessity, intuition and prejudice maintain with objectivity and determinacy? According to Holmes, and many who followed him, nothing. I would have to agree.

There is a move, however, amongst some legal theorists to reassert the notions of objectivity and determinacy. Proponents of analytic jurisprudence, most frequently those associated with legal positivism such as (Jules Coleman and Brian Leiter), are disturbed by the anti-foundationalism of legal realism and postmodernism.¹⁵ Theorists behind this reassertion complain that the assault on objectivity undermines faith in the legal system, and that the positions offered by realists and postmoderns is philosophically indefensible on a number of grounds. The philosophical defense of objectivity and determinacy in the context of law is as complex and intractable as the original epistemological propositions. Suffice it to say here, though, that theorists like Coleman and Leiter really do believe that metaphysical objectivity, and the determinacy of decisions that would flow from the ability to base judgments on such objectivity, is not beyond the reach of actors in the legal system. Yet they ultimately modify this position when they discuss distinctly legal reasoning, falling back to a safer position they identify as “modest objectivity.” According to Coleman and Leiter, “[m]odest objectivity allows the possibility that everybody could be wrong about what a rule requires.”¹⁶

They further assert that “according to [their theory of] modest objectivity, what seems right under ‘ideal epistemic conditions’ determines what is right.”¹⁷ They define ‘ideal epistemic conditions’- and here is the rub- as those that are “best for gaining reliable knowledge of something.”¹⁸ I understand this to be a redefinition of the term “objectivity” that admits some considerable measure of error and uncertainty that the strict notions of philosophical objectivity do not. This certainly does not sound like any absolute notion of “objectivity.” They, in short, wish to have their cake and eat it too. By redefining the term objectivity¹⁹ in the context of law to allow for the very things that objectivity is supposed to preclude, the term becomes contentless. If we must construct an argument to retain the notion of objectivity by explaining that we mean “sort of objective,” what is the point? I would suggest that a more prudent and defensible position would be to leave the debate about objectivity (metaphysical or otherwise) to logicians and epistemologists and seek refuge in more serviceable concepts.

Law and Certainty

Holmes was not alone in his position that legal decision-making is not a realm that is well suited to expectations of objectivity and determinacy. In fact, this has become a sort of cottage industry these days. Long before the consternation caused by postmodern attacks on foundationalism in epistemology, though, theorists with more mainstream views on the philosophical tradition of modernity were questioning whether received

notions of knowledge and human cognition were adequate to account for domains like art, literature and law. One such individual is the American pragmatist philosopher and educational theorist John Dewey. In what follows I will briefly explain Dewey’s contribution to the debate concerning legal reasoning, paying special attention to the effect such a contribution might have on the question of objectivity in the law. Ultimately, I believe that Dewey adopts a more sound position vis-à-vis the notion of certainty than actors in the legal system should expect. As one might suspect given the above discussion, this position does not hinge on an epistemologically rigorous notion of objectivity.

John Dewey’s notion of epistemology was, and remains, a radical departure from the tradition of philosophical rationalism. His pragmatist conception of knowledge eschewed the long-standing presumption that human understanding should strive for grounded objectivity. For Dewey, knowledge is a tool that humans use in particular contexts to advance their interests. Law is one such context. Dewey believed that legal reasoning displays what he called the “common structure or pattern of human inquiry.”²⁰ In all human activity, then, we utilize our reasoning abilities in similar ways.²¹ The structure of reason is not (as some may assume) fixed and abstract, however. Dewey parted ways with the rationalist tradition, and adopted a more fluid and practical form of thinking.²² This was fully in line with Dewey’s pragmatist project.



This “common structure or pattern of reasoning” involves several steps which yield a shifting pattern of data that humans can use to determine whether a course of action (or thought) will serve as useful or not.²³ This was Dewey’s most obvious disagreement with the rationalist tradition which insists that there are closed, constant and true forms of intuition and logic that the human mind understands.²⁴ For Dewey, human reasoning is an experimental process of inquiry and reflection.²⁵ Instead of looking into the philosophy of mind as the rationalists had done, Dewey wanted to bring human reason into the light of everyday experience. He said, for instance, that “[t]he search for the pattern of inquiry is . . . not one instituted in the dark or at large. It is checked and controlled by knowledge of the kinds of inquiry that have and that have not worked; methods which . . . can be so compared as to yield reasoned or rational conclusions.”²⁶

This produces a more contingent and mutable form of reasoning. As Richard Rorty puts it, “[t]he natural approach to sentences [which concern the way in which humans reason], Dewey tells us, is not ‘Do they get it right?’, but more like ‘What would it be like to believe that? What would happen if I did? What would I be committing myself to?’”²⁷ The search, then, is not for universal truths, but for “methods which experience up to the present time shows to be the best methods available for achieving certain results . . .”²⁸ This is a significant departure in the field of epistemology. Where traditional epistemologists sought logical constants, Dewey’s quest is more properly

characterized as a way to categorize experience in a useful and practical way.

So in legal matters, like other areas of human intellectual concern such as science and industry, decision-makers are initially presented with an indeterminate situation, some “complicated and confused case” which needs to be addressed.²⁹ In established legal systems this indeterminacy is a legal problem of some sort; such as a dispute that needs to be mediated or a transgression which must be addressed. It is the recognition that there is an indeterminate situation, says Dewey, that is the first step in the inquiry.³⁰ Following this, then, the engagement of the legal process is the beginning of the inquiry, a move which seems reasonable enough.

We do not begin this process of inquiry completely devoid of any and all preconceptions, however. As Dewey said explicitly, “we generally begin with some vague anticipation of a conclusion (or at least of alternative conclusions), and then we look around for principles and data which will substantiate it or which will enable us to choose between rival conclusions.”³¹ This is, after all, the lawyer’s role in the American legal system. According to Dewey:

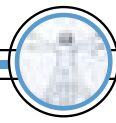
[A lawyer] begins with a conclusion which he intends to reach, favorable to his client of course, and then analyzes the facts of the situation to find material out of which to construct a favorable statement of facts, and to form a minor premise. At the same time he goes over recorded cases to find rules of law employed in cases which can be presented as similar, rules which will

substantiate a certain way of looking at and interpreting the facts.³²

The entire system is set up for an advocate to play the role of making determinant that which is not. The quest is not for objective truth, but for a sense of certainty that makes confused and indeterminate situations more settled and determinate.

For lawyers in the Anglo-American tradition there is a heavy element of partisanship built in here.³³ The process of reasoning employed by actors in the legal system “is too precommitted to the establishment of a particular and partisan conclusion . . .”³⁴ The vague conclusion that Dewey referred to here is largely determined by the outcome which will be most favorable to the particular lawyer’s client in the context of the legal problem faced. For judicial decision-makers, though, partisanship is to play no role, at least not officially.³⁵

Largely based on the preconceptions as to probable (or at least possible) outcomes mentioned above, legal decision-makers begin to grapple further with the indeterminacy by framing the legal issue or issues involved into a category that we recognize, and which is at the same time favorable to the vague conclusions originally embraced. As Dewey said, the “way in which a problem is conceived decides what specific suggestions are entertained and which are dismissed . . .”³⁶ The way in which a legal issue is initially drawn, then, very often determines the outcome of the case, as this framing will likely decide which law controls.³⁷ Statutes and codes apply to facts, and the way in



which the facts in any given case are arranged (some might say massaged) will determine the statutory or code provisions that will apply. More often than not the party which prevails is the one that arranged their facts in the most finely tuned fashion, thus availing themselves of the most favorable law.³⁸

Where several intermediate issues must be resolved before the ultimate issue can be addressed adequately, this process of framing issues in recognized categories and applying relevant determinate provisions will take place serially until the ultimate issue is sufficiently resolved.³⁹ Dewey's experimental logic is a progressive inquiry which concludes in a judgement that has "direct existential import."⁴⁰ The rendering of a judicial decision is perhaps the paradigm of just such a culmination. The deliberations and procedures followed at trial (concerning, for example, what evidence will be admitted, whose version of the applicable law will be adopted, and so on) are the intermediate steps in the progression of partial determinacies.⁴¹ This process ends, as we might expect, in the case of being disposed of through final judgment.⁴² These sorts of judgments are not objective in the absolute sense, but are certain. It is this alternative sense of certainty, one that does not hinge upon an absolute or foundationalist conception of objectivity, that serves actors in the legal system quite well.

Dewey goes into detail about the particular aspects of experimental logic and its application to the sphere of legal reasoning not because he thinks it

necessary to persuade legal decision-makers to change their reasoning, but because he believes that they already act in this way yet maintain a fiction in order to conceal it from the public at large.⁴³ This fiction is expressed in the idea that legal decisions must be "objective" in the strict epistemological sense. Often, this fiction is employed when judges suggest that their decisions are made according to formal rules of logic which are syllogistic in form.⁴⁴ Dewey says, for example, that "the [logic] which has had greatest historic currency and exercised greatest influence on legal decisions, is that of the syllogism."⁴⁵ This currency, however, is a façade. He says further, for example, that this logic "claims to be a logic of fixed forms, rather than of methods of reaching intelligent decisions in concrete situations, or of methods employed in adjusting disputed issues in behalf of the public and enduring interest."⁴⁶ This is what sets Dewey's pragmatic epistemology apart from the absolute notions of objectivity which proponents of traditional epistemology advance.

For Dewey, certainty in domains like the law is built around a reasoning process that yields reasonable (and perhaps well-reasoned) opinions about confused and contested issues. Indeterminacies are clarified, and resolutions are reached. We can call these resolutions determinant in the sense that the process of reasoning is made manifest and can be both substantiated and communicated to those who are impacted by the opinion.

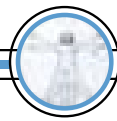
These are the legitimating functions, verifiability and communication. The

success of an inquiry in this alternative view is not based on correspondence with absolute truth, but is determined by whether the process has fostered a supportable conclusion that is communicated to members of the community (here, lawyers, judges, etc.), who can integrate that conclusion into the body of knowledge we call the law.

Understanding this about the law is vitally important, especially for those who have intermittent contact with the legal domain. This is particularly valuable advice for expert witnesses, for instance. When actors in the legal system discuss the certainty of someone's belief they do so on this scale, not on the scale of absoluteness that epistemologists might hope for, or the lay-public might suspect. This is why, to mention one obvious example, juries are not required to be absolutely certain about the guilt of a defendant in a criminal trial. This diminished expectation regarding the level of certainty we are comfortable with in the legal domain should not bother us. Law and legal decision-making share more in common with making sausage than with determining the square root of pi. Once we all accept this, we stand in a better position to discuss those things that actually matter (i.e., the facts, the law, and the policies behind the law).

Conclusions

The desire for some sense of consistency and uniformity in a domain like the law is natural enough. We would all like to think that legal decisions are not subject to whim and caprice, and that the law is neutral and detached from the views of



those who have the power to change lives. Consistency and uniformity do not require the adoption of a strict sense of epistemic objectivity, however. Sound legal reasoning is possible without the concept of objectivity, and neutrality is a charade. The discursive nature of legal reasoning precludes the sort of certainty that traditional notions of objectivity attempt to capture. Experts in the law understand this. Actors in the legal system accept the fact that there is a certain level of subjectivity and indeterminacy in every legal decision. The confusion really arises when the appearance of “objectivity” is perpetuated.

I have argued throughout this article that jettisoning the façade of objectivity in legal reasoning is not only necessary, but would ultimately contribute positively to the development of a more rigorous and comprehensive discourse about the law. Legal reasoning, and the decisions that flow from that reasoning, is a domain specific inquiry that seeks to address specific problems in specific situations. Consistency is important, to be sure, but the sort of foundational conception of certainty that traditional notions of objectivity attempt to convey is simply not possible in the law. Likewise, a certain level of detachment from the decisions made in legal contexts makes sense. The image of the wise neutral judge, however, is a myth. As Holmes said, judges share prejudices and biases with their fellows. Perpetuating these myths do not help us come to better legal conclusions, or make the system operate better or more efficiently. The notion of objectivity that many cling to obscures the true nature

of legal decision-making. Whenever such an important human endeavor is purposefully distorted we should wonder why, and be careful to ensure that we are not complicit in the perpetuation of that distortion.

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1. Associate Professor of Law, Appalachian School of Law, Grundy, Virginia. Thanks to Kirsten ButleRitchie and James McGrath for their comments on drafts of this paper. Thanks also to Michelle Talbott for her excellent editorial suggestions.
2. I ultimately accept this criticism, as I tend to think that abstract knowledge claims about objectivity have little-if any-currency in domains like law and policy.
3. For an excellent, and much more detailed, discussion of this see Andrei Marmor, “Three Concepts of Objectivity,” in Andrei Marmor, *Law and Interpretation: Essays in Legal Philosophy* (Oxford: Clarendon Press 1997), pp. 177 - 201.
4. *Ibid.*
5. *Ibid.*
6. There is also a relation to the concept of metaphysical realism here, but the details of that relationship are not necessary to our discussion. For more on this see, *Ibid.*, at pp. 183 - 184.
7. *Ibid.* at pp. 185 - 189.
8. Whether or not any particular person accepts the arguments offered in support of a certain notion of objectivity.
9. See, for instance, Jonathan Dancy, *Introduction to Contemporary Epistemology* (Oxford: Oxford Press 1985).
10. The reasons for this are manifold, but two important ones are the fact that individuals in the legal system desire this appearance of objectivity, and the fact that many of our cultural artifacts (literature, movies, and television for instance) reinscribe this appearance over and over and over. These may, in fact, be related, but this question is undoubtedly beyond the scope of this discussion.
11. Brian Bix, *Jurisprudence: Theory and Context 3rd ed.* (Durham: Carolina Academic Press 2004), p. 177.
12. Richard Rorty, *Philosophy and Social Hope* (New York: Penguin Books, 1999), pp. 93-94.
13. *Ibid.*; See also Bix, at pp. 177-186.
14. Oliver Wendell Holmes, Jr., *The Common Law* (Boston: Little Brown 1963), p. 5.
15. See Jules Coleman and Brian Leiter, “Determinacy, Objectivity, and Authority,” in Andrei Marmor, *Law and Interpretation: Essays in Legal Philosophy* (Oxford: Clarendon Press 1997) pp. 202 - 278.
16. *Ibid.*, p. 263.
17. *Ibid.*
18. *Ibid.*
19. I would point out, in passing, that this is one of the most frequent, and avowedly critical, complaints that analytic philosophers level at post-modernists. It appears, however that those who attempt to impose analytic rigor are as amenable as anyone to redefining terms to fit their purposes.
20. John Dewey, *Logic: The Theory of Inquiry* (1938), found in John Dewey, *The Later Works, 1925 - 1953*, Vol. 12 (Carbondale: Southern Illinois Press 1991), p. 105 [Hereinafter “Logic: The Theory of Inquiry”].
21. *Ibid.*
22. *Logic: The Theory of Inquiry*, Chapter 1; See also, Richard Rorty, *Consequences of Pragmatism* (Minneapolis: Univ. of Minnesota Press 1982), p. 161.
23. *Logic: The Theory of Inquiry*, 108.
24. See, for example, Immanuel Kant, *Critique of Pure Reason*, Trans. Norman Kemp Smith (London: Palgrave 2003).
25. *Logic: The Theory of Inquiry*, Chapter 6; John Dewey, *How We Think* (Amherst, N.Y.: Prometheus Books 1991), Chapter 6.
26. *Logic: The Theory of Inquiry*, 108.
27. Rorty, *Consequences of Pragmatism*, p. 163.
28. *Logic: The Theory of Inquiry*, 108.
29. John Dewey, “Logical Method and Law,” *Cornell Law Review*, Vol 10 (1924-25), pp. 17 - 27, p 23 [Hereinafter “Logical Method and Law”].
30. *Logic: The Theory of Inquiry*, pp. 105 - 106.
31. *Logical Method and Law*, p. 23.
32. *Logical Method and Law*, p. 23.
33. *Ibid.*
34. *Ibid.*
35. This is a related misconception about “objectivity” that the concept captures the ideal that judges should be neutral and detached. This conclusion seems as unsound as the assumption that legal decisions can be objectively true.
36. *Logic: The Theory of Inquiry*, p. 112.
37. See, e.g., *Logical Method and Law*, p. 23.
38. *Ibid.*, pp. 23 - 27.
39. *Ibid.*
40. *Logic: The Theory of Inquiry*, pp. 108 & 123.
41. *Ibid.*
42. *Ibid.*
43. *Logical Method and Law*, pp. 18 - 20.
44. *Ibid.*, 21.
45. *Ibid.*
46. *Ibid.*



IIB or NOT IIB? (THAT'S THE QUESTION

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Impairment Evaluation and Rating is usually the first step in determining disability resulting from claims of personal injuries.⁶ The medical examiner in such cases is asked to describe the nature and extent of physical impairment as objectively as possible. The AMA Guides (now in its 5th Edition) has become the “ gold standard” for impairment rating under workers’ compensation systems not only in the United States but also in Asia Pacific and other parts of the industrialized world.¹³

Range of motion method/model has been used to rate spinal impairment since the inception of the AMA Guides to the Evaluation of Permanent Impairment.^{1,2,3} The concept of using range of motion measurement to rate permanent impairment from neck and back injuries was further refined in the earlier edition of the AMA Guides in the form of range of motion model.⁴

In this regard it should be noted that even though range of motion method has been employed to rate permanent impairment from injuries and disorders of the spine since the inception of the AMA Guides, the organization of the model in its current form i.e. the three components (range of motion measurement, neurologic deficit if any,

and specific disorders of the spine table) did not come about until the 3rd edition of the AMA Guides in 1984.

The Range of motion Model describes 3 components to include range of motion deficit, neurologic deficit and diagnostic criteria in the form of a specific spine disorder table. For example, for the lumbar spine impairment rating, inclinometer measurements of lumbar flexion, extension and lateral bending are entered into various tables and converted to a whole person impairment percentage. Additionally impairment estimates from any neurologic deficits in the peripheral nerves measured by motor or sensory loss is combined with the measured reduced ranges of motion impairments. Finally, the third component of range of motion model the “ specific spine disorders” (table 75 on page 113 of 4th edition and table 15-7, page 404 in the 5th edition of the AMA Guides) is used to assign an impairment to be combined with the result from the other 2 components of the model.

The specific spine disorder table has 4 sections, I through IV, for various spine disorders. Section I represents spine disorder related to fractures with subsections A, B, and C representing various percentage of impairment of the

whole person for severity of spine disorder resulting from various vertebral fractures and dislocations in relevant spinal regions. The section II, via it’s various subsections A through G provides percentage of impairment of the whole person for various spine disorders resulting from intervertebral disc and related soft tissue lesions. Section III provides impairment recommendation for unoperated spondylolysis and spondylolisthesis and Section IV does the same for operated specific spine disorders resulting from a spinal stenosis, segmental instability, fracture or dislocation.

In the context of rating spinal impairment resulting from injuries, which is almost always the case in workers’ compensation claims¹³, the 4th edition of the AMA Guide all but excludes the use of range of motion model by recommending the exclusive use of the “ injury model” a.k.a. DRE (Diagnostic Related Estimates) model. Under the scheme of the AMA 4th, all of spinal injuries must be rated under the DRE, and range of motion model should be used when there is no injury or as a differentiator to assign a DRE category when there is a dispute between the two categories. The DRE method is based on eight different categories, which has



their own classification scheme based on clinical findings or inclusion criteria.

However, the AMA Guides 5th edition⁶ has restricted the use of DRE model (renamed DRE method in the 5th edition) and thereby liberalized the use of the range of motion model. Readers are referred to section 15.8 of the AMA Guides 5th edition page 398 to see the six situations where the range of motion method is appropriate in rating spinal impairment. Some jurisdictions have mandated the use of range of motion model (method) by judicial decisions¹⁴, the multiple potential sources of error in impairment estimates based on the range of motion method, not withstanding.

In addition to the main source of error of the ROM model i.e. the inaccurately low and inconsistent range of motion measurement leading to the inaccurate impairment estimates, the misuse of specific spine disorder table (table 75, page 113 in the 4th edition and table 15-7 page 404, 5th ed.) remains problematic and leads to grossly inflated impairment estimates. The main source of misuse is section II of the specific spine disorder table, the intervertebral disc or other soft tissue lesions which for example for a lumbar region unoperated disc lesion under II B is 5% impairment of the whole person. Hence the question: II B or not IIB.

The occasion for misuse of the specific spine disorder table mainly arises when

an evaluator assigns an impairment rating under II B for a lumbosacral or cervical sprain or strain claim.

Assigning impairment from section II of specific spine disorder in claims of strain or sprain of neck and back is inconsistent with the AMA Guides and is largely due to failure to understand the mechanism of such injuries, and the underlying pathology and the natural course of these common low back aches, strains/sprain which in 90% plus instances heal spontaneously and resolve completely in weeks if not months without leaving any permanent sequeli.^{7, 12}

Most claims of neck and back injuries are strain/sprains of soft tissue affecting muscles and surrounding connective tissue.⁸ A great majority of the claims of neck and back strain are result of indirect trauma (i.e. strain/sprain) where a paraspinal muscle has been subject to excessive stretch or tension with some microscopic disruption of fibers.⁹ Macroscopic disruption of paraspinal muscles is indeed rare in indirect trauma of the usual claims of strain/sprain. Both animal and human research documents a rapid healing of even partially torn muscles with rapid return to normal functions.^{10, 11}

Contraction induced injuries (strain/sprain type) to the muscles have been shown to fully recover within a couple of weeks.¹¹ This being the case there should never be an occasion to use section II B of the specific spine disorder

table to assign an impairment for neck and back strain/sprain claims because the footnote of the specific spine disorder table states that this section applies only if a permanent impairment exists which is at least partially due to the condition being evaluated.

The author has observed that, evaluators misusing the specific spine disorder table often rely on degenerative changes found on the imaging studies. The peer reviewed scientific literature is quite clear that this degeneration is part of aging. By age 30, most people have early degenerative changes; by age 50, everyone does.⁸ Thus, as such disc degeneration is normal and this degeneration is not a traumatic event but rather a slow development over years and decades.¹² Indirect trauma (strain/sprain) to neck and back can temporarily exacerbate symptoms of degeneration but unless it is so severe that it disrupts the integrity of the motion segment, the symptomatic exacerbation lasts for a few weeks to a month only.⁸

Peer reviewed scientific literature is replete with data documenting the high prevalence (greater than 50%) of disc bulges, disc protrusions and frank herniations found on the imaging of the lumbar spine in people without back problems⁶ (i.e. normal population). Therefore unless an injury to the back is so severe that it disrupts the integrity of motion segment and surrounding



supporting ligaments (which is highly improbable to occur from indirect trauma i.e. neck and back strain/sprain claims), it is improbable to cause any disc related soft tissue injury. Only violent trauma, such as a direct hit to the spine (in a motor vehicle accident) or a fall from a height is likely to fracture the normal spine or disrupt a motion segment integrity¹⁵. The strain/sprain of neck and back does not cause or contribute to the normal aging degenerative disease of the spine nor do they result in any permanent changes at the spinal level.^{12, 15} Therefore it is inappropriate to use Section II of spine disorder table of ROM model to estimate impairment in neck and back strain/sprain claims.

Finally, the use of specific spine disorder table section II B to add additional impairment for strain/sprain type claims of injuries to neck and back is inappropriate and inconsistent with the AMA Guides because these are indirect trauma to muscle and are not specific spine disorders. As can be seen, the section II of specific spine disorder is restricted for its use of intervertebral disc or other soft tissue lesion specific to the disc. Strain/sprain is not a specific spine disorder. The underlying premise of section II is intervertebral disc and the soft tissue of the motion segment i.e. spinous ligament and not paraspinal muscles, the strain of which is the underlying pathology in indirect trauma of strain/sprain of neck and back.

As stated earlier, the mechanism of injury caused by excessive stretch or tension from strain/sprain does not cause any injury to the underlying motion segment and its surrounding soft tissue i.e. ligaments. When one looks at the context of the section II of specific spine disorder, it becomes abundantly clear that this section is clearly limited to specific spine disorders related to intervertebral discs or various soft tissue i.e. ligaments and connective tissues of the joint maintaining the integrity of the motion segment. The paraspinal muscles certainly are not part of the soft tissue related to intervertebral disc. This can be further inferred by the language used in the Section II referring to disease related condition “unoperated on” versus “surgically treated” implying deeper soft tissue as described above rather than the paraspinal muscles. No one operates on paraspinal muscles for strain/sprain.

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Answer Key for CME questions, ABIME Journal Vol. 4, No. 2

The Questions can be found on page 50.

Answers: 1. C, 2. D, 3. D, 4. C, 5. B, 6. A, 7. D, 8. A, 9. A, 10. B

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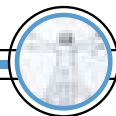
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Preventing Chronic Disability from Low Back Pain

RENAISSANCE PROJECT

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Editor's Note:

Here is an article from the other side of the Atlantic with European perspective on preventing and managing chronic disability from low back pain. Dr. Clement Leech is a member of ABIME advisory board and has been involved with impairment and disability issues relating to spine for number of years. Reader's comments and questions in the form of letter to the Editor are welcome. It is my sincere hope that Dr. Leech's work would generate a good discussion.

Acknowledgements

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Professor Gordon Waddell CBE, Professor Kim Burton and Professor Mansel Aylward CB for their pioneering work in evidence-based back pain research and disability evaluating medicine which inspired me to conceive this project.

The working groups responsible for Occupational Guidelines for the Management of Low Back Pain, Faculty of Occupational Medicine, and the European Guideline for the Management of nonspecific Low Back Pain on which the premise of this project is based.

The Board of the Faculty of Occupational Medicine of the Royal College of Physicians of Ireland and the Council of the European Union of Medicine in Assurance and Social Security (EUMASS) and the Health & Safety Authority who have endorsed the European Guidelines.

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The DSFA's medical staff whose dedicated involvement in the project ensured the highest professional standards.

Minister, Mary Coughlan TD, whose personal interest in reducing chronic disability from low back pain enabled this project to be undertaken.

Renaissance Project

Preventing Chronic Disability from Low Back Pain

1. Introduction

Back pain is not a new phenomenon. Man has suffered from back pain throughout recorded history. There is no evidence that back pain has increased in incidence or severity throughout the

ages. Despite this, however, in Western society, particularly in the past two decades, there has been a marked increase in chronic disability resulting from low back pain. In the hope of arresting, and perhaps, reversing this trend the Renaissance Project was conceived. The conduct, conclusions and recommendations of the project are outlined below.

2. Definitions

Pain The International Association for the Study of Pain defined pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"

Low Back Pain (LBP) is pain in the lumbo-sacral region, buttocks and thighs

Disability The World Health Organisation (WHO) defined disability as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being".

Chronic Disability is disability lasting continuously for a period of 3 months or more.

Diagnostic Triage Diagnostic tool for the differential diagnosis of LBP. See Appendix A for further details.



3. Background

3.1 Problem Identified

Chronic disability, arising from (LBP), is increasing. This trend is common to most industrialised countries and worryingly continues in spite of Health and Safety legislation, improved ergonomic practice, automation and advances in technology and medical science.

In addition to the human suffering involved there are substantial financial implications involving healthcare cost, absenteeism, loss of production, insurance and sickness benefit costs. See Appendix B for increase in numbers and expenditure in social welfare illness-related schemes in Ireland. A proportion of this increase (approximately 27%) is due to musculo-skeletal problems, the majority of which is due to LBP.

This is not solely a medical problem, there are many players involved who need courageously, objectively and critically to reassess their particular roles in the management of low back pain. This presents a challenge to all of the players involved, the main players being:

- General Public, its Attitudes and Beliefs
- Person With LBP
- Medical Profession
- Legal Profession
- Employers
- Unions
- The Health and Safety Authority
- Insurance Industry
- Social Welfare Illness-Related Schemes

3.2 Re-Assessment of Role of Social Welfare Illness-Related Schemes

In facing its challenge the Department of Social and Family Affairs (DSFA) decided to re-assess its particular role in the management of LBP.

In appreciation of the facts that:

- a) while necessary to the maintenance of the integrity of society - by providing income support for those who cannot work - illness benefit schemes can, by their nature, facilitate, reinforce and perpetuate disability,
- b) the longer a person is off work with LBP, the lower their chances of ever returning to work, and
- c) most people with simple LBP are able to return to work despite persistent symptoms, have a better outcome and less chance of re-injury than those who rest and avoid work

the DSFA decided to address the problem in the acute, sub-acute and chronic stages by implementing the Renaissance project, so called, so as to rekindle the Hippocratic Principle '*first, do no harm*'.

The acute phase was considered to be from 0 to 6 weeks, the sub-acute from 6 weeks to 3 months and the chronic for durations in excess of 3 months.

Priority was afforded to the acute stage in the first instance. We would attempt to 'turn off the tap' as it were, rather than 'continuously mop up the floor'.

The sub-acute and chronic stages are to be addressed with job retention, rehabilitation and work re-integration schemes.

4. Aim of Project

The aim of the project was to determine if early intervention, using international evidence-based guidelines in the assessment of claimants with LBP would decrease the incidence of progression to chronic disability. Statements from international guidelines are given in Appendix C.

5. Method

In the period January to June 2003 new Disability Benefit (DB) and Injury Benefit (IB) claimants, aged 20 to 50 years in Dublin and Cork who were certified by their General Practitioners to be suffering from LBP, were targeted for early intervention. Approximately 3,300 new claims were involved. The claims covered in the project areas account for approximately 34% of all new LBP claims for persons aged 20-50 nationwide in 2003.

A control group of cases, similar to those targeted in the project, for the period January to June 2002 was used to make some comparisons with the results of the project.

6. Processing the Targeted Claims

In processing the 3,300 claims in the project the following outcomes occurred.



- As expected, 1,700 claimants (51.5%) returned to work within 4 weeks, of their own volition.
- Approximately 1,600 claimants were selected for early referral and invited to attend for medical assessment at 4 to 6 weeks from date of claim. (Hitherto, referral would have taken a considerably longer period and the illness would have gone beyond the acute stage).
- Interestingly, on receipt of invitation to attend for assessment, a significant proportion of the 1,600 claimants - 1,000 (62.5%) - came off benefit and returned to work.
- The remaining 600 (approximately) were assessed using the 'Diagnostic Triage' system of assessment.

7. Medical Assessments

As part of the project it was necessary to train medical assessors in the use of the Diagnostic Triage which categorises LBP into 3 main groups, to determine management.

The 3 groups are;

1. Simple Back Pain - majority of cases (approximately 95%), prognosis is excellent, with recovery expected in days to weeks.
2. Nerve Root Pain - 3-5% of cases, prognosis is moderate, with recovery expected in weeks to months, only a minority requiring surgery
3. Potential Serious Spinal Pathology - 1-2% of cases, which includes fractures, infections, inflammatory conditions and tumours. Prognosis depends on the diagnosis.

Cases in the Simple Back Pain category were considered for work capacity.

Fitness for work was determined not solely through categorisation as Simple LBP. Medical assessors also took into consideration other relevant factors such as the severity of the symptoms, type of work involved and potential for work restriction or accommodation in the workplace.

Cases in the other categories Nerve Root Pain and Potential Serious Spinal Pathology were considered to be unfit for work for varying periods, depending on the diagnosis.

Detailed records of medical assessments were held for analysis which included a breakdown by gender, work type and age group. See Appendix D.

8. Results

The incidence of progression from the acute Simple LBP to chronic disability employing the method described above was reduced significantly; 64 per cent of the LBP cases assessed under the project were declared capable of work, compared to circa 20 per cent of all claimants with a variety of illnesses, including LBP, who were assessed under the DB/IB schemes in 2002. See Appendix E.

Under the DB/IB schemes where a person is found capable of work s/he can appeal against this finding. When this occurs the person undergoes a second assessment by a different assessor who can find the person

capable or incapable of work. Under the project fewer people appealed against the capable decision than for all DB/IB claims in 2002 (44% versus 61%). Following the second assessment the percentage of people found incapable was 17% under the project. For all DB/IB claims in 2002 the percentage found incapable at the second assessment was 49%. See Appendix F.

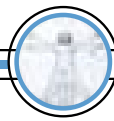
In comparisons with a similar group over a similar period in the previous year (the control group) there was a circa 40% reduction in claims progressing to long duration. See Appendices G and H.

A secondary benefit of the project is that the reduction in duration resulted in a reduction in expenditure on the DB/IB schemes. If the patterns in expenditure in the project were retrospectively applied to expenditure in 2002 the estimated savings that would have occurred in DB/IB expenditure on LBP claims in 2002 are shown in Appendix I.

9. Promoting the Renaissance Project

To assist in the dissemination of the guidelines on which the project is based and to encourage their implementation in other areas the author has:

- made the 'Back Book', published by TSO (the UK Stationery Office), available to DSFA customers and relevant organisations
- obtained commitments from
 - 1) the Board of the Faculty of Occupational Medicine of the Royal College of Physicians of Ireland



- 2) the Health and Safety Authority
 - 3) the Council of the European Union of Medicine in Assurance and Social Security (EUMASS) to endorse the European Guidelines on Best Management of Acute Low Back Pain, to assist in their dissemination and to encourage their implementation
- Made several presentations at conferences nationally and internationally to medical and relevant non-medical audiences
 - Contributed to the media dissemination of the guidelines.

10. Conclusions

The Renaissance Project employing early intervention by the DSFA has resulted in a significant reduction in the progression to chronic disability from simple LBP. The impact of this early intervention in the acute stage should result not only in the improved health of LBP sufferers in the long term but also in decreased health care costs, reduced absenteeism, increased production and significant savings in long-term illness benefit schemes.

11. Recommendation

Whereas, unilateral intervention by the DSFA has proved to be effective in reducing chronic disability from LBP, it is only part of a solution to a multifaceted problem.

Ideally, to sustain and improve the effectiveness of early intervention a coalition of disability managers, mainly

representing those players listed in 3.1 above, needs to be formed. This coalition should implement a universally agreed, evidence-based protocol for best management of LBP.

In this regard some initial progress has been made. The Health and Safety Authority, in association with the DSFA, is to launch a poster campaign to effect a change in the attitudes and beliefs of the general public regarding LBP. This initiative has been endorsed by the majority of the role players.

12. Extending the Practice of Early Intervention.

On account of the results being achieved in the project it was decided to extend beyond June 2003 the processing of LBP cases in the manner described above. This involved the targeting of a further 8,400 cases in Dublin, Cork and Galway. Almost 4,700 of these cases have been referred for assessment and the findings to date have remained consistent with those in the Project. (See Appendix J).

Appendix A

APPENDIX A1: DIAGNOSTIC TRIAGE

LBP is very common, affecting 60-80% of the population at some stage.

Although rarely serious, it can, however, be the presenting symptom of serious spinal disease.

The first priority, therefore, is to distinguish between non serious and potentially serious conditions.

This distinction is essential to determine the management of LBP.

Fundamental to this distinction is the use of Diagnostic Triage.

This diagnostic tool is internationally recognised and recommended.

It is based on detailed history taking and physical examination and designed to differentiate between LBP caused by possible serious spinal pathology, nerve root pain (sciatica) caused usually by disc prolapse (slipped disc) and Simple LBP.

Simple LBP is a term used to describe LBP which is not attributable to possible serious spinal pathology or nerve root pain.

APPENDIX A2: FORMS DESIGNED FOR USE IN PROJECT

The following 3 forms were designed to:

- A. - assist the medical assessors in the differential diagnosis of LBP
- B. - assess the degree, if any, of resulting disability and
- C. - achieve and maintain consistency.



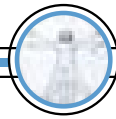
A. Diagnostic Triage

1. SIMPLE LOW BACK PAIN	YES	NO	3. POTENTIAL SERIOUS SPINAL PATHOLOGY	YES	NO
• 20 -55 YRS	<input type="checkbox"/>	<input type="checkbox"/>	• Past history - carcinoma, immune suppression (from use of steroids, or HIV)	<input type="checkbox"/>	<input type="checkbox"/>
• L/S region, buttocks and thighs	<input type="checkbox"/>	<input type="checkbox"/>	• Systemically unwell, weight loss, infection	<input type="checkbox"/>	<input type="checkbox"/>
• Mechanical in nature	<input type="checkbox"/>	<input type="checkbox"/>	• Persisting severe restriction of lumbar flexion	<input type="checkbox"/>	<input type="checkbox"/>
• Patient well	<input type="checkbox"/>	<input type="checkbox"/>	• Widespread neurological signs & symptoms	<input type="checkbox"/>	<input type="checkbox"/>
2. NERVE ROOT PAIN			• Structural deformity	<input type="checkbox"/>	<input type="checkbox"/>
• Unilateral leg pain worse than low back pain	<input type="checkbox"/>	<input type="checkbox"/>	3.1 INFLAMMATORY DISORDERS (Ankylosing spondylitis & related disorders)		
• Radiates generally to foot or toes	<input type="checkbox"/>	<input type="checkbox"/>	• Marked morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>
• Numbness & paraesthesia in same direction	<input type="checkbox"/>	<input type="checkbox"/>	• Persisting limitation of spinal movements	<input type="checkbox"/>	<input type="checkbox"/>
• Nerve irritation signs - SLR restricted	<input type="checkbox"/>	<input type="checkbox"/>	• Peripheral joint involvement	<input type="checkbox"/>	<input type="checkbox"/>
• Nerve compression signs - motor, sensory or reflex changes	<input type="checkbox"/>	<input type="checkbox"/>	• Iritis, skin rashes (psoriasis), colitis, urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
3. POTENTIAL SERIOUS SPINAL PATHOLOGY			• Family history	<input type="checkbox"/>	<input type="checkbox"/>
• Age: onset under 20 or over 55 years	<input type="checkbox"/>	<input type="checkbox"/>	3.2 CAUDA EQUINA SYNDROME		
• Violent trauma relative to age e.g. fall from height in young patient or heavy lift by older person with Osteoporosis could indicate fractures	<input type="checkbox"/>	<input type="checkbox"/>	• Difficulty with micturition	<input type="checkbox"/>	<input type="checkbox"/>
• Constant, progressive non-mechanical pain	<input type="checkbox"/>	<input type="checkbox"/>	• Sphincter disturbance	<input type="checkbox"/>	<input type="checkbox"/>
• Thoracic pain	<input type="checkbox"/>	<input type="checkbox"/>	• Gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
			• Saddle anaesthesia (pelvic area)	<input type="checkbox"/>	<input type="checkbox"/>

B. Disability Assessment: Degrees of Resulting Disability

These degrees are then depicted on the Ability/Disability Profile, which affords a readily visible and reasonably accurate portrait, not only of resulting disability but also and very importantly of, residual functional capacity. The degrees of disability are estimated as follows:

	Normal 0-5%	Mild 5-20%	Moderate 20-50%	Severe 50-75%	Profound 75-100%
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting / Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend / Kneel / Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



C: Medical Report on Back Condition

Surname: _____ **Initials:** _____ **PPS No.** _____

1. Is an appliance worn? _____
(a) Type _____
(b) Has the customer been instructed not to remove it? _____
(c) If not was the appliance removed for the examination? _____

2. (a) Posture _____
(b) Gait _____
(c) Spinal Curve _____
(d) Deformities _____

Is the customer able to:

- (a) Tiptoe? _____
(b) Squat? _____
(c) Kneel? _____

3. Site of any muscle spasm elicited _____

5. Pain (a) Site and nature _____
(b) Direction _____
(c) Site of local tenderness _____

4. Movements (Should never be permitted beyond the limit of comfort) _____
(a) Flexion (Measured to tibial thirds and inches from the floor) _____
(b) Extension _____
(c) Lateral flexion (fingertips in relation to popliteal crease) _____
(d) Rotation _____

7. Is the customer able to touch toes sitting on couch? _____

8. Unassisted straight leg raising (lying down) _____

9. Measurements _____
(a) Thighs (4 inches above upper border of patella) _____
(b) Calves (4 inches below tibial tuberosity) _____

10. Central Nervous System _____
(a) Knee jerks _____
(b) Ankle jerks _____
(c) Plantar responses _____
(d) Sensory disturbance _____
(e) Loss of power of dorsiflexion of hallux _____

11. General observations and or other physical signs not shown above _____



APPENDIX B

Growth in Illness Schemes

The Department of Social and Family Affairs (DSFA) operates various illness-related schemes. These schemes are designed to:

- provide income support for people who, because of illness or injury, are unable to work or are suffering from a major disability or require constant care and attention
- afford compensation to people who are deemed to have suffered a 'loss of faculty' as a result of injury at work or contracting a work-related disease.

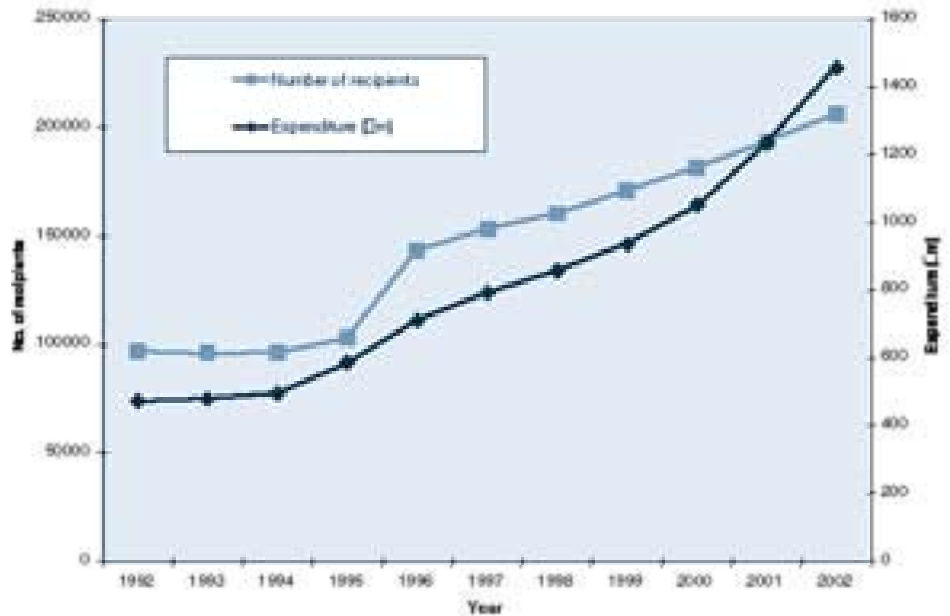
Some schemes are designed to cater for short-term illnesses, others for long-term illnesses or incapacity.

The number of recipients of benefits/ allowances from these schemes has risen from 100,000 in 1992 to 206,137 in 2003.

The sharp increase in 1995 was due to the transfer of approximately 38,000 recipients of Disabled Person's Maintenance allowance (DPMA) from the Department of Health to the DSFA, following its transfer the DPMA was renamed the Disability Allowance (DA).

As expected, the trend in expenditure follows the trend in numbers.

Table B; Number of Recipients and Expenditure on Illness Related Schemes, 1992 - 2002



APPENDIX C

Statements from International Guidelines for Management of LBP

The following are some of the evidence based statements derived from research and supported by strong evidence ***, that is, generally consistent findings in multiple, high quality scientific studies.

*** Most adults (60-80%) experience LBP at some time

*** Care seeking and disability due to LBP depend more on complex individual and work-related psychosocial factors than on physical features or physical demands of work.

*** Most workers with LBP are able to continue working or return to work within a few days or weeks, even if they have some residual or recurrent symptoms, and they do not need to wait until they are completely pain free.

*** The longer a worker is off work with LBP, the lower their chances of ever returning to work. Once a worker is off

work for 4 to 12 weeks, they have a 10 to 40% (depending on the setting) risk of still being off work at one year; after one to two years absence it is unlikely they will return to any form of work in the foreseeable future, irrespective of future treatment.

*** In patients with non-specific LBP, X-rays and MRI findings do not correlate with clinical symptoms or work capacity.

*** Advice to continue ordinary activities of daily living (ADL) as normally as possible despite the pain can give equivalent or faster symptomatic relief, and leads to shorter periods of work loss, fewer recurrences and less work loss over the following year than "traditional medical treatment" (advice to rest and 'let pain be your guide' for return to normal activity).



APPENDIX D

Profile of Persons Medically Assessed During the Renaissance Project

Breakdowns of persons assessed by gender, work type and age group are given in the table below. Of those assessed, the majority were women, though somewhat less so than for DB/IB claims in general. A relatively low share of the total group were in work situations described as 'heavy' by the medical assessors. Finally, persons assessed were somewhat more likely to be in younger age groups than otherwise for DB/IB claims.

Table D; Profile of persons medically assessed under the Renaissance project, January - June 2003; profile of all DBAB claims (persons aged under 50), December 2002

Category	Number of Persons	% of total assessed	All DB/EB claims, Dec. 2002	% of total DB/IB claims
<i>Gender</i>				
Men	216	39.9%	10,980	31.5%
Women	325	60.1%	23,891	68.5%
<i>Work type</i>				
Light	195	36.0%	n.a.	
Moderate	251	46.4%	n.a.	
Heavy	95	17.6%	n.a.	
<i>Age</i>				
20-29	127	23.5%	6,431	18.4%
30-34	112	20.7%	6,663	19.1%
35-39	107	19.8%	7,514	21.5%
40-44	99	18.3%	7,173	20.6%
45-50	96	17.7%	7,090	20.3%
Total assessed	541		34,871	

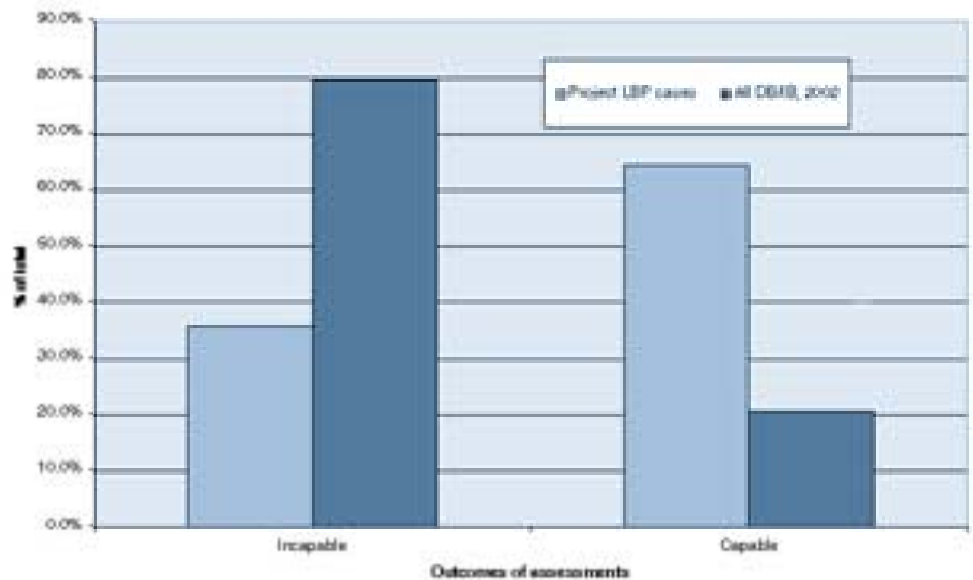
APPENDIX E

Outcomes of Medical Assessments (Project vs All 2002 DB/IB Claims)

For the table below it was not possible to do a comparison with the control group because it was identified retrospectively and detailed medical records had not been held for the claimants in the group. Comparisons had to be made against all types of (DB/IB) claims in 2002.

When claimants attended for assessment, the percentage of claimants found incapable was much lower for LBP cases examined under the project than those assessed in 2002 for all DB/IB illnesses. Conversely the percentage found capable of work was much higher. This pattern is maintained through the appeals procedure. See Appendix F.

Table E; Comparison of outcomes of assessments, all DB/IB in 2002 compared to project LBP cases





APPENDIX F

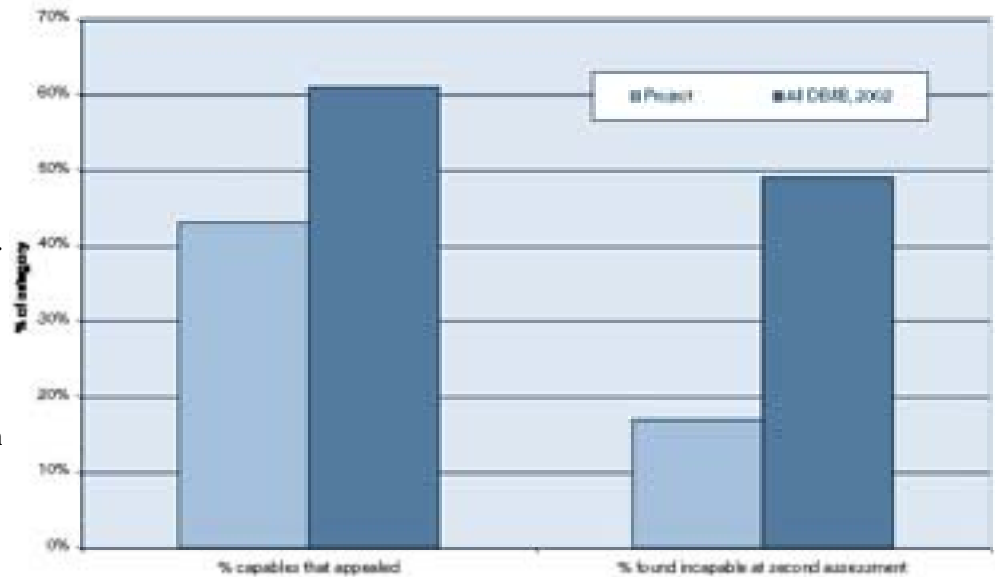
Outcomes for Appeals Cases (Project vs All DB/IB 2002 Claims)

Data similar to that shown in the table below was not available for the Control Group Comparisons had to be made against all types of Disability/ Injury Benefit (DB/IB) claims in 2002.

The rate of appeals as a percentage of persons found capable is much lower under the project than for all DB/IB claims in 2002 (44 per cent vs. 61 per cent).

The pattern of outcomes described in Appendix E is maintained through the appeals procedure, as c. 49 per cent of appeals for all DB/IB claims assessed in 2002 were found incapable at a second assessment compared to 17 per cent of appeals under the project.

Table F; Percentage of capables (i.e., persons fit for work) that appealed and outcomes of appeals assessments, all DB/IB 2002 compared to project cases



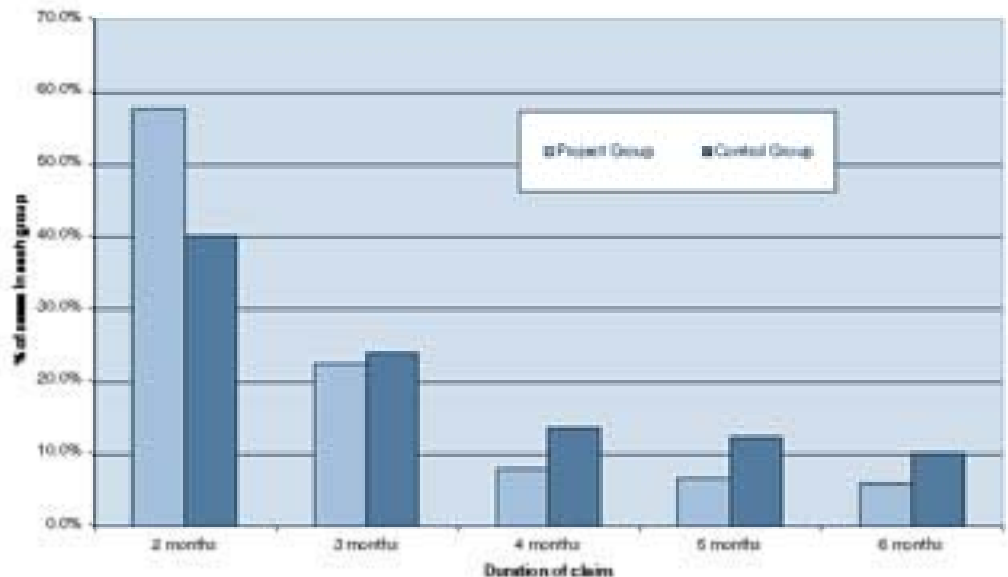
APPENDIX G

Analysis of Claims Duration (Project vs Control)

For this analysis, a cut-off of 4 weeks has been used to compare claim durations for the project and control groups. The reason for this is that early intervention took effect only after 4 weeks. Therefore processing of claims in the first 4 weeks would have been broadly the same as in 2002.

The difference between the duration patterns for the project and control groups is statistically significant according to a chi-square test¹. The fact that there is a reduction in longer duration cases is very significant as these cases tend to become chronic and they could stay on benefit for many years.

Table G; Share of total project and control group cases by duration of claim (claims over 4 weeks duration)





APPENDIX H

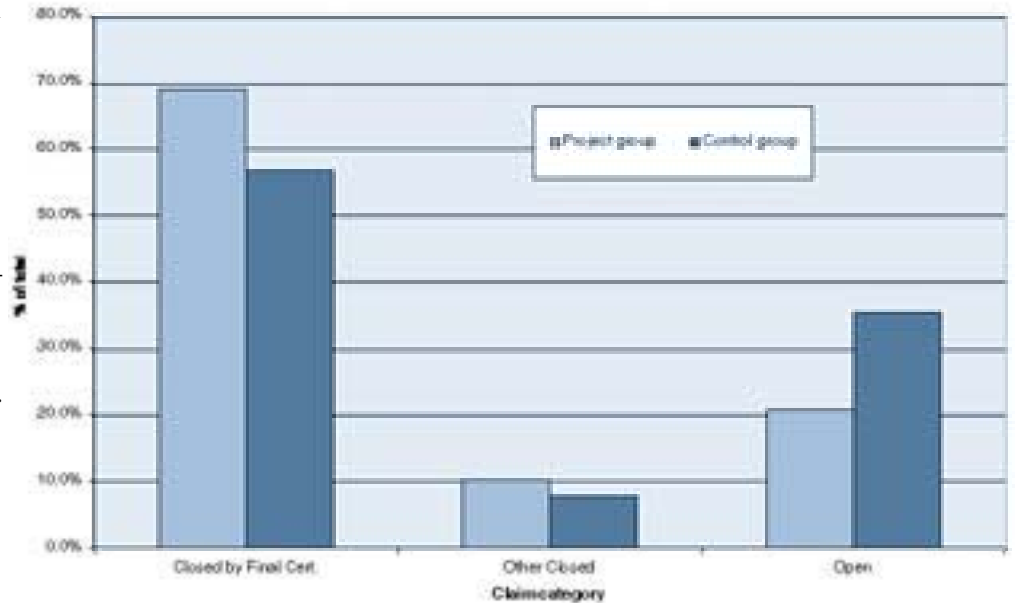
Outcomes of Calls for Assessment (Project vs Control)

Table H below shows how early intervention has an impact on termination of claims through submission of a final medical certificate by the claimant.

The percentage of claimants going off benefit by returning final certificates under project conditions has risen in the project group to 68.9% from 56.8% in the control group, with a corresponding drop in open claims at the end of the project period (to 20.8% in the project from 35.4% in the control group).

For all DB/IB claims (LBP and non-LBP) in 2002 the percentage returning final certificates as a result of being called for assessment was only 9%.

Table H: Breakdown by claim category for LBP claims in Dublin and Cork



APPENDIX I

Estimated Savings from Project

Estimated savings in DB/IB expenditure for the year 2002, based on the findings of the project, for claims of duration up to and including six months, are given in the table below. The figures for expenditure in each of the months shown below are the costs of claims terminating in that month.

Under the heading 'Control group expenditure' the actual expenditure in 2002 is given. This is the amount of Disability Benefit/Injury Benefit paid to claimants.

The heading 'Project expenditure' is estimated by applying to the 2002 expenditure the patterns of claim duration experienced in the Renaissance Project in 2003. This then gives the

Table 1: Breakdown of project expenditure for LBP cases by claim duration, 2002; estimated savings based on evidence from the project

Duration	Control group expenditure, 2002 (C)	Project expenditure (O)	Project savings (O)	% savings
Under 1 month	1,146,158	1,146,158	0	0.0%
Up to 2 months	772,464	1,107,061	-334,597	-43.3%
Up to 3 months	716,422	671,383	45,039	6.3%
Up to 6 months	1,928,825	1,075,914	852,911	44.2%
Total	4,563,869	4,000,516	563,353	12.3%

estimated expenditure in 2002 had the Project been in existence. The savings figure is the difference between the actual and the estimated expenditure in 2002.

These savings are principally due to the reduction in long duration cases.

The reason for increased expenditure for claims terminating in the second month is due to shorter duration of all claims

under the project. (See Appendix G). In the control group such claims would have terminated after 3 or 4 months or perhaps a longer period.

In addition to the above savings, there were administrative savings of approximately €62,000 during the project period.



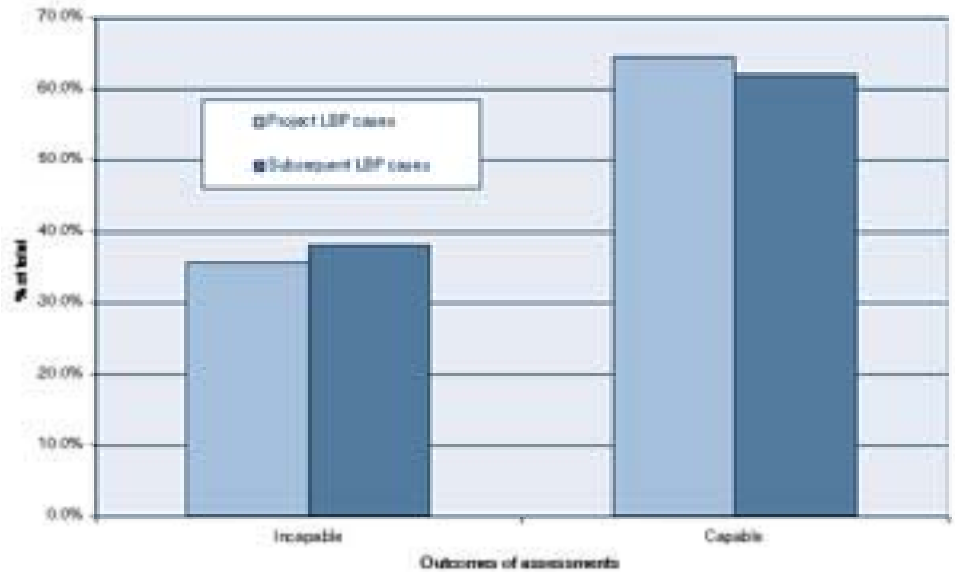
APPENDIX J

Outcomes of Subsequent Medical Assessments Utilising the System Established by the Renaissance Project since June 2003

8,400 claims (to be updated) have been processed under similar conditions to the Renaissance project since June 2003. The following outcomes have been recorded for these cases:

- 4,700 (55.7% - tbc, seems high) returned to work within 4 weeks, of their own volition.
- Approximately 3,700 were selected for early referral and invited to attend for medical assessment at 4 to 6 weeks from date of claim. (Hitherto, referral would have taken a considerably longer period and the illness would have gone beyond the acute stage).
- On receipt of invitation to attend for assessment, a significant proportion of the 3,700 claimants - 2,500 (67.4%) - came off benefit and returned to work.
- The remaining 1,200 (approximately) were assessed using the 'Diagnostic Triage' system of assessment. 594 were found capable for work, 364 were found incapable due to LBP and the remainder were incapable due to other incapacities.

Table J; Comparison of outcomes of assessments, project LBP cases compared subsequent assessed LBP cases



2005 Education and Certification Examination Schedule:

Las Vegas, NV May 20-22

**Chicago, IL
October 21-24**

**San Diego, CA
(exam only) June 13**

**Alexandria, VA
August 12-14**

*Tentative dates/locations at press time,
check our website*

**www.abime.org
for updates**



CASE STUDY

You! Rate the Impairment

Terry J. Beal, M.D.

History

This 36-year-old female was working as a secretary for an insurance agency when she injured her right foot and ankle. She was leaving the office on an errand; fell on a stairwell when she slipped on the stairs.

She was unable to get up or ambulate; and the local Emergency Medical Service took her to the Emergency Department of a community hospital. The on-call orthopaedic surgeon was able to reduce this medial subtalar dislocation of the foot in a closed manner under general anesthesia. Vascularity was not impaired. She was subsequently immobilized in a short-leg walking boot, for several weeks.

It is now eight months after the injury, and she is working full time at her prior job. She complains of pain, swelling of the foot after she has been up and ambulatory for about two hours. She also reports intermittent pain and difficulty in the area of the hind foot when walking on any uneven surface. She has not been able to resume the aerobic exercises, and jogging which she had done in the past.

There is also a persistent burning type sensation in the dorsum of the foot; although this is slowly improving. She does take nonsteroidal anti-inflammatory medication and occasional analgesics at night.

Past Medical History:

There is no prior history of any difficulty with her ankle or foot.

Review of Systems:

This individual did not have any concurrent health problems.

Physical Examination:

On examination of the right ankle, dorsiflexion or extension of the ankle is 8 degrees and there was 25 degrees of plantar flexion. On the measurement of the subtalar joint of the right hind foot, it was virtually fixed in a neutral position. Only a few degrees of inversion or eversion could be measured. There was no instability.

Record Review: On review of the medical records, the attending physician had discussed with this individual the possibility of doing a formal surgical arthrodesis of the subtalar joint because of the persistent symptoms, but nothing was definitely scheduled.

You have been asked by the State Worker's Compensation Bureau for an Independent Medical Evaluation and Impairment Examination.

Questions posed by the examiner include:

1. Is this individual at maximum medical improvement? What about the possibility of further surgical procedure (subtalar arthrodesis)?

2. Your state uses the Guides of Evaluation of Permanent Impairment, Fourth Edition. Which sections of the Guides should be referenced in this situation?
3. What considerations need to be made about the loss of recreational activity such as aerobics, and jogging?
4. Why is the dorsum of the foot symptomatic in this situation?

Discussion:

1. It is felt that this individual is at maximum medical improvement. Although, this individual still takes some medications because of the symptoms in the ankle and hind foot, it is not felt that there would be to be a substantial change in her examination in the future. We have discounted the small possibility that the subtalar joint will be arthrodesed in as much as it is virtually fixed at this point with arthrofibrosis and in neutral position and that has been accounted for in the impairment evaluation. So, it is felt that a formal surgical arthrodesis will not change the impairment rating. We also feel that at this date, since there has not been any formal scheduling of a surgical procedure that the prior discussion will not result in a surgical procedure.
2. Section of the Guides to the Evaluation Of Permanent Impairment, fourth edition that are relevant in this situation include:



A. Section 3.2e (Table #42) indicates the range of motion of this individual's ankles (tibiotalar joint) is equivalent to a 3% impairment of the whole person.

Table 42. Ankle Motion Impairments.

Motion	Whole-person (lower extremity) [foot] impairment		
	Mild: 3% (7%) [10%]	Moderate: 6% (15%) [21%]	Severe: 12% (30%) [43%]
Plantar flexion capability	11°-20°	1°-10°	None
Flexion contracture	—	10°	20°
Extension	10°-0° (neutral)	—	—

B. Section 3.2f (This was used in place of 3.2e-Table #43) Text indicates ankylosis of the subtalar joint is 4% whole person impairment. You felt this was indicated because of the clinical findings and that the tibiocalcaneal and talonavicular joint were involved.

C. With reference to table #68 (3.2k), there is an additional 2% impairment because of the dysesthesia of the superficial peroneal nerve.

Table 68. Impairments from Nerve Deficits.

Nerve	Whole-person (lower extremity) [foot] impairment (%)		
	Motor	Sensory	Dysesthesia
Femoral	15 (37)	1 (2)	3 (7)
Oculomotor	3 (7)	0	0
Superior gluteal	25 (62)	0	0
Inferior gluteal	15 (37)	0	0
Lateral femoral cutaneous	0	1 (2)	3 (7)
Sciatic	30 (75)	7 (17)	5 (12)
Common peroneal	15 (42)	2 (5)	2 (5)
Superficial peroneal	0	2 (5)	2 (5)
Sural	0	1 (2)	2 (5)
Medial plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]
Lateral plantar	2 (5) [7]	2 (5) [7]	2 (5) [7]

Tables from AMA Guides to the Evaluation of Permanent Impairment-4th Ed.

3. Additional allowance for difficulty with recreational activities are not accounted for the the Guides. The Guides recognize the medical records, physical examination and other objective findings.

4. It is recognized that the injury to the sensory aspect of superficial peroneal

nerve can occur in this type of injury and that will explain the ongoing symptoms in the dorsum of the foot.

5. Combining these ratings of impairment, you have calculated that there is 9% impairment of the whole person and this individual has reached maximum medical improvement. Ratings, in this situation, will be the same or the 4th or 5th editions. Your report was submitted four months ago and has not been challenged to date.

Table 17-11 Ankle Motion Impairment Estimates

Motion	Whole Person (Lower Extremity) Foot Impairment		
	Mild 3% (7%) [10%]	Moderate 6% (15%) [21%]	Severe 12% (30%) [43%]
Plantar flexion capability	11°-20°	1°-10°	None
Flexion contracture	—	10°	20°
Extension	10°-0° (neutral)	—	—

Table 17-11 AMA Guides to the Evaluation Permanent Impairment-5th Ed.



Figure 1: Oblique view Rt Ankle: Subluxation of the tibiotalar joint is evident as is misalignment of the midfoot.



Figure 2: AP view of the ankle. The talus is reasonably well positioned in the ankle mortise but the talocalcaneal and talonavicular joints are dislocated.

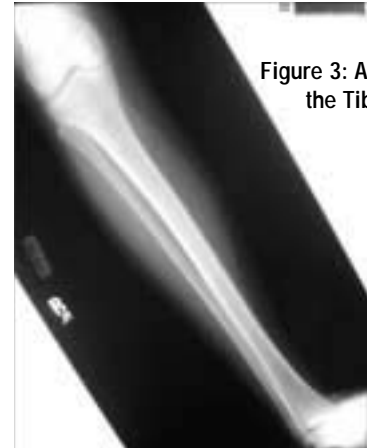


Figure 3: AP X-Ray of the Tibia/fibula.



Figure 4, 5 & 6: Clinical Photo prior to reduction Mechanism Injury: Significant inversion force



Figure 5: Peritalar dislocation involving the talocalcaneal and talonavicular joints



Figure 6: Medial subtalar dislocation most common

Nomenclature:

Peritalar (Subtalar) dislocation= Talocalcaneal and talonavicular dislocations
Total talar dislocation= Tibiotalar and subtalar dislocation



Book Review

The Back Pain Revolution, 2nd Edition 2004

By Prof. Gordon Waddell CBE, DSc, FRCS

Publisher: Church Hill Livingston/Elsevier Science Publishers U.K.

Reviewed by Mohammed I Ranavaya MD, MS, FFOM, FRCPI

Professor Gordon Waddell needs no introduction to the readers of *Disability Medicine*. A generation of doctors has learned "Waddell's signs" during the medical training. In fact I know of no living person after whom a sign or syndrome is named.

In the 2nd Edition of his book, *The Back Pain Revolution*, Professor Waddell makes the case that we really need to rethink the strategies in management of back pain and resulting disability.

Professor Waddell is convinced—and he did a good job of convincing this reader as well that the word revolution in the title of his book is not a hyperbole or exaggeration but rather truly a revolution in our approach to back problems. The name is not only provocative but also a perfectly accurate description of his work.

The book is divided in 21 chapters over 450 pages. There is an excellent introduction in Chapter 1 to the problem, what Professor Waddell calls 20th Century Medical Disaster—Back Pain. The chapter on back pain through history really brings home the message that the current epidemic of back pain related disability essentially is unique to funded societies and in fact back pain has been always with us since the dawn of humanity and is not different today than it was 5000 years ago.

To lay the ground work for his balanced scientific review on the back pain problem, Professor Waddell in Chapter 5, on epidemiology of back pain, Chapter 6, on risk factors for back pain and Chapter 7, on the clinical course of back pain provides a solid and comprehensive account of the basics of the theoretical and methodological underpinning of both the clinical science and psychosocial issues involved with the epidemic of back pain disability.

As an Independent Medical Examiner, rather than an orthopedic surgeon, I found the overview of the epidemiology of back pain, the physical basis of back pain and the discussion in Chapter 10 on illness behavior and Chapter 11 on emotions and Chapter 12 on beliefs about back pain and various social interactions in Chapter 13, particularly useful.

Of special interest throughout the book are those instances where Professor Waddell revisits these basics as applied to the current issues and discusses the scientific literature and weaves these various statistics and facts into a tapestry of practical guidelines for dealing with back pain from all causes. Professor Waddell uses his own lifelong research along with data from the peer reviewed scientific literature to crystallize the concept of the common sense approach to dealing with back pain problems.

After these various introductory chapters Professor Waddell leads us through the key clinical guidelines from various august bodies of science in Chapter 15 and 17.

Perhaps the most interesting discussion in the book is in Chapter 16, *The Information and Advice for Patients*, since it is critical that patients get a straight forward understanding of their problem without much medical jargon to prevent delayed recovery. Earlier in the book, Professor Waddell informs us that much of the back pain disability from common back pain is due to misinformation and misunderstanding of the problem and many doctors without any scientific basis informs their patient with back pain to stop working which leads to needless disability. In Chapter 16, Professor Waddell offers an antidote to that problem.

The Back Pain Revolution also does an excellent job of showing how rehabilitation can be used to enable people to

return to normal activities. Professor Waddell offers a new thinking for rehabilitating people with back pain. The emphasis is on the importance of timing. This chapter also contains an extensive comparison of various key studies in the role of healthcare in occupational intervention and return to work. Finally there is a good discussion on functional restoration, which is an important rehabilitation principle, however Professor Waddell concludes that based on the current data the evidence does not support that functional restoration achieves the goal of getting patient back to work.

Toward the end of the book in Chapter 19 and 20, Professor Waddell discusses the healthcare for back pain on both sides of the Atlantic and this discussion is both instructive and insightful. Finally, the Chapter 21, Professor Waddell talks about future healthcare for back pain and discusses some research priorities for future research on low back pain. As we all know, most of the back pain is treated in the primary care setting and much of the traditional research on back pain has little relevance to primary healthcare. Indeed the suggested list of future research in this area is critical to our better understanding of back pain and its management.

In summary, *The Back Pain Revolution* is an excellent work which is highly relevant to all healthcare providers dealing with back pain, particularly the Independent Medical Examiners involved in the impairment and disability issues related to back pain. The work is clearly a reflection of Professor Waddell's thoughtful style, his command of scientific data on the subject and his lifelong clinical practice in the area. It is indeed the best edition to the medical knowledge since the discovery of Penicillin.



Letter to the Editor

Editor's Note:

The following is a letter from our colleague outlining his views. It is my sincere hope that this will generate a dialogue among colleagues. Opinions from all sides of the isle are welcome and would be considered for publication. The editors and all contributors to Disability Medicine enjoy a full latitude in expressing opinions on the subjects presented to better inform the readers. The views expressed by contributors are not necessarily those of the editor or ABIME.

Dear Editor:

I am obliged to write **REGARDING THE CONCEPT OF PHYSICIAN AS PATIENT ADVOCATE.**

At the recent 2004 annual AADEP meeting in Miami multiple speakers repeatedly stated that physicians should be, and are legitimately perceived as, patient advocates. In my opinion this advocacy notion (or a misguided physician role) is incompatible with other aspects and concepts presented at the annual meeting mentioned below.

The emphasis of the meeting was Prevention, Evaluation, Rehabilitation, and Treatment (PERT). All of which are legitimate primary concerns of physicians who provide clinical services of evaluation, diagnosis, treatment, and management for patients whether in the

role of attendant (attending) second opinion or consultant physician.

Never minding the argument of whether or not such emphasis on PERT is highly appropriate for disability evaluating physicians. (Since our role is limited by personal choice and those who reimburse us for our time.) I appreciated the speakers being confident and competent enough to criticize the delivery of medical services especially as they relate to initial and early diagnosis, treatment and management decisions that support and promote patient disability. In other words misguided clinical decision-making that not only does not prevent disability but also promotes disability.

In my opinion the primary reason this oxymoron of healthcare occurs, as well as many other medical errors, is the notion that the physician should be a patient's advocate.

I say leave the advocacy to the lawyers! They are reimbursed for it whereas our duty is to do no wrong and promote health including full participation in activities of daily living— especially work.

Webster's New World Dictionary, 2nd College Edition, 1980 defines:

Advocate as " a person who speaks or writes in support of something. A person who pleads another's' case specifically a lawyer.

Advocacy is defined as the act of writing or speaking in support of something.

The minute a physician becomes a patient advocate; this act disables his/her ability to use " probability reasoning" (p = .49). Misguided " caring, empathy, sympathy" by a physician Enables and often times Disables patients. Such physician's feelings destroy his/her ability to consider objective medical evidence to be of greater significance than subjective symptoms and findings. And as a result decreases the likelihood that probability reasoning for medical decision making (rather than possible, maybe, and perhaps) will be used. Such quality of care does, if nothing else, promote the idea that diagnosis hopefully can be made by obtaining expensive tests, etc., leading in turn to the patient " knowing something is seriously wrong" furthering the disability mentality.

If we are to truly prevent and control disability in the U.S. and other developed countries we must throw out the idea that physicians are patients' advocates with the dirty bath water.

Donald D. Hubbard, MD, FAAOS, DABOS, FAADep, FACOEM, CIME, FACSM, FACFE