CHAPTER 9
Clinical Impression

Chapter Outline

I. Overview

II. List of Subtopics

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I. OVERVIEW

This chapter will consider the use of the concepts of a "clinical impression," "chiropractic diagnosis," and “analysis" in the practice of chiropractic.

The application of diagnosis in chiropractic practice, the perspective of the practitioner relative to chiropractic diagnosis, and the diagnostic responsibility of the practitioner vary with respect to state laws, board regulations, and court rulings.

While the exact language may vary, it is clear, however, that the practitioner is dealing with the process of conveying the salient findings of his or her examination relative to the patient in question. The consequence of the chiropractic diagnosis, clinical impression, or analysis impacts directly on the management of the patient.

Protocols and guidelines for quality assurance and standards of practice are expressed and understood within historical, legal and professional perspectives of the profession. In addition, standards must be developed to reflect the advancement in the quality of chiropractic care, the protection of the patient and the continuing process of assessment of effectiveness.

Appropriate interpretation of a patient's case history and examination must be made to determine if the patient has a chiropractic problem and if so, to formulate an appropriate protocol for corrective care developing a clinical impression done by integrating and analyzing the patient's history and examination findings.

Guidelines for clinical impressions need to be established to distinguish chiropractic evaluation and care from that employed in other health care disciplines.

II. LIST OF SUBTOPICS

1. Necessity
2. Initial Responsibility
3. Subsequent Responsibility
4. Terminology
5. Content
6. Process
7. Dynamics
8. Communication
9. Patient Representation

III. LITERATURE REVIEW

Information regarding the evolution of concepts of diagnosis, clinical impressions, or analysis has been available from the writings of early chiropractic pioneers [Palmer, D.D.; Palmer, B.J., Firth] through to current chiropractic experts. It has also been described in a legislative framework.

Chiropractic Analysis

The concept of chiropractic analysis as something unique and distinct from a medical diagnosis was expressed as early as 1910 by Palmer and 1916 by Firth. The term has continued to be used in

this way by the profession. The commonality in its use is based on the concept that structure, primarily the spine, affects function. Chiropractic analysis includes evaluation of the structural and functional components of the subluxation and their relation to the clinical status of the patient.

Chiropractic analysis can also be viewed in more general terms as the process of reaching a clinical impression or chiropractic diagnosis. This incorporates the complete art of clinical decision-making.

Chiropractic Diagnosis

Chiropractic practice is universally recognized as a portal of entry into the health care system which individual patients may access without referral from any other professional. In light of this fact, the chiropractic practitioner is charged with certain responsibilities, legal and professional, and possess certain rights and privileges shared by all doctors. The courts have not concerned themselves with which words a practitioner elects to use to describe a diagnostic situation but to insure that the provider strives to protect the public. Therefore the issue of diagnosis, clinical impression, or analysis is paramount for the reason that it is necessary prior to the implementation of an appropriate plan of care.

The purpose of a chiropractic diagnosis as described in legislative acts, government commission hearings and the literature is twofold: 1) to identify the problem to determine if it is amenable to chiropractic care; and 2) to determine if the patient should be referred.

Application of Chiropractic Diagnostic and Analytical Concepts

Williams, Slosberg, Winterstein, and Masarsky and Weber have all attempted to address the question of the role of diagnosis from the point of view of the practicing chiropractor. Harrison and Sportelli, et. al., have addressed the issue from the perspective of legal necessity as a component of legal defense. Herfert has addressed the question from the perspective of the relationship with third party payers.

It is clear that all of these authors advocate acceptance of the diagnostic responsibility of the chiropractic profession. The concern remains for the appropriate use of language and the context of a diagnostic statement. Choice of language -- diagnosis, clinical impression, analysis or assessment -- reflects the clinician's philosophical constructs. There is however, uniformity regarding the need for appropriate, responsible steps to be taken on the patients' behalf, regardless of the paradigm, to establish the clinical findings of each individual practitioner. It is the right of the patient to receive an appropriate evaluation and statement of their problem as a prerequisite for delivery of care.

The ethical, moral, legal and professional responsibility of a chiropractic practitioner does not change with the terminology used to express his or her clinical findings. The practitioner is required to assess the patient on presentation and respond to the clinical situation in a manner consistent with the best interests of the patient and the practitioner's clinical judgment.

IV. RECOMMENDATIONS

The analytic procedures employed in the chiropractic assessment may include, but are not limited to, the following:

Physical Exams:

- Palpation (Static osseous, Static muscle, Motion)
- Range of motion
- Postural
- Comparative leg length (Static, Flexed, Cervical syndrome)
- Manual muscle test
- Nerve function tests
- Vital signs

Instrumentation Exam:

- Range of motion (see Chapter 14)
- Thermography (see Chapter 14)
- Temperature-reading instrument (see Chapter 14)
- Muscle testing (see Chapter 14)
- Electromyography (see Chapter 14)
- Pressure algometry (see Chapter 14)
- Nerve-function tests (see Chapter 14)

Imaging Exam:

- Spinography (see Chapter 13)
- Videoflouroscopy (see Chapter 13)
- Computerized Tomography (see Chapter 13)
- Magnetic Resonance Imaging (see Chapter 13)
- Clinical Laboratory
- Urinalysis
- Blood tests (serum, whole blood, components, etc.)

A. Necessity

Arrival at a clinical impression or diagnosis, or diagnostic conclusion or analysis, is a necessary outcome of the patient encounter.

Comment: The responsibility of a chiropractic practitioner does not change with the terminology used to describe clinical findings. The practitioner is required to assess the patient upon the presentation and respond to the clinical situation in a manner consistent with the best interests of the patient, the practitioner's clinical judgment, and the law of the jurisdiction in question.

9.1.1. **Rating**: Necessary
Evidence: Class I, II, III
Consensus Level: **1**

B. Initial Responsibility

Determining Appropriateness of Care: The doctor of chiropractic is responsible for determining the presence of vertebral subluxation and other malpositioned articulations and structures and to recommend a plan of care to reduce vertebral subluxation and other malpositioned articulations and structures. The chiropractor should make an assessment of the patient's initial clinical situation consistent with the patient's best interest and the attending doctor's clinical judgment.

The doctor of chiropractic should be expected to recognize and respond to emergency

situations, as defined by the International Red Cross, and inform the patient of any unusual findings during examination/evaluation.

9.2.1 **Rating**: Strong positive recommendation
Evidence: E, L
Consensus Level: **1**

C. Subsequent Responsibility

After the initial evaluation has been completed the practitioner begins a series of differentiations that result in many clinical decisions being implemented. This process is not an end in itself, but merely designates suspected conditions that become the focus for prognostic judgements, further assessment and patient management. Initiation of chiropractic care, additional studies, referral with or without continuing chiropractic care and cessation of chiropractic care are possible.

9.3.1 **Rating**: Necessary
Evidence: Class I, II, Ill
Consensus Level: **1**

D. Terminology

The terminology utilized to describe a clinical impression, chiropractic diagnosis, clinical finding, conclusion, or analysis should be consistent with appropriate usage in chiropractic. If a practitioner is required to use specific terminology, or is prohibited from the use of such terminology by law, then that legal requirement is the guiding factor.

9.4.1. **Rating**: Recommended
Evidence: Class II, III
Consensus Level: **1**

E. Content

Patients may have various conditions/symptoms/findings that result in a number of unrelated clinical impressions. Secondary diagnosis should be prioritized and addressed as needed and may be of greater clinical consequence to the patient.

9.5.1 **Rating**: Recommended
Evidence: Class II, III
Consensus Level: **1**

The clinical impression, chiropractic diagnosis, clinical finding or analysis should reflect a classification scheme that consists of statements reflective of severity, region, and organ/tissue involvement.

9.5.2 **Rating**: Recommended
Evidence: Class II, III
Consensus Level: **1**

Once a clinical assessment has been completed the doctor of chiropractic may elect to evaluate the patient on each visit. This evaluation is to determine the specific care for that visit and then to render care as appropriate. The doctor of chiropractic should employ a minimum of one analytical procedure on each visit.

- Modification in technique or evaluation procedures should be undertaken as necessary.
- Reassessment and reevaluations should be performed as the clinical need dictates and should be compared to the initial assessment.

9.5.3 **Rating**: Strong positive recommendation
Evidence: E, L
Consensus Level: 1

F. Process

When additional confirmatory tests are required to establish the clinical impression, diagnosis, diagnostic conclusion, or analysis, these studies should completed in as timely and efficient a manner as possible. Practitioners may perform such procedures consistent with their qualifications and the law, or they may seek to have such procedures performed by other qualified parties.

9.6.1 **Rating**: Recommended
Evidence: Class I, II, III
Consensus Level: 1

Where procedures relevant to a diagnosis, clinical impression, diagnostic conclusion, or analysis are not within the qualifications or competence of a practitioner, the practitioner should make appropriate consultations with others.

9.6.2 **Rating**: Recommended
Evidence: Class I, II, III
Consensus Level: 1

It is the responsibility of the attending doctor of chiropractic to be knowledgeable of and consistent with the methodology of his/her chosen analytic/technical approaches, to maintain a system to execute the effectiveness of his/her procedures and to maintain a high degree of technical excellence.

9.6.3 **Rating**: Strong positive recommendation
Evidence: E, L
Consensus Level: 1

The clinical impression, diagnosis, diagnostic conclusion, or analysis should be recorded in the patient's record and qualified as to its certainty.

9.6.4 **Rating**: Necessary
Evidence: Class I, II, III
Consensus Level: 1

G. Dynamics

The clinical impression, diagnosis, diagnostic conclusion, or analysis should be a working hypothesis that may change over time, given additional information and/or changes in condition of the patient.

9.7.1. **Rating**: Necessary
Evidence: Class I, II, III

Consensus Level: **1**

H. Communication

The practitioner should communicate the diagnosis or clinical impression or diagnostic conclusion or analysis, and its significance, to the patient in understandable terms, and convey such findings to other providers or agencies as the patient requests and consents to, or as the law requires.

9.8.1. **Rating**: Necessary
Evidence: Class I, II, III
Consensus Level: **1**

It is the responsibility of the doctor of chiropractic to educate patients as to the significance and consequence of vertebral subluxation. The chiropractor may communicate the causes, if possible, and the rationale for the detection and reduction of vertebral subluxation.

9.8.2. **Rating**: Strong Positive recommendation
Evidence: E, L
Consensus Level: **1**

I. Patient Representation

The reason the patient initially consults a doctor of chiropractic should be recorded in the patient record. The reason or patient symptomatology may direct the doctor of chiropractic to select or modify his/her adjusting procedures during the gathering of information process.

9.9.1. **Rating**: Strong positive recommendation
Evidence: E, L
Consensus Level: **1**

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