



Oregon

John A. Kitzhaber, MD, Governor

Oregon Board of Chiropractic Examiners

3218 Pringle Road SE, Suite 150

Salem, OR 97302-6311

(503) 378-5816

FAX: (503) 362-1260

E-mail: oregon.obce@state.or.us

www.oregon.gov/OBCE

Lyme Disease

After review of the ETSDP Committee discussion notes, the OBCE adopted this statement at their November 2010 meeting:

In the treatment of patients with Lyme disease, it is standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges.

Attached are the November 2010 Board meeting minutes and the ETSDP (Examinations, Tests, Substances, Devices and Procedures) Committee discussion notes (Nov 2010)



Oregon

Theodore R. Kulongoski, Governor

Oregon Board of Chiropractic Examiners

3218 Pringle Road SE, Suite 150

Salem, Oregon 97302-6311

(503) 378-5816

FAX (503) 362-1260

E-mail: Oregon.obce@state.or.us

Web: www.oregon.gov/OBCE

PUBLIC MEETING MINUTES

Oregon Garden

879 W Main St

Silverton, OR 97381

November 18, 2010

Members Present

Joyce McClure DC, President

Michael Vissers DC Vice-President

Cookie Parker-Kent, Secretary, Public Member

Daniel Cote DC

Ann Goldeen DC

Huma Pierce DC

Douglas Dick, Public Member

Staff Present

Dave McTeague, Executive Director

Kelly Beringer, Admin Asst

Donna Dougan, Admin Asst

Tom Rozinski, Investigator

Lori Lindley, Assistant AG

Others Present: Usha Honeyman DC/ND; Lester Lamm DC for UWS; Sharron Fuchs DC; David Wheeler DC; Nicole Krishnaswami, OMB Operations and Policy Analyst; Collin Stoll L.Ac, OAAOM Vice-President; Dixie Young L.Ac., OAAOM board member; Christo Gorawski L.Ac; Stephen Kafoury, lobbyist for OAAOM

CONVENE: 12:55 p.m.

ADOPTION OF THE AGENDA

DISCUSSION ITEMS *(in order actually addressed)*

1. ETSDP committee report: Lyme disease applications

Dr. Ann Goldeen synopsis. She and Dave McTeague met with the ETSDP by phone conference in early November. A statement was developed by the committee:

In the treatment of patients with Lyme disease, it is standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges

Usha Honeyman, an ND and DC would like to see the Board adopt the policy language. She treats many patients with Lyme disease. She thinks treating Lyme disease with antibiotics is mandatory, and “yes, treating chronic cases is valid (*chiropractic?*)”

Dr. McClure asked for a motion. Michael Vissers DC moved to accept the language as posed by the ETSDP; the motion was seconded by Daniel Cote DC. Discussion: Dr. Vissers asked why other board members are suggesting the use of “actively” versus “adjunctively.” Drs. Joyce McClure and Ann Goldeen explained that use of “adjunctively” might infer the DC is secondary in roll to another healthcare professional. All in favor. Huma Pierce, aye; Joyce McClure, aye; Michael Vissers, aye; Doug Dick, aye; Ann Goldeen, aye; Cookie Parker-Kent, aye; Daniel Cote, aye.

(The Board has continued to discuss this issue and may revisit this in the future.)

ETSDP Meeting

11-2-2010

(meeting notes)

Present:

Ann Goldeen DC, chairing (member)
Minga Guerrero DC (member)
Lee Cowan DC (member)
Lester Lamm DC member)
Mike Underhill DC (member)
Jay Harris DC (member)

Judy Boothby DC (member)
James Aungst DC (member)
Dave McTeague, Ex. Dir.
Sharron Fuchs DC (non member)
Usha Honeyman DC, ND (non member)
Virginia Shapiro DC (non member)

Meeting begins at 10:15AM teleconference

The ETSDP recommends the following policy language be adopted by the OBCE:

In the treatment of patients with Lyme disease, it is standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges.

Dr. Goldeen opens meeting. Requests Drs. Honeyman and Shapiro to make opening statements.

Dr. Honeyman: requested a determination re scope of practice re Lyme Disease in Oregon. She's taking off her ND hat and keeping the DC hat on. States as a DC that DCs aren't qualified to advise patients regarding medications. Lyme is complex. Issue of whether chronic Lyme disease exists. Management is intricate, multifaceted. Most Lyme patients suffer from significant NMS pain/difficulties. DCs can do adjunctive management of NMS. Patients can be sickest of the sick, multi system problems, broad range of GI symptoms/dysfunctions. DC can advise re health eating, etc. Bottom line is controversy between two medical societies, OBCE shouldn't be ruling on which anti biotic regime is best, DCs on shaky ground in this. IF DCs treat LD patients "holistically" and this delays treatment with antibiotics, then patient care is at risk. If DCs don't get clear on this issue other forces will do it for us.

Dr. Shapiro: asks about the process. Agrees with a lot of Dr. Honeyman, agrees with referral for anti biotic treatment, clearly I initial disease and acute phase. Where there's a difference: with chronically ill, health picture stable (but unwell), many patients already on countless courses of anti-biotics for years. She treats in context of health history. Her experience in Lyme endemic areas of Main and Minn., she made referrals for anti-biotics. Patients did best then when in acute state and had recent exposure. Chronic patients don't do as well with anti-biotics. Disagrees with Dr. Honeyman, that DCs shouldn't comment about anti-biotic use: says DCs are obligated to give their informed opinion, but not to interfere with other (MD) doctor's prescriptions.

Shapiro continued: Clear difference between trigger of an illness and the illness itself. That's where an integrative DC approach can be useful. There is mixed evidence that short or long term anti-biotics is effective in treating long term cases. To whom to DCs refer in long term cases for effective treatment. Chronically unwell: referrals become much more difficult, hard to know to whom to refer the patient and for what.?

The IDS vs. ILADs then becomes very pertinent to issue of the DC referral. Finding a physician to take on a chronic patient is becoming easier.

The chronically unwell are “stable” unwell, they are stable, don’t have a clearly progressive illness. Documented cases that were successful under her care. Didn’t document the other chronically unwell that she does. Would like the opportunity to provide a 2nd iteration of her paper that is better references.

Boothby: What is the risk level for Dr. Shapiro’s application?:

Shapiro: Low risk

Honeyman: Patients should be referred for anti-biotics. All treatment for Lyme disease has moderate to high risk. Had a patient die of Lyme disease. Says patients are at high risk if their central nervous system has been penetrated by the disease (high risk).

Boothby: Cites features of the ETSDP rule. Has patient family with Lyme, the chronic patient is being treated differently from the acute patient. States reason for the rule is to help DCs/patients evaluate risk.

Cowan: Don’t see a difference between the two applications or other type of infectious disease, as long as they’re referring for anti-biotics, sees this as standard care.

Aungst agrees: doesn’t know why we’re dealing with this?

Guerrero: Didn’t see the conflict right away. Sees a confluence of views, this is taught in multiple colleges, at least from a diagnostic; every college, has a protocol re acute vs. chronic phases. Referral in acute phase to be standard. If a patient has Lyme and hasn’t been treated with anti-biotics. Agrees with Dr. Honeyman, that there’s a moderate to high risk factor if not done right.

Harris: DCs treating people nutritionally (for cancers), doesn’t see how this is any different? This is within our scope of practice.

Lamm: Agrees with most statements, we’ve been treating patients with chronic illnesses forever. A DC needs to have another physician make the Lyme diagnosis. Issues is about risk. Patients that are health compromised with Lyme, makes risk high. Difficult disorder that will confound any practitioner, relative to symptoms, ability to diagnosis accurate (same can be said for cancer)

His concerns: Two groups, ISDA, ILADs. Third loose knit group; Dr. Shapiro’s states, most clinicians believe that pathogenesis is exacerbated by (list). His position is this is an approach based on a belief system; it is inherent in a claim of efficacy is the requirement that they offer some compelling evidence/science. No issue if patients are being co managed. If the DC is going it alone, if Western blot test is negative, the secondary test diagnosis is to use AK and homeopathics, that disturbs him. Why would not the scientifically community endorse a more scientifically valid test? Has reservations about a DC going it alone.

Underhill: Agrees that this is like other problems that come into office. Says both applications are very well written.

Boothby: One patient, only warning sign was low tone connective issue (complicated by pregnancy and MVA), partner had Lyme which was an indication to her. Questions how we recognize Lyme when it's so easy miss? How many tests do we run?

Fuchs: Both ILADs and IDSA have meticulous guidelines through the different phases, with different testing. Co-management is for what DCs can do, nutritional assessment, NMS therapy. Nothing in either guideline says the DC can go it alone. There's nothing to investigate. Chiropractic colleges says, DCs are not primary managers of Lyme, DCs can treat (co-manage). DCs cannot go it alone.

Lamm: Questions to Dr. Shapiro. Is your management "go it alone"?

Shapiro: Not all are being co managed. Many already been treated by anti-biotics. The ones not co-managed: patients who have made the decision. (responding to "belief" comment) Directs all to "functional medicine" (article?) and says there's scientific evidence. Cites article "Persistent complaints related to Lyme Disease." Only one of which involves an active ongoing infection. Not answered in scientific literature is whether patients have active Lyme or merely chronic conditions.

Boothby: Concern: do all patients with inflammatory conditions need to be evaluated for Lyme?

Guerrero: Dr. Boothby makes a good point, DCs are managing inflammatory conditions. Once you develop any reasonable suspicion of Lyme, then ask the patient if they have addressed Lyme with their medical or ND physician?

Lamm: Agrees testing every patient with inflammation or other symptoms, does not in and of itself mean the DC has to test for Lyme. When Lyme does come into the question, for Lyme or Lyme residual, then co-management is indicated.

Fuchs: Oregon Dep. of Health on Lyme link to CDC, you need to suspect Lyme disease (Typical [symptoms](#) include fever, headache, fatigue, and a characteristic skin rash called [erythema migrans](#).) for inflammatory conditions, needs to be up there on your list of conditions that need laboratory testing.

<http://www.oregon.gov/DHS/ph/acd/diseases/lyme/lyme.shtml>

Goldeen: Literature says: Doesn't want to do a lot of laboratory testing, because it doesn't give accurate results.

Honeyman: Says two tests are missing half the patients with Lyme disease. New CDC criteria. Reads CDC criteria.

Boothby: Her patient didn't have a rash. Treated her for five years, but w/o the rash wouldn't know to have the test. We don't want to be so specific.

Goldeen: A lot of medical management of Lyme is abysmal as well.

Guerrero: Treatment and management of Lyme is mostly standard. Found some of the treatments in Dr. Honeyman's information to be investigational. Believes treatment with micro-current to be investigational.

Boothby: Valid to ask a person to get a formal investigation of the treatment under the standard guidelines. Wants the patients to have the right to choose and hears the risks of treatment.

Goldeen: B is proposing that patients be informed of their treatment options and be able to choose between standard and investigational treatments.

Guerrero: Motion: Treatment of Lyme diagnosis is standard and recommends co-treatment and informing patients regarding use of anti-biotics in early and acute phase and also instances of arthritis and neuroborreliosis. It is highly recommended anti-biotic phase be considered in chronic phase when indicated.

Honeyman: Says other stages also need co-management

Cowan: Says the protocols taught by the colleges should be followed, more specifics open up DCs to malpractice claims.

Fuchs: Doesn't appear DC colleges have protocols down. Both IDSA/ILADs have protocols for use of anti-biotics. Thinks that an informed consent form has its own problems.

Cowan: agrees with Dr. Guerrero.

Aungst: Describes how he makes the referral, by sharing the information with the MD, who also does his own exam/diagnosis.

Lamm: Needs to have some degree of ambiguity.

Suggests: "In treating patients with Lyme disease, DCs are considered adjunctive in the co-management with other appropriate health care providers (MD, DO, ND)."

Fuchs: That is too ambiguous, the other provider must have prescribing privileges. DCs are not the primary care providers for this diagnosis. We are co-treaters.

Goldeen: Where are we at with patients who won't go to a MD or refuse to see anyone else.

Aungst: A statement from the patient that they're making that choice would address that.

Shapiro: Agrees with language: Either ILADs or ISDA guidelines should be followed. When is it Lyme or inflammatory residue or not Lyme at all?? There's a huge population of patients who may have Lyme disease, but whose lab testing is negative. Says, ILADs is willing to prescribe anti-biotics based on symptoms alone; but those symptoms reflect a wide array of disorders.

Aungst: Agrees. We're dealing with compromised health as a result of Lyme, cancer or anything else.

Lamm: Suggests: “In the diagnosis and treatment of patients with Lyme disease, it is the standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges.”

Boothby: Add “ Patient have the right to choose once they are fully informed of the risks and alternatives.”

Fuchs: That is a slippery slope to dissuade the patient from getting needed medical management.

Lamm: Inherent is you can't force a patient to do anything.

Lamm moves: Guerrero seconds:

In the treatment of patients with Lyme disease, it is standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges.

Vote:

Minga Guerrero DC yes

Lee Cowan DC (said yes before he signed off)

Lester Lamm DC yes

James Aungst DC yes

Mike Underhill DC yes

Jay Harris DC yes

Judy Boothby DC yes