



# THE CHIROPRACTIC REPORT

An international review of professional and research issues, published bimonthly.

Editor: David Chapman-Smith, LL.B. (Hons.), FICC (Hon.)

March 1992 Vol. 6 No. 3

## North American Guidelines for Chiropractic Practice The Mercy Center Consensus Conference – January 1992

*What records are discretionary, which records must I keep?*

*Is demineralization of bone a relative or absolute contraindication to high-velocity thrust techniques?*

*How does my profession define adjustment, manipulation, mobilization today?*

*What is a recommended course of management for a patient with sub-acute pain, and with what frequency - according to the standards of my profession - should I re-assess the patient? What factors affect this?*

*To what extent do practice guidelines bind me in each individual case?*

### A. Introduction

1. In 1992 the myth has gone. The public now knows that the practice of health care, for all its fine achievements, is mostly unscientific and run on the basis of custom and personal preference. In a recent editorial entitled 'Where is the Wisdom? ... The Poverty of Medical Evidence'<sup>1</sup> the British Medical Journal quotes one of the experts who has researched and penetrated the myth of scientific health care during the past 20 years. David Eddy, Professor of Health Policy and Management, Duke University in North Carolina acknowledges:

- a) Only about 15% of medical interventions are supported by valid scientific evidence.
- b) One reason is that "only 1% of articles in medical journals are scientifically sound".
- c) Another is that "many treatments have never been assessed at all".

2. Eddy is one of the most respected advisors to the Agency for Health Care Policy and Research (AHCPR), the U.S. Federal agency established in December 1989 to assist in the development and maintenance of national health practice guidelines.

As a cardiothoracic surgeon in Stanford, California Eddy became seriously concerned at the lack of evidence to support the effectiveness of what he and his colleagues were doing. He selected a common condition presented in medical practice that had well established treatments - glaucoma - and found there was not a single controlled trial to support

medical practice. The confident statements in texts and medical journals had simply been handed down generation to generation.

After repeating this experience on analysis of other treatments, he took a mathematics degree at Stanford then embarked on a career that has made him one of the consultants on health standards and policy most in demand in the U.S. Running courses for medical expert groups trying to reach consensus on best management, he has now dealt with 21 areas of medical practice. For 17 areas the assembled experts have judged the scientific evidence in support of current practice to be "between poor and none ... usually the best evidence was something less than a randomized controlled trial".<sup>1</sup>

(Interestingly, where there is evidence it often contradicts current medical practice - 16 of 17 trials on giving lidocaine prophylactically for patients with chest pain showed no benefit - yet this remains common practice in the United States.)

As the British Medical Journal concludes "the weakness of the scientific evidence underlying medical practice is one of the causes of the wide variations that are well recognized in medical practice".<sup>1</sup>

3. One could make a credible argument that presently the practice of chiropractic is more scientific than the practice of medicine. The majority of chiropractic practice involves management of patients with low-back pain using adjustment/manipulation together with early patient mobilization and rehabilitation. The effectiveness and cost-effectiveness of this approach for both acute and chronic pain is supported by a substantial body of scientific evidence.<sup>2</sup> In comparison, medical management of common presenting complaints, such as non-specific back pain and benign headache, has very little scientific basis.

4. However, much of chiropractic practice is in as unhealthy a state as medical practice and all providers must acknowledge:

**Mercy Center Guidelines – How to get your copy:** Every doctor of chiropractic will want a copy. Available from many chiropractic organizations and suppliers by May 1992 at a price of US\$20.00 (Publication is non-profit and subsidized).

### Professional Notes

#### Two Important Second Editions

'Principles and Practice of Chiropractic', ed. by Haldeman S, Second Edition (1992), Appleton and Lange, Norwalk, Connecticut and San Mateo, California. ISBN No. 0-8385-6360-0. 'Manipulative Therapy in Rehabilitation of the Locomotor System' Lewit K, Second Edition (1991) Butterworth-Heinemann Ltd., Oxford and Boston. ISBN No. 0-7506-1123-5.

The first shows where the chiropractic profession is in 1992 - a position of growth and maturity of which it can justly be proud. A major publishing event, Haldeman's long awaited new text covers all aspects of chiropractic - history, philosophy and sociology; principles and practice; international development - and the contributing authors are a who's who from chiropractic, medicine and basic science around the world.

The second text, by Czech neurologist Karel Lewit, shows where manual medicine is beginning to go in 1992, and is also compelling reading. Like U.S. osteopath Dr. Phillip Greenman, Lewit is at the cutting edge of medical understanding of the vast potential of a manipulative approach to health care and:

- Accepts that neurology is the basis of assessment and treatment in manipulative health care.
- Following his visits to chiropractic colleges in recent years and closer contact with the profession, acknowledges that "chiropractors have a full medical curriculum enabling them to make diagnoses ... and chiropractic colleges now teach and undertake research on a modern scientific basis."
- Admits that, in a "somewhat paradoxical" way, over recent decades "while osteopaths and chiropractors ... were elaborating sophisticated manipulation techniques, (medical) doctors began to use very crude methods of manipulation ..."
- Clearly understands the somatovisceral and viscerosomatic relationships between the neuromusculoskeletal system and internal organ dysfunction.
- Is a strong advocate of prophylactic manipulation as part of preventive care, especially with children and high risk groups such as professional athletes.

- Too much care is not of the highest quality possible.
- The variations found in practice, and the costs, are unacceptable to the public and third party payors who are finally asserting themselves and vigorously exercising new control.
- As there will never be controlled trials for most procedures, because of cost and time factors, there is an urgent need for professional consensus to establish appropriate guidelines for practice.
- If such guidelines are not developed according to accepted methodology and in a timely fashion, then two rather terminal events will occur - guidelines will be imposed by others and, frankly, other health services with more coherent standards will be substituted and preferred. Given the rapid rise of managed care, and the new pace of competition in the health care market, these threats are real.

5. Against this sobering background it is exciting to report:

a) At the Mercy Center, San Francisco January 25-29, 1992, a duly constituted consensus group of 35 doctors of chiropractic met and, notwithstanding their substantially different backgrounds, achieved a high level of consensus on guidelines for the practice of chiropractic in North America.

b) Those in the final consensus group are listed in Figure 1. Their work was commissioned by the Congress of Chiropractic State Associations (COCSA) and expressly supported by nearly all major chiropractic organizations in North America, including the American Chiropractic Association, the Canadian Chiropractic Association, the International Chiropractors' Association, the Federation of Chiropractic Licensing Boards and the Association of Chiropractic Colleges.

c) The guidelines agreed upon relate to all aspects of chiropractic practice, with chapters on:

History and Physical Examination  
Radiology  
Instrumentation  
Clinical laboratory  
Record keeping  
Clinical impression  
Modes of care  
Frequency of care  
Reassessment  
Outcome assessment

Collaborative care  
Management of complications  
Preventive/Maintenance Care  
Professional development

d) Each chapter contains a literature review then succinct guidelines. The publication, over 500 pages and currently being edited by Scott Haldeman (Commission Chairman) and David Chapman-Smith (Commission Counsel), will be available in April 1992. Because of sponsorships and other support it will be available to individual chiropractors in North America for \$20.00. It will be distributed by a number of professional organizations.

6. This Report now comments on:

- The process used
- The ratings systems and consensus levels adopted
- Areas of particular interest
- How these guidelines will be used

### B. Process

7. Background and process for the Mercy Center Conference were discussed in detail in the March 1991 issue of this Report (Vol. 5 No. 3). In essence:

a) A properly representative consensus group was established with strong participation from the practising and research arms of the profession - vital since guidelines for practice must be practical and a blend of the scientific literature with clinical experience.

b) Preparations for the January 1992 consensus meeting followed a modified Delphi process.<sup>3</sup> A committee of six from the consensus group of 35 worked on development of each chapter. They used such advisors in the profession as they desired. Over a 12 month timeframe, they built agreement or consensus by preparing then twice revising the chapter.

In January 1992 all 35 consensus group members were given the third drafts of all chapters in preparation for the Mercy Center meeting.

8. The agenda for this four-day full consensus group meeting was:

#### **i) Day 1**

- Opening addresses from Paul Shekelle MD of RAND Corporation and UCLA on the consensus process; Herve Guillion MD of AHCP, Washington DC, on the importance of the consensus process on development of national health policy; and Scott Haldeman DC MD PhD on the precise process for the meeting.

- Committee meetings on the first five chapters to confirm final draft to be submitted to the full consensus group.
- Afternoon and evening full consensus group sessions debating and voting on each guideline in these five chapters.

#### **a) Days 2 and 3**

Similar process on the remaining nine chapters.

#### **b) Day 4**

Clean up. Resolving contentious issues then signing off the final guidelines. Sophisticated office support, with banks of computer terminals and printers and round-the-clock staff, allowed completion before the meeting disbanded.

### C. Ratings Systems Adopted

9. The key to comprehending the new chiropractic guidelines lies in understanding the ratings systems used. Developing appropriate ratings was a major challenge because:

- The technique of ratings is still evolving and there was no definitive correct precedent to follow.
- The guidelines covered broad territory, the whole practice of chiropractic, and ratings for one aspect (e.g. when is it appropriate to use stress xrays or use certain treatment approaches - i.e technical matters) are not suitable for other aspects of practice (e.g. what records should be kept and what are the recommended guidelines for continuing education or referral or collaborative care - i.e. procedural matters).

10. Two basic systems were adopted and appear in Figure 2.

#### **Ratings Systems 1**

The first, suitable for scientific/technical areas of practice, is modified from a system developed by the American Medical Association. Features are:

a) Procedures are judged, in descending order of approval;

- *Established*
- *Promising*
- *Equivocal*
- *Investigational*
- *Doubtful*
- *Inappropriate*

b) The first three ratings are positive, supporting use and reimbursement in clinical practice. The latter three are

*continued on page 3*

**Editorial Board. United States:** Peter Gale, D.C., Chiropractor, Boston, Massachusetts. Scott Haldeman, D.C., M.D., Ph.D., Neurologist, Santa Ana, California. Reginald Hug, D.C., Chiropractor, Birmingham, Alabama. Dana Lawrence, D.C., Chiropractor, Chicago, Illinois. John M<sup>c</sup>M. Mennell, M.D., Physical Medicine, Advance, North Carolina. Michael Pedigo, D.C., Chiropractor San Leandro, California. Louis Sportelli, D.C., Chiropractor, Palmerton, Pennsylvania. Aubrey Swartz, M.D., Orthopaedic Surgeon, Oakland, California. **Canada:** J. David Cassidy, D.C., M.Sc., Chiropractor, Saskatoon, Saskatchewan. Donald J. Henderson, D.C., B.Sc., Chiropractor, Toronto, Ontario. William Kirkaldy-Willis, M.D., F.R.C.S. (C), Orthopaedic Surgeon, Saskatoon, Saskatchewan. **Europe:** Arne Christensen, D.C., F.I.C.C., Chiropractor, Odense, Denmark. Australia: Miriam A. Minty, D.C., Chiropractor, Perth, W.A. Lindsay Rowe, B.App.Sc., D.A.C.B.R., Chiropractic Radiologist, Newcastle, New South Wales.

The **Chiropractic Report** is published by Fumia Publications Inc. You are welcome to use extracts from this Report. Kindly acknowledge the source. However neither the complete Report nor the majority or whole of the leading article may be reproduced in any form whatsoever without written permission. **Subscriptions: for rates and order form see page 6.** Subscriptions are for the year commencing November. All subscriptions and changes of mailing instructions should be sent to The Chiropractic Report, 3080 Yonge Street, Suite 3002, Toronto, Ontario, Canada M4N 3N1, Tel: (416) 484-9601, Fax: (416) 484-9665. Printed by Harmony Printing Limited, 123 Eastside Drive, Toronto, Ontario, Canada M8Z 5S5. Second Class Mail Registration No. 7378. Copyright © 1992 Fumia Publication Inc. **ISSN 0836-1444.**

negative. In the chapter on modes of care for example, high-velocity adjustment and manipulation are rated:

- *Established* for back pain
- *Established* for other neuromusculoskeletal disorders
- *Equivocal* for other purposes

c) What is the exact status and meaning of the rating *equivocal* in the example above? If one looks at Fig 2 it is seen that the ratings are supported by defined classes of evidence and strength ratings. These should be read with care. Under the emerging technology in the field of professional guidelines, ratings must be established in this manner to be valid and credible - not only to the profession but to third parties, the public and government.

In the above example use of adjustment/manipulation to manage somatovisceral problems is rated *equivocal*. Within chiropractic there is a wealth of clinical experience and a number of case series or case reports evidencing the value of adjustment, for example, for some vision disorders<sup>4</sup> or a range of pelvic organic disorders.<sup>5,6,7</sup> Why the rating *equivocal*? Because:

- The evidence in support is, by definition, Class III evidence.
- Again by definition this only allows a Type C recommendation ("positive recommendation based on strong consensus of Class III evidence").
- '*Equivocal*' is the Type C positive recommendation.
- For some the heart, heavily influenced by personal experience, may find this rating inappropriate. Maybe the head, upon review of the definitions, will agree with the consensus group.
- The rating level at which third parties are justified on these guidelines in restricting reimbursement for clinical services is *investigational*.
- A final complexity is that, from a chiropractic perspective, the visual and pelvic conditions mentioned above are in fact neuromusculoskeletal problems. Management will only include chiropractic adjustment in the presence of a spinal functional lesion or subluxation. Accordingly a chiropractic interpretation might be that these guidelines provide an *established* rating for the treatment in question. The answer to this dilemma appears in the section on definitions, which provides that for the purposes of these guidelines neuromusculoskeletal conditions do not include internal organ disorders or Type 'O' disorders.

### 11. Rating System 2

This system is suited to procedural/administrative aspects of practice and is used for chapters with guidelines in areas such as history and physical exam, record keeping and patient consent, collaborative care and professional development.

Rating levels are:

- *Necessary*
- *Recommended*
- *Discretionary*
- *Unnecessary*

Again, rating is linked to quality of evidence. See Fig 2 for details.

### 12. Management of Complications (Chapter 12)

A special third rating system has been developed for the unique area of potential complications from high-velocity thrust procedures. This uses defined criteria relating to:

- Severity of potential complication.
- Probability/incidence
- Quality of evidence

From these criteria two conclusions are drawn - firstly a rating of different conditions presented, then an overall 'level of contraindication' which may be:

- *No contraindication*
- *Relative contraindication* - "high-velocity thrust procedures may be used with appropriate care and/or modification."
- *Relative to absolute contraindication* - "careful clinical judgement dictates whether contraindication is relative or absolute with each specific patient."
- *Absolute contraindication*

Potential complications are defined under categories of articular derangements, bone weakening and destructive disorders, circulatory and cardiovascular disorders, and neurological disorders. See Figure 3 for example ratings from the first category, articular derangements.

Consider the legal significance of this in a malpractice setting. Assume you are being sued for damages for injury by a patient with spondylolisthesis and progressive slippage whom you adjusted. For the guideline on this, see Fig. 3, para d).

continued on page 5

Figure 1

### Mercy Center Conference - Consensus Panel of Chiropractors

\* = in private practice (23 of the 35)

Primary professional qualifications only given for those in private practice, but areas of special expertise noted.

**Alan Adams DC MS** - California, Vice-President, Chiropractic Education, Los Angeles College of Chiropractic; **Meredith Bakke DC\*** - Wisconsin, Federation of Chiropractic Licensing Boards; **Ralph Boone DC PhD\*** - California, President, Southern California College of Chiropractic, Straight Chiropractic Academic Standards Association; **Linda Bowers DC\*** - Minnesota, Orthopedics, nutrition, Professor, Northwestern College of Chiropractic; **Gerard Clum DC** - California, President, Life-West College of Chiropractic, President, Association of Chiropractic Colleges; **Tammy DeKoekkoek DC\*** - California, Associate Professor, Los Angeles College of Chiropractic; **Rob Francis DC\*** - Texas, Dean, Clinical Sciences, Texas College of Chiropractic; **Arlan Fuhr DC\*** - Arizona, Activator Methods; **James Gregg DC\*** - Michigan, hospital practice, President, ICA; **Daniel Hansen DC\*** - Washington, orthopedics; **Donald Henderson DC\*** - Ontario, radiology; **John Hsieh DC RPT\*** - California, physical therapy, research, Associate Professor, Los Angeles College of Chiropractic; **Thomas Hyde DC\*** - Florida, sports chiropractic; **Donald Kern DC** - Iowa, President, Palmer College of Chiropractic; **Norman Kettner DC DACBR** - Missouri, Chairman, Department of Radiology, Logan College of Chiropractic; **Charles Lantz DC PhD** - California, Director of Research, Life-West College of Chiropractic; **Eugene Lewis DC\*** - North Carolina, Past-President, North Carolina Chiropractors' Association and Southeastern Chiropractic Federation; **John Martin DC\*** - Texas, Past-President, Texas Chiropractic Association and Congress of Chiropractic State Associations; **Dale Mierau DC\*** - Saskatchewan, hospital practice, research; **Marion McGregor DC MSc FCCS\*** - Illinois, Associate Professor, Research Dept., National College of Chiropractic; **Rick McMichael DC\*** - Ohio, Past-President, Ohio State Chiropractic Association, Vice-President, Congress of Chiropractic State Associations; **William Meeker DC MPH** - California, Dean of Research, Palmer-West College of Chiropractic, President, Consortium for Chiropractic Research; **Silvano Mior DC\*** - Ontario, Associate Dean, Graduate Studies, Canadian Memorial Chiropractic College; **Robert Mootz DC\*** - California, Associate Professor, Research Dept., Palmer-West College of Chiropractic; **Michael Pedigo DC\*** - California, Past-President, ICA; **Kelli Pearson DC\*** - Washington, HMO practice, Past-President, Washington Chiropractic Association; **Reed Phillips DC PhD** - California, radiology, President, Los Angeles College of Chiropractic; **William Remling DC\*** - New York, Chairman, New York Chiropractic Council; **Dennis Skogsbergh DC\*** - Illinois, orthopedics, National College of Chiropractic; **Marilyn Smith DC** - California, Chair, Board of Governors, Palmer-West College of Chiropractic; **Monica Smith DC** - Missouri, health sciences research, St. Louis University Medical School; **Louis Sportelli DC\*** - Pennsylvania, Past-Chairman, Board of Governors, ACA; **John Triano MA DC** - Illinois, Director of Ergonomics and Research Laboratory, National College of Chiropractic; **Howard Vernon DC\*** - Ontario, Director of Research, Canadian Memorial Chiropractic College; **James Winterstein DC** - Illinois, President, National College of Chiropractic.

Figure 2

PROCEDURE RATINGS (SYSTEM 1)

**Established:** Accepted as appropriate by the practising chiropractic community for the given indication in the specified patient population.

**Promising:** Given current knowledge, this appears to be appropriate for the given indication in the specified patient population. As more experience and long-term follow-up are accumulated, this interim rating will change. This connotes provisional acceptance, but permits a greater role for the current level of clinical use.

**Equivocal:** Current knowledge exists to support a given indication in a specified patient population, though value can neither be confirmed nor denied. As more evidence and experience accumulates this rating will change. Expert opinion recognizes a need for caution in general application.

**Investigational:** Evidence is insufficient to determine appropriateness. Further study is warranted. Use for a given indication in a specified patient population should be confined to research protocols. As more experience and evidence accumulates, this rating will change.

**Doubtful:** Given current knowledge, this appears to be inappropriate for the given indication in the specified patient population. As more experience and long term follow-up are accumulated, this interim rating will change.

**Inappropriate:** Regarded by the practising chiropractic community as unacceptable for the given indication in the specified patient population.

Quality of Evidence

**Class I:** Evidence provided by one or more well-designed controlled clinical trials; or well-designed experimental studies that address reliability, validity, positive predictive value, discriminability, sensitivity, and specificity.

**Class II:** Evidence provided by one or more well-designed uncontrolled, observational clinical studies, such as case-control, cohort studies, etc; or clinically relevant basic science studies that address reliability, validity, positive predictive value, discriminability, sensitivity, and specificity; and published in refereed journals.

**Class III:** Evidence provided by expert opinion, descriptive studies or case reports.

Strength of Recommendation Ratings

**Type A:** Strong positive recommendation. Based on Class I evidence or overwhelming Class II evidence when circumstances preclude randomized clinical trials.

**Type B:** Positive recommendation based on class II evidence

**Type C:** Positive recommendation based on strong consensus of Class III evidence.

**Type D:** Negative recommendation based on inconclusive or conflicting Class II evidence.

**Type E:** Negative recommendation based on evidence of ineffectiveness or lack of efficacy based on Class II or Class I evidence.

PROCEDURE RATINGS (SYSTEM II)

**Necessary:** Strong positive recommendation based on Class I evidence, or overwhelming Class II evidence when circumstances reflect compromise of patient safety.

**Recommended:** Positive recommendation based on consensus of Class II and/or strong Class III evidence.

**Discretionary:** Positive recommendation based on strong consensus of Class III evidence.

**Unnecessary:** Negative recommendation based on inconclusive or conflicting Class II, III evidence.

Quality of Evidence

The following categories of evidence are used to support the ratings.

Class I:

- A. Evidence of clinical utility from controlled studies published in refereed journals.
- B. Binding or strongly persuasive legal authority such as legislation or case law.

Class II:

- A. Evidence of clinical utility from the significant results of uncontrolled studies in refereed journals.
- B. Evidence provided by recommendations from published expert legal opinion or persuasive case law.

Class III:

- A. Evidence of clinical utility provided by opinions of experts, anecdote and/or by convention.
- B. Expert legal opinion

Figure 3

MANAGEMENT OF COMPLICATIONS

Articular Derangements

a) Acute rheumatoid, rheumatoid-like and non-specific arthropathies including acute ankylosing spondylitis characterized by episodes of acute inflammation, demineralization, ligamentous laxity with anatomic subluxation or dislocation, represent an *absolute contraindication* to high-velocity thrust procedures in anatomical regions of involvement.

Risk-of-complication Rating:

Severity: Moderate to High Condition Rating: Type III  
Probability: High Quality of Evidence: Class II, III

b) Sub-acute and/or chronic ankylosing spondylitis and other chronic arthropathies in which there are no signs of ligamentous laxity, anatomic subluxation or ankylosis are *not contraindications* to high-velocity thrust procedures applied to the area of pathology.

Risk-of-complication Rating:

Severity: Minimal Condition Rating: Type I, II  
Probability: Low Quality of Evidence: Class II, III

c) Degenerative joint disease, osteoarthritis, degenerative discopathy and spondyloarthritis are *not contraindications* to high-velocity thrust procedures to the area of pathology but treatment modification may be warranted during active inflammatory phases.

Risk-of-complication Rating:

Severity: Minimal Condition Rating: Type I, II  
Probability: Low to negligible Quality of Evidence: Class II

d) In patients with spondylolysis and spondylolisthesis caution is warranted when high velocity thrust procedures are used. These conditions are *not contraindications*, but with progressive slippage they may represent a *relative contraindication*.

Risk-of-complication Rating:

Severity: Minimal-Moderate Condition Rating: Type I, II  
Probability: Low Quality of Evidence: Class II

e) Acute fractures and dislocations, or healed fractures and dislocations with signs of ligamentous rupture or instability, represent an *absolute contraindication* to high-velocity thrust procedures applied to the anatomical site or region.

Risk-of-complication Rating:

Severity: High Condition Rating: Type III  
Probability: High Quality of Evidence: Class III

f) Unstable os odontoideum represents an *absolute contraindication* to high-velocity thrust procedures to the area of pathology.

Risk-of-complication Rating:

Severity: High Condition Rating: Type III  
Probability: High Quality of Evidence: Class III

g) Articular hypermobility, or other circumstances where the stability of a joint is uncertain, represent a *relative contraindication* to high-velocity thrust procedures to the areas of pathology.

Risk-of-complication Rating:

Severity: Minimal Condition Rating: Type I, II  
Probability: Low Quality of Evidence: Class II, III

h) Post surgical joints or segments with no evidence of instability are *not a contraindication* to high-velocity thrust procedures but may represent a *relative contraindication* depending on clinical signs. (e.g. response, pre-test tolerance or degree of healing).

Risk-of-complication Rating:

Severity: Minimal Condition Rating: Type II  
Probability: Negligible to low Quality of Evidence: Class III

i) Acute injuries of osseous and soft tissues may require modification of treatment. In most cases high-velocity thrust procedures to the area of pathology are *not contraindicated*.

Risk-of-complication Rating:

Severity: Minimal to Moderate Condition Rating: Type I, II  
Probability: Moderate Quality of Evidence: Class I, II

j) The presence of scoliosis is *not a contraindication* to high-velocity thrust procedure.

Risk-of-complication Rating:

Severity: Minimal Condition Rating: Type I, II  
Probability: Low to negligible Quality of Evidence: Class II, III

a) Prior to the existence of these national guidelines your playing field is unattractive. You and the patient will present two conflicting expert chiropractic witnesses. The plaintiff's expert will say that this condition was a contraindication and your treatment was thus a breach of the legal duty of reasonable care, and amounts to negligence. Your expert disagrees. The plaintiff will also call a medical expert, who will express surprise that anyone would dream of using manipulation in these circumstances, and the plaintiff is heavily favored to win. In fact your defence is so difficult that, assuming you are insured, your insurer is likely to settle the claim and not let it get near a court.

b) These guidelines, if accepted by the profession as a whole which seems most likely given their pedigree, change things dramatically. The playing field tilts in your direction. You and your chiropractic expert have the weight of the whole profession behind you. It becomes most difficult for any chiropractic witness (who is now inconsistent with express national guidelines for practice) or a medical witness (who is now more obviously from another discipline and thus not competent as an expert on this issue) to challenge your treatment.

They cannot assert adjustment is inappropriate and negligent. They must manoeuvre in a more narrow space, and indicate precise aspects of this case that show negligence - in circumstances where it is generally appropriate to treat as you did.

13. Quite simply, these authoritative national guidelines out of Mercy Center, the first ever, provide a vastly improved foundation and a new safety net for chiropractic practice. This is of particular interest, of course, to malpractice insurers, who have powerful new evidence with which to contest claims and reduce settlements. That is why leaders in the U.S. and Canadian chiropractic institutions providing malpractice protection (e.g. NCMIC, OUM and CCPA) were represented at the Mercy Center on an observer basis, were sponsors, and are actively assisting publication and distribution of the guidelines.

14. Let us look at the other side of the coin. What happens if you cause injury by giving treatment in circumstances judged an *absolute contraindication* in these guidelines (e.g. high-velocity thrust to a region with acute rheumatoid arthropathy - see Fig. 3 para. a). There will be clear and strong inference of negligence. If, in practical terms, this means that the guidelines present new legal risk that is a major concern. However, upon review of the publication it will be found that these guidelines - finally published by a united chiropractic profession rather than imposed by third parties - only document legal risk where it most surely exists already.

#### D. Levels of Consensus

15. There is obvious importance in defining level of agreement, and providing for minority views, in the setting of guidelines. The five levels of consensus adopted at the Mercy Center meeting were:

**Level 1** - over 85% (more than 30 votes out of 35)

**Level 2** - 70-85% (25-29 votes)

**Level 3** - 51-69% (i.e. a majority)

**Level 4** - 26-50%

**Level 5** - no agreement by more than 25%

Minority opinions on any guideline required nine or more votes (over 25%) for recognition and inclusion in the guidelines to be published.

16. The meeting produced vigorous debate but an extremely high level of consensus. The great majority of guidelines received Level 1 consensus. Only 2 of 304 guidelines produced minority opinion, both at Level 3 consensus. These minority opinions both appear under instrumentation (Chapter 3) in the area of thermographic recordings and are:

a) Infrared thermography. This was viewed as safe but controversial as to effectiveness by the majority, leading to the rating *equivocal* to *promising*. The minority report is more confident of effectiveness with "specially trained personnel, specially adapted surroundings, and exclusive protocols" and, on this basis, gives a rating of *promising*.

b) Thermocouple devices. These are rated *doubtful* in the majority recommendation because, although safe, they have insufficient evidence of effectiveness. The minority opinion assesses the evidence differently and rates the use of these devices as *equivocal*.

17. In summary, a representative consensus panel of chiropractors have not only produced authoritative guidelines, but these have an unusually high level of consensus behind them. There was often need for compromise in vigorous debate - but when all sides were heard there was impressive unity. Thus the process worked - in 1992 the clinicians, educators, researchers, 'chiropractors', and 'chiropractic physicians' of the chiropractic profession had the evidence, process and maturity to achieve real consensus.

#### E. Areas of Interest

##### 18. Title

Some of the panel strongly preferred use of the traditional title 'chiropractor'. Others, because of legal ramifications in their jurisdictions where use of 'chiropractic physician' is not only authorized by law but is also fundamental to continued status as a primary provider with broad diagnostic rights and duties, preferred liberal use of that title. These guidelines will, after all, be extensively used by government.

Following debate this issue was resolved through use of the neutral title 'practitioner', with reference to 'chiropractic practitioner' or 'chiropractic profession' where the context requires. An appropriately worded explanatory note will appear in the introduction.

##### 19. Disclaimers

The guidelines were carefully vetted by legal counsel throughout. The publication carries a number of disclaimers of legal and practical significance. Thus:

a) There is a general opening disclaimer indicating that the guidelines are "part of an ongoing effort ... may need to be modified, and are intended to be flexible", and expressly noting that the consensus group "understands that alternative practices are possible and may be preferable under certain conditions."

b) Many individual recommendations are qualified. In record-keeping, for example, there are guidelines on keeping and maintaining clinical records. While certain fundamental records must be kept, and are rated *necessary*, it is expressly noted that much remains in the discretion of each practitioner (e.g. methods of recording, level of detail, etc).

##### 20. Range or Content

The RAND Corporation, has recently convened two consensus meetings in the specific field of treatment of patients with mechanical low-back pain by manipulation. This condition was sub-divided into 1550 categories and assessed in detail.<sup>8</sup> The Mercy Center guidelines have a different and more general focus - they look at all aspects of chiropractic practice and provide:

a) General guidelines - e.g. whether it is appropriate to use a mechanical device with a moving stylus as one method of delivering a high-velocity low-amplitude thrust in chiropractic practice. (It is. This technique, which includes for example activator methods, is rated *equivocal* to *promising*). But the guidelines do not rate specific instruments or specific techniques within the category of 'Mechanical force,

manually assisted, moving stylus instruments'. There is no breakdown for specific presenting complaints or specific patient groups such as infants, minors, seniors, etc.

b) A starting point for further research and consensus meetings in many specific areas. (Such areas, warranting a separate consensus process and set of guidelines of their own, might be the management of children, seniors or some other population group, the management of specific conditions such as certain headache or sports injuries, or preventive care either generally or with specific population groups).

**E. How Will These Guidelines be Used**

**21. Practice guidelines are used in:**

- Education • Research • Quality improvement
- Risk management • Reimbursement

The first three are self-evident and involve major benefits for patients and the profession. In the words of Tom Bergmann DC, editor of *Chiropractic Technique*, opening the Seattle Consensus Conference in March 1990:

"Our profession and health care in general lack consensus on the correct way to practice ... we must test and improve what we do, as health professionals, to and for our patients."<sup>9</sup>

The last two uses, in risk management and reimbursement, cause the average chiropractor legitimate concern. He/she is used to cookbook approaches adopted by third party payors - x dollars and y treatments within z days for a specific condition.

The Mercy Center guidelines, are different. They have been established by a representative group from within the chiropractic profession, the majority of whom (23 of 35) are in private practice and came to the meeting sharing the concerns of the average chiropractor. These are guidelines that deal in a practical and useful way with the challenging issues in chiropractic practice, such as the appropriate roles for supportive and maintenance care. (The committee which developed a full chapter on these and other issues pertaining to prevention and health promotion, included such widely

respected practitioners as Rick McMichael DC, Past-President, Ohio State Chiropractic Association, Michael Pedigo DC, Past-President, International Chiropractors' Association, and Louis Sportelli DC, Past Chairman of the Board, American Chiropractic Association. The committee's recommendations, as with everything in these guidelines, were then debated and approved by the full consensus group).

22. With respect to use of the guidelines in risk management, for an extended example see para 12. With respect to use in reimbursement:

- a) One must read the full guidelines document to understand the recommendations properly.
- b) Taking an example, however, from the chapter on frequency and duration of care, the guideline given for management of acute, uncomplicated neuromusculoskeletal disorders is:

Up to a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total), following which manual procedures may no longer be appropriate in the absence of significant documented improvement.

(This follows the guideline for manipulation for back pain adopted by the interdisciplinary consensus group in the RAND study).<sup>8</sup>

c) Various complicating factors justifying modification of care are then noted - including duration of pain pre-consultation, severity of symptoms, number of previous episodes, injury superimposed on pre-existing condition, etc. There is acknowledgement that care is given to individual patients and that there may be circumstances you can document in particular cases that justify variation from the guidelines.

d) Is this limiting? If you wish to give a patient with acute uncomplicated back pain two months of daily adjustments with the same technique with no evidence of improvement and no reassessment - yes, these guidelines by your peers suggest that is unreasonable, and will limit your practice.

All chiropractors, however, will be influenced in a more attractive way. These guidelines provide an impressive new foundation for negotiations with third party payors that will justify and in due course achieve increased levels of reimbursement for short and long term care given from a truly chiropractic perspective. They provide a coherent basis for inclusion of chiropractic services within a U.S. national health care program. That's the thing about good consensus methods. The divergent views of many, confusing to the world and ineffective as a result, are refined into one - here that of 50,000 North American chiropractors - that brings new authority and opportunities for all.

**References**

1. Smith R (1991) 'Where is the Wisdom: The Poverty of Medical Evidence', *BMJ* 303:798-799.
2. For a detailed literature review see *The Chiropractic Report*, September 1991 (Vol. 5 No. 6).
3. For a description of consensus methods see Fink A, Kosecoff J et al (1984) 'Consensus Methods: Characteristics and Guidelines for Use', *AJPH* 74(9):979-983.
4. Gilman G and Bergstrand J (1990) 'Visual Recovery Following Chiropractic Intervention' *J Behavioral Optometry* 1(3):74-77; reprinted in *California Chiropractic Journal* (1990) 15(6):22-28.
5. Browning JE (1990) 'Mechanically Induced Pelvic Pain and Organ Dysfunction in a Patient without Low Back Pain', *J Manipulative Physiol Ther* 13(7):406-411.
6. Liebl NA and Butler LM (1990) 'A Chiropractic Approach to the Treatment of Dysmenorrhea', *J Manipulative Physiol Ther* 13(3):101-106.
7. Falk JW (1990) 'Bowel and Bladder Dysfunction Secondary to Lumbar Dysfunctional Syndrome', *Chiro Technique* 2(2):45-48.
8. Shekelle PG, Adams AH et al (1991) 'The Appropriateness of Spinal Manipulation for Low Back Pain: Indications and Ratings by a Multidisciplinary Expert Panel, (extracts), RAND, Santa Monica, California. Monograph No. R-4025/2 - CCR/FCER.
9. Bergmann T (1990) 'Introduction and Opening Statement', *Chiro Technique* 2(3):71.

**SUBSCRIPTION AND ORDER FORM**

(6 bi-monthly issues). Year commences November.

		Check One
US and Canada (your currency)	1 year \$ 70.00 2 years \$130.00	<input type="checkbox"/> <input type="checkbox"/>
Australia and NZ (your currency)	1 year \$ 95.00 2 years \$180.00	<input type="checkbox"/> <input type="checkbox"/>
Europe / elsewhere	1 year US\$ 75.00/£40 2 years US\$140.00/£76	<input type="checkbox"/> <input type="checkbox"/>
Quebec (issues in French or English)	1 year \$110.00 (Prices include a new 7% GST - Goods & Services Tax).	<input type="checkbox"/>

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_  
Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_  
Zip \_\_\_\_\_

Tel. No. ( ) \_\_\_\_\_

**PLEASE CHECK ONE**

- Visa Card Number \_\_\_\_\_
- Master Card Exp. Date \_\_\_\_\_
- Check/Cheque Enclosed

Payable to: The Chiropractic Report  
3080 Yonge Street, Suite 3002  
Toronto, Ontario M4N 3N1 Canada  
Tel: (416) 484-9601 Fax: (416) 484-9665