The Chiropractic Report

www.chiropracticreport.com Editor: David Chapman-Smith LL.B. (Hons.) November 2003 Vol. 17 No. 6

Professional Notes

Chiropractic Manipulation for OA of the Knee

Tucker, Brantingham and Myburg, chiropractic researchers from South Africa, have recently completed the first controlled trial comparing standard medical management and manual therapy – in this instance chiropractic manipulation – for treatment of osteoarthritis (OA) of the knee. The report of the trial, appearing in the *European Journal of Chiropractic*, notes:

a) OA is the most common joint disease in human beings, with knee OA resulting in more disability than any other form of the disease.

b) A major recent trial of arthroscopy for OA of the knee – the first such trial – established that surgery was no better than placebo. (Moseley JB, O'Malley K et al. (2002) *A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee*, NEJM 347(2): 81-87. For review of this see the November 2002 issue of *The Chiropractic Report*)

c) NSAIDS are the mainstay of drug therapy but their prolonged use is con-

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Marketing Evidence-Based Chiropractic Services

A Precedent and Guide from Canada

A. Introduction

SOFT-TISSUE MUSCULOSKELetal injuries and pain, including back and neck pain, represent the largest and most costly category of claims for individual employers, workers' compensation schemes and motor vehicle insurers throughout the developed world. They also represent the largest part of chiropractic practice.

Following the various upheavals of the 1990s – important new trials and clinical guidelines, a revolution in the management of musculoskeletal pain, the emergence of spinal manipulation as a first line approach to management, new market forces giving third party payors more say in who delivers care and how, the rise of patient motivation and satisfaction as key outcomes for patients and payors – we have finally reached the exciting point in health care history where:

- chiropractic scope of practice, both methods of diagnosis and management;
- best evidence-based care, now including patient reassurance and education, manipulation/mobilization and exercise;
- cost-effectiveness; and
- the needs of employers, workers' compensation schemes and other third party systems – and their willingness to break traditional patterns of care to answer those needs have finally come together.

There has never been a better time for individual doctors of chiropractic to market their services to local industries, and for associations to negotiate change with motor vehicle, workers' compensation, and indeed broad government health plan authorities. Just one example of the latter is the new legislation in the US providing coverage for chiropractic services for the military and veterans under the Department of Defence and the Department of Veterans' Affairs respectively.

2. But how does the individual chiropractor, group of chiropractors, or professional association go about presenting its case? How does one find the evidence – scattered amongst many journals, systematic reviews and clinical guidelines, which continue to pour forth with attendant inconsistencies and arguments.

How do you summarize this? We have all learnt that evidence and guidelines have to be reduced to a very simple format if they are going to be understood and of influence.

What, from their perspectives, do third parties want and require? They are being approached by other professional groups also. How will your chiropractic services dovetail with those of other health professionals in an appropriate way that will work in the real world?

3. What is needed is a thoroughly developed, market-tested, practical and authoritative precedent to use as a model. Fortunately such a model now exists in the key field of back pain, the single most common and expensive source of injury and claims for those you will be speaking to – and this model can be readily adapted for all neuromusculoskeletal disorders or all of chiropractic practice.

This model comes from the workers' compensation system in Ontario, Canada, and is presented in this issue of the Report.

Have you resubscribed?

The third and final resubscription notice for 2004 is enclosed with this issue. If you have not yet resubscribed please take a moment to do this now.

However, as we begin and to help focus attitudes on the perspective of buyers/payors in the complex world of contemporary mainstream health services, understand and note that the Ontario model involves a program of care for which:

a) Chiropractors can deliver all key services – indeed they have a better strategic position than anyone else to do this.

b) Despite this, there is no specific mention at all of chiropractic services – or the services of any other professional group. The focus, as is necessary in a multi-stakeholder situation, is on evidence-based, generic services (e.g. spinal manipulation), not the services of an individual profession (e.g. chiropractic adjustment or medical manual therapy, or physiotherapy/physical therapy exercises).

B. Ontario WSIB Programs of Care – Background

4. In Ontario there is one government-appointed agency providing workers' compensation, the Workplace Safety and Insurance Board (WSIB). We are about to look at its programs of care for acute (up to 4 weeks), sub-acute (5-12 weeks) and chronic (13-24 weeks) phases of management of low-back injuries. All necessary information for chiropractors and others to implement these programs is available online at www.wsib.ca (click on Health Professionals and then Programs of Care (POC)).

These are the reasons why you, and those you may be negotiating with, can rely on this model as an evidence-based practical plan of care acceptable to all reasonable parties:

a) The Province of Ontario, with a population of 12 million, has a large and sophisticated health care system. The chiropractic profession is one of 21 regulated health professions, has been regulated since 1927, and currently totals approximately 2,700 practising doctors of chiropractic. Reasonable and necessary chiropractic services have been funded under the government's general health care plan, under statutory motor vehicle insurance benefits and under workers' compensation since the 1970s.

b) Ontario has the largest industrial base in Canada, and the WSIB is one of the largest workers' compensation authorities in the world. As for all workers' compensation schemes, back pain injuries are the most common and costly form of injury and claims.

c) Therefore, when there was significant controversy over the best approach to the management of back pain injuries in the mid-1990s, the WSIB had both the need and resources to resolve the matter properly. This involved:

- Establishing a multidisciplinary panel of experts from relevant health professions to provide a literature review and guidelines on best evidence-based methods of management of acute back injuries, and then another representative panel of providers, employers and employees to recommend a specific program of care. (For the record, and because of the impressive work they did for the profession, chiropractic representatives on these panels and subsequent ones for chronic pain were Dr. Ted Crowther, Dr. Robert Haig, Dr. Donald Henderson and Dr. Silvano Mior, all nominated by the Ontario Chiropractic Association).
- Running a six month trial of the pilot POC to test its practicality and effect.
- Following this pilot, developing a final POC for management of back pain injuries in the acute and sub-acute phases.
- Undertaking a completely separate but similar process for chronic or persistent low-back pain following injury.

d) Issues that the WSIB made clear at the outset – and that all treating professions respected – included:

i) The WSIB would continue to appoint nurses as case managers for claims by injured workers.

ii) Evidence-based management chosen would be described in terms of treatment methods (e.g. spinal manipulation, exercise, medication) rather than choice of professions (e.g. chiropractic, medical or physiotherapy care) and could be provided by any regulated health profession authorized to provide that treatment and chosen by the injured worker.

iii) Each health provider's management responsibilities would extend beyond simply offering treatment – the POC would include communication with employers with a view to understanding work status and demands, and promoting early return to or maintenance of full or modified work.

iv) The POC needed to be described in simple and practical terms, easily understood by all parties.

v) The POC should include guidance on standard outcome measures to be used to measure results.

vi) Complicated cases, involving significant red flags, yellow flags or multiple injuries, might require co-management and/or individualized care outside the POC. However decisions on this, and decisions as to which services and/or providers to use within the POC, should be the responsibility of the primary treating professional chosen by the injured worker.

vii) There would be a block fee for management to the point of discharge within each of the acute (first 4 weeks) and sub-acute (5-12 weeks) phases of

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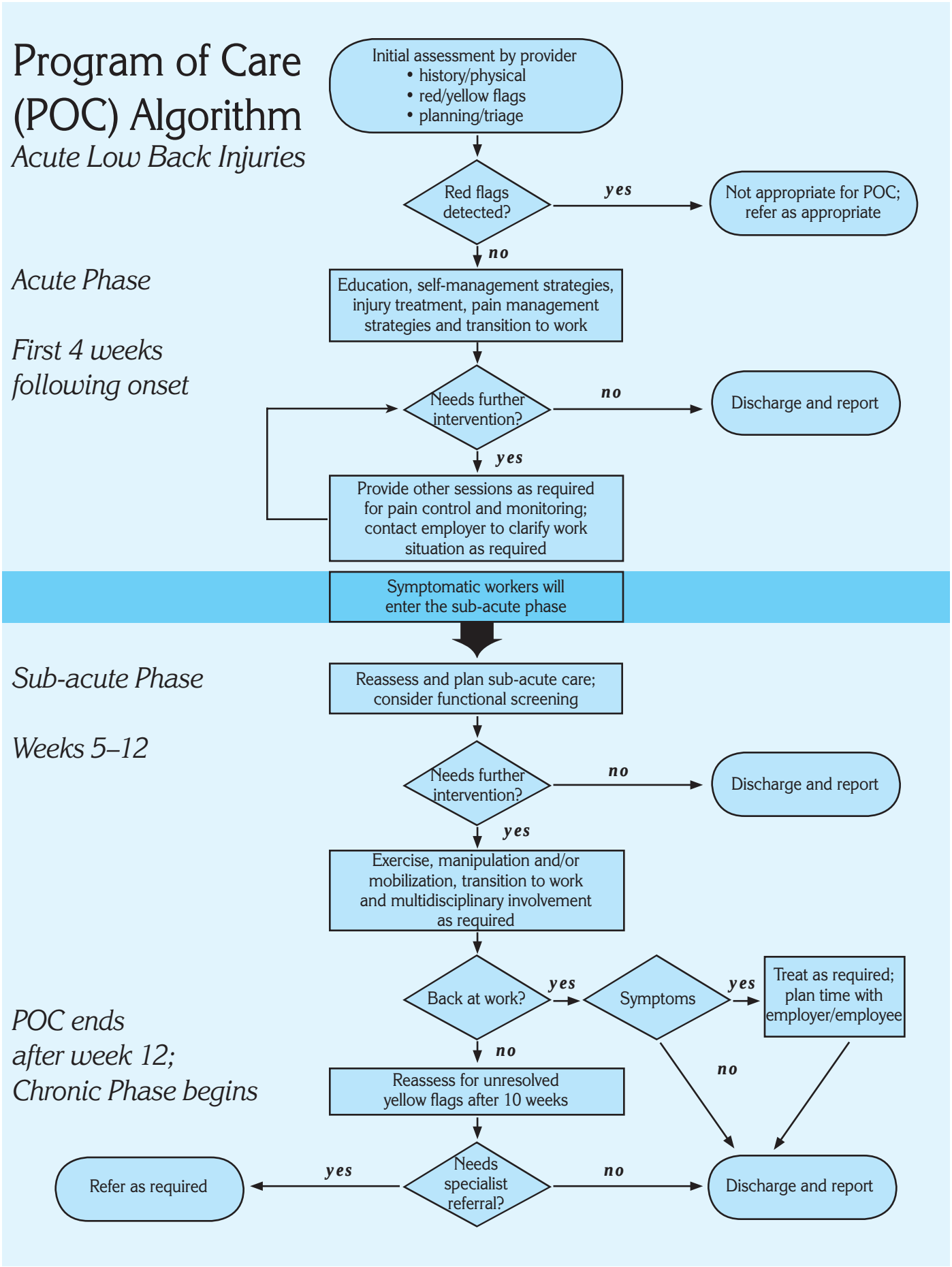
Changes of mailing instructions should be sent to The Chiropractic Report, 3080 Yonge Street, Suite 5065, Toronto, Ontario M4N 3N1, telephone 416-484-9601, fax 416-484-9665. Printed by Harmony Printing Limited, 123 Eastside Drive, Toronto, Ontario, Canada M8Z 5S5. **ISBN 0836-144**

Figure 1. Ontario WSIB Program of Care for Acute Low-Back Injuries – Algorithm



Chiropractic Manipulation of OA for the Knee

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troversial because of side effects and "recent evidence that some of these anti-inflammatory agents may depress the synthesis of essential proteoglycans in cartilage".

d) There are no previous trials comparing the use of NSAIDs and any form of manual therapy for the treatment of OA of the knee.

Summary details of this new trial are:

a) Subjects were 60 adults with OA of the knee randomly assigned either to a chiropractic manipulation group (n 30 – 8 consultations over 3 weeks) or an NSAIDs group (n 30 – Meloxicam 7.5 mg tablets once daily for 3 weeks).

b) Outcome measures, taken after the 1st, 4th and 8th consultations, were both subjective (Numerical Pain Rating Scale – 101, Visual Analog Scale and Patient Specific Function Scale) and objective (goniometric and pressure algometer measurements).

c) Both groups showed significant improvement and the researchers conclude that "both manipulation and Meloxicam are equally effective in the short-term management of OA of the knee."

Further larger trials with longer term results are needed before anything too definitive can be said. However, this trial begins to plug a major gap in the literature and is consistent with the clinical experience of chiropractors and their patients – namely that a periodic course of manipulation offers effective palliative care to keep many patients with OA largely pain-free and able to manage their activities of daily living without the side effects and risks of long-term drug use. (Tucker M, Brantingham JW, Myburg C (2003) Relative Effectiveness of a Non-steroidal Anti-inflammatory Medication (Meloxicam) versus Manipulation in the Treatment of Osteo-arthritis of the Knee, Europ J Chiro 50:163-183.)

Other Research Highlights

1. **Denmark – Back Pain Not Related To Inactivity In Children.** There are obvious benefits to physical activity for everyone including children – from increasing bone strength to reducing obesity. But is there a relationship between physical inactivity and back pain in children and adolescents? Some studies have said yes, others no, but activities have never been measured objectively and fully.

In this new more thorough study from Weddekopp, Leboeuf-Yde et al., 806 children and adolescents in Odense, Denmark had their levels of activity objectively measured by an accelerometer worn on the right hip for four days. On this basis results were clear that there was in fact no association between levels of physical activity and back pain. (Wedderkopp N, Leboeuf-Yde C et al. (2003) Back Pain in Children: No Association with Objectively Measured Level of Physical Activity, and Brown D Point of View, Spine 28(17):2019-2024).

2. **Netherlands – Muscle Relaxants for LBP.** *Spine* has recently published a systematic review by van Tulder, Touray et al. assessing current evidence and practice relating to the use of muscle relaxants for patients with non-specific low-back pain. Key findings and observations from this detailed review, prepared for the Cochrane Collaboration, include:

a) 30 randomized controlled trials establish that muscle relaxants do provide effective pain relief for acute and chronic LBP. However their use remains controversial because of the central nervous system side effects of drowsiness and dizziness, and because there is no evidence to say they are more effective than medications with fewer side effects – analgesics and NSAIDs.

b) Even though national clinical guidelines in the UK and the US do not recommend the use of muscle relaxants for back pain, 91% of physicians report using them and 35% of patients visiting a primary care physician for LBP are prescribed muscle relaxants.

c) The term muscle relaxants describes a wide range of drugs with different indications and mechanisms of action. These are described in the paper. Main categories are *Antispasmodics,* used to decrease muscle spasm and sub-classified into:

- Benzodiazepines – sedatives, hypnotics, anticonvulsants and/or skeletal muscle relaxants (e.g. diazepam, tetrazepam).
- Non-benzodiazepines – a variety of drugs that act at the brain stem or spinal cord level through mechanisms not fully understood (e.g. Cyclobenzaprine, Carisoprodol and Chlorzoxazone)

and *Antispasticity medications* – e.g. Baclofen which inhibits transmission at the spinal level and depresses the central nervous system.

(Van Tulder MW, Touray T et al. (2003) Muscle Relaxants for Nonspecific Low Back Pain: A Systematic Review Within the Framework of the Cochrane Collaboration, Spine 28(17): 1978-1992.) Abstract available online at www.cochrane.org search word 'muscle relaxants' or order full review.

3. **Switzerland – Prescription Rights In Chiropractic Practice**. The last issue of *The Chiropractic Report* (September 2003), reviewed a survey indicating that approximately half of North American chiropractors supported limited prescription rights for OTC and musculoskeletal medicines within the scope of chiropractic practice. A new survey of Swiss chiropractors just published in the *European Journal of Chiropractic* presents this information:

a) Since 1995 Swiss chiropractors have been able to prescribe various over-the-counter (OTC) drugs, available to patients without prescription but reimbursed by government and private insurances when they are prescribed by chiropractors.

b) A 1999 survey mailed to all 246 Swiss chiropractors and completed by 126 (a response rate of 51.2%) showed majorities in favor of these prescription rights, and of extending them. 61% of respondents were using the present prescription rights, 82% thought that this limited prescription right was "an advantage for the profession" and 76% thought that rights should be extended to a limited range of other prescription drugs. (Robert J (2003) *The Multiple Facets of the Swiss Chiropractic Profession*, Europ J of Chiro 50:199-210).

The World Federation of Chiropractic is just commencing a major international consultation on the role and identity of the chiropractic profession – it seems like this is much needed. (For information on the WFC consultation visit www.wfc.org and click on identity consultation. This Report will bring you more information in due course).

4. **USA – Anatomy of the Facet Joints in the Cervical Spine.** Little has been known about the cartilage in the cervical facet joints. A new study from biomedical engineers at the Department of Neurosurgery, Medical College of Wisconsin, Milwaukee, perhaps explains why females are more vulnerable to whiplash-associated disorders. Using cryomicrotomy techniques to quantify facet joint geometry, it reports that the thickness of the cartilage and the gap within the joint depend not only on the region of the spine (upper versus lower cervical spine) and location (dorsal versus ventral) but also on gender, and that:

a) Overall mean thickness of the cartilage is significantly lower in females than males in both the upper cervical spine (0.6 mm vs 0.9 mm) and lower cervical spine (0.4 mm vs 0.5mm).

b) The cartilage gap in the joints in the dorsal region is greater in females than males and that therefore, for anatomical and biomechanical reasons, bone to bone contacts and injury to the subchondral bone are more likely in whiplash in females.

(Yoganandan N, Knowles SA et al. (2003) *Anatomic Study of the Morphology of Human Cervical Facet Joint,* Spine 28(20): 2317-2323)

World Notes – Italy

The long struggle for legislative recognition and regulation of the chiropractic profession in Italy reached a new flash point in September-October with a Supreme Court decision that it was illegal to practise chiropractic without a medical licence – followed by police closure of five chiropractic offices.

It is important to understand the political background to these legal steps which, paradoxically, may finally be the catalyst for recognition of the profession by the Italian government. But first some facts about chiropractic in Italy:

• There are approximately 220 duly qualified doctors of chiropractic (DCs) in Italy, 160 belonging to the Italian Chiropractic Association (AIC – Associazione Italiana Chiropratici, website: www.chiropratica.com). A 1999 survey indicates that approximately 25% are Italian and 25% American, with the other 50% being from a variety of mostly European countries.

• There is a higher percentage of North American graduates than in most other European countries – approximately 3 in 4 (72%) have graduated from Canadian or US colleges, with 30% being Palmer College graduates. Most others are graduates of the Anglo-European College of Chiropractic in the UK.

• There is good acceptance of chiropractic services by the public and individual members of the medical profession and a growing number of private insurance plans provide coverage for services. However approximately 1 in 2 (47%) of DCs work in medical clinics offering chiropractic services. There is a long history of DCs, particularly young DCs from North America, working in 'static clinics' and other medically owned clinics in Italy, and this economic situation clearly underlies current legal and political difficulties.

• The highest concentration of DCs, over 1 in 5 (21%), is in the northern region of Lombardi where the centre of commerce and power is Milan. Interestingly the government of Lombardi has just provided the World Health Organization with a grant of €6 million for research to better describe and promote the role of the leading forms of complementary and alternative medicine (CAM) including chiropractic.

And now to the political situation. There can be little doubt that DCs will ultimately be recognized as a separate and distinct profession under Italian law. This is partly because of developments in the wider European Community and partly because of the leadership and achievements of the AIC whose current President is Dr. Eddy Pellissier of Genoa. Here is the context in Europe and Italy:

• By the mid-1990s chiropractic was regulated as a separate profession under chiropractic legislation in 8 European countries – Cyprus, Denmark, Finland, Liechtenstein, Norway, Sweden, Switzerland and the United Kingdom. However in civil law countries such as Belgium, France, Italy, Portugal and Spain, the profession was established but its practice was technically illegal. There had been recent prosecutions in France and Spain, commenced on complaints by medical groups rather than patients.

Because of these inconsistencies within the European Community, and after political action led by the European Chiropractic Union, the European Parliament referred the matter of regulation of chiropractic to an expert committee. However it saw chiropractic as one of several major complementary and alternative medicine (CAM) disciplines widely used in Europe and needing a consistent regulatory framework – other beings homeopathy, traditional Chinese medicine (including acupuncture),), naturopathy and osteopathy. Accordingly the expert committee, when it delivered its Lannoye Report in March 1997, dealt with chiropractic within the framework of CAM. The Lannoye Report, as adopted by the European Parliament in May 1997, called for consistent recognition and regulation of chiropractic and other major CAM disciplines across Europe.

• As a result of the Lannoye Report various governments have since announced a new policy of recognizing and regulating major forms of CAM, specifically including chiropractic. These are Belgium (1999), France (2001) and most recently Portugal (2003). Last year the national medical association in Italy re-asserted that all forms of CAM formed a part of medical practice. At a December 2002 meeting convened by legislators at the urging of the AIC, medical association representatives acknowledged that chiropractic should indeed be regulated and recognized as an independent profession – but current developments suggest they have not yet persuaded all their members. The Supreme Court decision involved 2 duly qualified DCs, but ones who were not AIC members. Clearly the time has arrived for the Italian government to act.

Figure 2. Ontario WSIB Program of Care for Acute Low-Back Injuries – Quick Reference Guide

Program of Care

for Acute Low Back Injuries –

Quick Reference Guide *(see www.wsib.ca for exact format and artwork)*

Initial assessment report

The health care provider will communicate the key findings of the initial assessment (including red and yellow flags) and treatment plan with specifics on the expected frequency and duration of the treatment program. Send to the WSIB within 24 to 48 hours. Fax: 1-888-313-7373 or (416) 344-4684.

Communication with employer

Phone calls and/or letters to inform the employer of involvement of the injured worker in the Program of Care, to provide general guidance regarding level of abilities, to verify job demands and to discuss availability of modified work. All phone calls should be documented in the injured worker's chart. Frequency: at intake and discharge.

Care & Outcomes Summary

The Care & Outcomes summary will include the level of participation in the Program of Care, key treatment progress, the injured worker's functional abilities, job status and any further recommendations. The Care & Outcomes summary should be completed at any point when the injured worker is discharged from the Program of Care. Send to the WSIB as soon as possible after discharge.

Communication with WSIB

Call the WSIB . . .

- If the worker is not progressing as expected
- If the worker is referred to another health care provider within the Program of Care
- If red and yellow flags are identified that would warrant further evaluation outside the Program of Care
- If any other issue arises.

Red Flags

Neurological: major motor weakness, disturbance of bowel or bladder control. *Infection*: fever, urinary tract infection (UTI), intravenous (IV) drug use, immune suppressed. *Fracture*: significant trauma, osteoporosis risk. *Tumour*: history of cancer, weight loss, fever, pain worse supine or at night.
Inflammation: morning stiffness > 1h

Yellow Flags

- Believes hurt equals harm
- Fears/avoids activity
- Low mood/social withdrawal
- Prefers passive treatments
- Home environment concerns
- Work environment concerns

Acute Phase

Recommended:

Education, Self Management Strategies, Injury Treatment (stretching exercises, spinal manipulation and/or mobilization), Pain Management Strategies, Transition to Work.

Not recommended:

Acupuncture, Prolonged/total bed-rest, Bio-feedback, Electrical Stimulation, Flexion exercises, Magnet therapy, Mechanical traction, Ultrasound.

Sub-acute Phase

Recommended:

Exercise, Manipulation and/or Mobilization, Transition to Work

Not recommended:

Acupuncture, Prolonged/total bed-rest, Bio-feedback, Electrical Stimulation, Magnet Therapy, Mechanical Traction, Transcutaneous Electrical Nerve Stimulation (TENS), and Underwater Traction and Underwater Massage, Ultrasound .

Workplace Safety & Insurance Board

WSIB ONTARIO CSPAAT

Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

the POC, irrespective of who provided the services and how many. Additional amounts would be available for imaging, where necessary. At the discretion of the treating professional, and in the presence of reasonable grounds, patients could be treated outside the POC on the existing fee-for-service schedule.

C. POC for Acute Low-Back Injuries

5. The Algorithm and Quick Reference Guide, summarizing the POC, are reproduced as Figures 1 and 2. These are designed to be printed on two sides of one page, which is then laminated in plastic and used by all parties from the patient and supervisor at the work site to the WSIB nurse case manager and treating professionals. Its value lies in its comprehensiveness yet brevity and clear sense of direction. All key services, including spinal manipulation, fall within the chiropractic scope of practice.

6. The various aspects of the POC are then more fully described, but still clearly and simply, in a more complete 17 page Reference Guide. (To access this online go to www.wsib.on and click on Health Professionals then POC, then POC for Acute Low-back Injuries and finally – near the end of that POC – on Reference Guide). It is noted:

a) *Admission Criteria*. This POC is designed for workers with an acute soft-tissue low-back injury (symptoms up to 4 weeks), assessed within the first 28 days "from the date of injury and/or recurrence", with no clinical evidence of "significant red flags", and where the worker is either at work or off work. In other words, it applies to most patients with low-back pain.

b) *Assessment.* Standard elements of the initial assessment, which include a pain scale and the Roland Morris Disability Scale, and the report form which incorporates a brief treatment plan, appear online and may be downloaded for your review, adaptation and use.

(The pilot program included additional objective (modified Schober Test for lumbar flexion and extension) and subjective (Functional Abilities Confidence Scale – FACS) assessments but these were regarded as too cumbersome and unwarranted, and were deleted from the final program).

Assessment of yellow flags, psychosocial risk factors that may change patient behavior, expectations and recovery rate, is made but the presence of these flags is anticipated in patients entering the POC. Yellow flags only provide grounds for referral and co-management in exceptional cases or on reassessment after 10 weeks without satisfactory progress.

c) *Acute phase (first 4 weeks) – care components*. These, consistent with the scientific evidence and chiropractic management, include patient reassurance, promotion of activities of daily living, instruction in and periodic supervision of exercises and spinal manipulation and/or mobilization as indicated by assessment.

d) *Medication and medical care*. In the Reference Guide you will see no mention of medical care and little reference to medication, only the suggestion that non-prescription analgesics and NSAIDs may be suggested as an optional part of pain management – but only as "a temporary palliative measure in conjunction with other pain relief interventions" such as heat/ice and manipulation/mobilization.

Reasons are that medical treatment services in Ontario, including those for injured workers, are reimbursed under the government's general health insurance plan rather than through the WSIB, and that this new WSIB program deals with soft-tissue injuries for which evidence-based management now relies on more active and motivational treatments typically provided by chiropractors, massage therapists, physiotherapists and psychologists.

e) *Care and outcomes summary*. The Reference Guide includes the form for this, which must be completed on discharge from the acute phase even if continued management is then needed in the sub-acute phase.

f) *Frequency and duration of care*. This is left to professional judgement and is anticipated to range between 1 and 5 treatments in the first week depending upon the case.

g) *Fees*. There is a block fee of $340.00 for treatment and report in the acute phase, subject to a minimum of 3 visits. Additional amounts are payable for receiving telephone enquiries from the WSIB ($23.24 per call) and imaging where necessary. (Chiropractic diagnostic imaging is reimbursed at the same rate as medical imaging.)

h) *Sub-acute phase* (5-12 weeks) – *care components*. These are similar to the acute phase. However, where a "course of manipulation and/or mobilization" was not used in the acute phase, it is now strongly recommended. Conversely, where it was used it should only be continued with clear evidence of response. It should be accompanied by "a graduated, structured quota-based" program of exercise focusing on "strength, flexibility and general fitness . . . aimed at improving the ability to perform physical job function." Exercise may be supervised in a "health care professional setting" or at home, or in the workplace or in a community exercise facility, and should be undertaken 3-5 times per week for 30-90 minutes.

i) *Fees*. Block fees in this phase are at weeks 5-6 (minimum of 3 visits during the two week period) – $150; weeks 7-8 (min. 2 visits) – $120; weeks 9-10 (min. 1 visit) – $90; weeks 11-12 (min. 1 visit) – $70. As in the acute phase imaging and report fees are additional.

D. POC for Persistent Low-Back Pain

7. This POC covers management during a further 12 week phase (weeks 13-24) after sub-acute care. All elements of the program have been finalized, except the block fees to be paid, and it is scheduled to be posted online at the WSIB website by the end of December. Key points are:

a) It is based on a comprehensive literature review and chronic pain report by a multidisciplinary panel convened by the WSIB.[1] For discussion of this impressive study see the March 2002 issue of *The Chiropractic Report* (Vol. 16 No.2).

b) Interventions are similar to those in the acute and sub-acute phases, with mainstays being education/reassurance, manipulation/mobilization, and structured exercise. New and additional options in this phase are cognitive behavioral therapy and massage.

For details check online in the weeks ahead.

As discussed earlier, it is exciting to have reached the point in history where the scientific evidence and policy development within a sophisticated health care agency such as the Ontario WSIB both support all major chiropractic diagnostic and treatment methods for the management of patients with acute and chronic spinal pain, including the core treatment approach of spinal adjustment or manipulation.

E. Conclusion

8. In the July 2003 issue of this Report, we summarized the evidence supporting the safety, effectiveness and cost-effectiveness of chiropractic management of back pain, together with the evidence of patient preference and satisfaction. These evidence-based POCs from Ontario now provide an authoritative and practical blueprint for converting this evidence into marketable programs of care.

This can be done in countries where chiropractic services are substantially integrated into mainstream health care, as in Canada, Denmark, Switzerland and the USA, right down to countries where chiropractic services are newly introduced and largely unknown. The ability to gain acceptance from government and medical authorities and third party payors when chiropractic services are presented as an evidence-based rational response to their needs and the needs of patients – rather than in a manner perceived as promotion of chiropractic interests – has been well demonstrated by recent pioneers such as Dr. Claudia Mikus Kuchnick in Liechtenstein, Dr. Rajeshwar Roy in Mauritius, Dr. Charles Sebwana in Uganda, Dr. David Tyggum in Guatemala and Dr. Jameson Uy in the Philippines.

In Liechtenstein, for example, there are now three chiropractors serving a population of 32,000. They have negotiated excellent private insurance coverage for reasonable and necessary chiropractic services under health care plans that cover the great majority of citizens. Within three years of returning to Uganda as that country's first chiropractor, Dr. Charles Sebwana, a graduate of the Anglo-European College of Chiropractic in the UK, had established a chiropractic unit within Mulago Hospital in the capital city of Kampala after negotiations with and approvals from the hospital, medical and governmental authorities. Dr. Tyggum and Dr. Uy have found similar acceptance in health care systems unfamiliar with chiropractic services, and Dr. Roy, who became the first Mauritian to commence chiropractic practice in his country in the 1990s, soon had employers/private insurers paying for his services because of the evidence of cost-effectiveness he presented – and subsequently confirmed in his practice.

Perspective is everything. The question is 'what needs am I answering for the union/employer/buyer of services that I am approaching?' not 'how can I persuade them they need and will benefit from the availability of chiropractic services?' The standard needs of employees and employers, in almost all industries given the pervasiveness of back pain and soft-tissue injuries, is effective prevention and management of injuries, at a quantifiable and acceptable cost, with choice of providers, interprofessional coordination and a balanced and effective return to work/modified work program.

The Ontario WSIB POCs show how to get there – adapt them to your circumstances, and use them with confidence. TCR

Reference:

1 *Chronic Pain Initiative: Report of the Chronic Pain Expert Advisory Panel* (2000), Ontario Workplace Safety and Insurance Board, Toronto.

Yellow Flags and Chronic Disability from LBP

"I suspect that any attempt to return workers with chronic disabling regional backache to work may be as doomed as the precedents . . . Most people with regional backache manage to get on with their lives but for transient compromises in function at work and at home. 'Workers with chronic disabling regional backache' are people who have been transformed into insurance claimants.

"Most people with regional backache are neither inclined toward nor susceptible to this fate. The people at risk for insurmountable regional backache . . . are distinctive. Life inside the workplace and outside the workplace succors them not. They have multiple somatic symptoms and are generally 'tired and worn out.' Their next backache may be the 'last straw.' Disabling backache is their surrogate symptom. For these people who live under a pall, 'return to work' is too narrow a public health goal and likely to prove iatrogenic in its pursuit."

Nortin Hadler, MD, University of North Carolina at Chapel Hill, commenting on a new study from Norway reporting disappointing long-term results. (Hadler NM, (2003) *Spine*, 28(20):2316)