



THE CHIROPRACTIC REPORT

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Independence - Its Strengths and Limitations for Chiropractors

A. Introduction

1. Stephen Covey's 'The 7 Habits of Highly Effective People'¹ is profoundly wise. Its principles apply to professions as well as people, and it contains valuable and practical advice for chiropractors in an era of rapid change.

Covey, an MBA from Harvard whose book is the most successful on personal or corporate growth and effectiveness since Scott Peck's 'The Road Less Travelled',² emphasizes the need for a 'principle-centered' approach to solving personal and professional problems - for having the security and ability to take advantage of opportunities created by change. The 'personality ethic' and other gimmicks may bring temporary benefit - true insight and lasting effectiveness require something more substantial.

2. One of Covey's central messages is that independence represents limited maturity and frustrates effectiveness - whether for an individual or an organization. He describes three stages of maturity:

a) **Dependence.** As infants we are all dependent on others. As we move to adulthood we seek independence - physically, mentally, emotionally, financially. "I can do it, I am self-reliant, I can choose."

Many adults, independent in various respects, remain dependent - on family, a spouse or friend, or on a self-limiting quality such as hatred for another, regrets, anxiety for easy wealth.

b) **Independence.** This is the first goal in seeking maturity and effectiveness. Covey's first three habits, fundamental to achieving independence are:

- *being proactive*: initiating change and action.
- *beginning with the end in mind*: working towards clear goals.
- *putting first things first*: knowing and acting on your priorities.

However independence is merely a start. No person or profession will be 'highly effective' at this level of maturity.

c) **Interdependence.** This is the final goal. It involves appreciating that one can

only do so much alone and needs to nurture and be nurtured by others, and work in concert with them. The three habits vital to interdependence are:

- *thinking win/win*: the course of action must benefit both parties.
- *seeking first to understand - then to be understood*: listen, and appreciate the deep differences in perception that you and those around you have.
- *synergize*: trust others. The ability to do this, notwithstanding the slings and arrows of life, is the key to high effectiveness. To quote Covey:

"Many people have not really experienced even a moderate degree of synergy in their family life or in other interactions. They've been trained and scripted into defensive and protective communications or into believing that life or other people can't be trusted. As a result, they are never really open to Habit 6 and to these principles.

This represents one of the great tragedies and wastes in life, because so much potential remains untapped - completely undeveloped and unused. Ineffective people live day after day with unused potential. They experience synergy only in small, peripheral ways in their lives. They may have memories of some unusual creative experiences, perhaps in athletics, where they were involved in a real team spirit for a period of time. Or perhaps they were in an emergency situation where people cooperated to an unusually high degree and submerged ego and pride in an effort to save someone's life or to produce a solution to a crisis.

To many, such events may seem unusual, almost out of character with life, even miraculous. But this is not so. These things can be produced regularly, consistently, almost daily in people's lives. But it requires enormous personal security and openness and a spirit of adventure."³

The 7th habit is '*sharpening the saw*' or constant attention to renewal (re-creation). If the goose is to continue to lay golden eggs, look after the goose.

3. These principles seem to speak loudly to the profession of chiropractic in the 1990s, an era of rapid change in the

Professional Notes

A New Practice Guidelines Council

The US Council on Chiropractic Education, now affiliated with similar accrediting agencies in Australia, Canada and Europe, has established and continually reviews minimum standards for chiropractic education. It has provided a vital foundation for the dramatic growth and increased acceptance of the profession during the past 30 years.

Leaders in the profession have seen a clear need in the 1990s for a similar comprehensive agency in the area of practice guidelines because:

- Government, the public and all those who pay for health care are demanding guidelines. Managed care and multidisciplinary care are here to stay - they are built upon practice parameters (general guidelines for practice) and clinical guidelines (guidelines for management of specific conditions).
- A fragmented response is inadequate. Many guidelines established by the medical profession are not being accepted by government and insurers because there are so many sets of guidelines from diverse self-appointed groups. That is why the US federal government has established the Agency for Health Care Policy and Research (AHCPR) to provide nationally-based, government-led, guidelines initiatives.

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1995 Centennial Celebrations

Canada: May 31 to June 4, Toronto, Ontario. United States: July 5-9, 1995, Washington DC (incorporating the 1995 World Chiropractic Congress) and September 13-17, 1995, Davenport Iowa. Clear those dates now.

profession and the health care marketplace. Chiropractors have a history of fierce independence. Their drive for independence has not only been impressive but is described by sociologists as perhaps one of the most distinctive social achievements in North America in the 20th century.

In some ways the profession has been interdependent (e.g. with patients) and in some ways it has been dependent (e.g. on a few major leaders, and on an antipathy to its historic opponent, the medical profession).

As chiropractors approach the centennial of the profession in 1995, most observers see chiropractic as substantially independent - a remarkable achievement. Despite powerful opposition and lack of public funds the profession has a unified and strong educational basis worldwide, a firmly based commitment to high quality research and scientific literature, and widespread public and legislative support for chiropractic practice. But what now are the practical strengths and limitations of the spirit of independence that has brought chiropractors to this point?

4. Last month student leaders from virtually every chiropractic college in Australia, Canada, Europe and the United States met in St. Louis, Missouri for the annual World Congress of Chiropractic Students. Two related questions they considered were:

- What is your attitude towards the medical profession?
- What role do you see medical doctors having in the establishment and growth of your practice?

On these questions, important for all chiropractors, students and the future of the profession, the students had highly divergent views. This was to be expected. Some come from chiropractic colleges that are housed and funded within universities, some from colleges that are private but have many faculty members with cross appointments in medical schools and which include hospital rounds as an integral part of their training. Yet others are from private colleges that still place a strong emphasis on the independence of the chiropractic profession. Accordingly:

- a) For some students, delivery of chiropractic care would essentially be a matter of educating the public about the benefits of chiropractic and serving patients independently and well.
- b) For others the need for improved understanding between doctors of medicine and chiropractic, and orderly inter-referral of patients, were seen as important, but of no great significance.
- c) For yet others the growth of new chiropractic practices and the profession in an era of managed care was seen as heavily dependent upon much greater acceptance of chiropractors by medical doctors and all others within the mainstream health care system.

5. Which way chiropractors answer these questions, whether they go for continuing independence or a new habit of interdependence, may well be the central issue to how 'highly effective' chiropractic will be in the fundamentally changed health care marketplace of the next 10 years. As Wardwell explains in his illuminating new text 'Chiropractic: The History and Evolution of a New Profession':⁴

- a) Historically there have been only been two outcomes for alternative health professions in North America - they have died (e.g. Thomsonism, the popular school of botanical medicine in the United States at the time of early chiropractic) or been absorbed into the medical mainstream (e.g. osteopathy and homeopathy).
- b) Chiropractic is the sole vibrant exception. This is because of the fiery independence of charismatic leaders such as B.J. Palmer, vital as chiropractic withstood the wholesale attack of organized medicine earlier in the century.
- c) Many chiropractors forged their identities and attitudes in this era of independence. However the relationship between the chiropractic and medical professions is much changed, and there is much mutual advantage in a new spirit of cooperation.

6. 'Success is a journey, not a destination'. The world changes. A clear illustration is the health care marketplace, particularly as it relates to chiropractic practice. Thus:

- a) Most of chiropractic practice involves patients with spinal pain syndromes - back pain, neck pain, referred pain and headache.
- b) This vast and growing group of patients in the health care marketplace was once accessible directly. Patients paid for their own care. Medicine and chiropractic offered markedly different treatments.
- c) Today the marketplace is heavily structured. Most patients have private and/or government insurance. In the 1990s that insurance is subject to greatly increased review. 'Case managers', who will usually not be health care providers, frequently control the levers. If this motor vehicle accident patient, or that workers' compensation patient, or that enrollee of a managed care plan for all primary health needs, wants to have chiropractic care a chiropractor's services must be:

- In the insurance contract/scheme/plan.
 - Approved by watching managers who devour all the new evidence on effectiveness, cost-effectiveness and clinical guidelines and tend to distrust - as does the public - all providers.
- d) Most significantly, in terms of the future of chiropractic practice, the medical profession is acknowledging that its whole basis of management of spinal pain syndromes - rest and medication, physical therapy modalities, unspecific exercises and little patient education - is wrong. On the basis of new research evidence and professional developments medicine is open to the use of specialist spinal manipulation services, and cooperation with chiropractors is one possible route - but there are others.

7. The rather dangerous assumption of some students in St. Louis was - and of some chiropractors is - that their futures are not much changed by this turmoil in the marketplace. Chiropractic is separate and distinct - only chiropractors adjust subluxations. To illustrate the quicksand beneath that proposition:

- a) A natural market response to the success of chiropractic and the new research evidence that skilled manipulation is more effective, cost-

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effective and safer than any other treatment for spinal pain is that others will seek to learn about spinal manipulation. For this they will turn to the language and ideas of the chiropractic profession as the market leader in terms of education, skill, clinical practice and research. Thus:

- In a recent article in the Canadian Family Physician David Howe MD, a family physician who uses spinal manipulation, adopts the hypothesis that the cause of back pain he is treating "is a subluxed facet joint." He manipulates so that it goes "back to its correct alignment."⁵
- Stanley Paris PT, a US physical therapist discussing sacroiliac dysfunction describes the SI joint as "locked or subluxed" causing "displacement or subluxation."⁶
- In the Family Practice Research Journal and the Journal of Orthopedic Medicine Jeffrey Daly MD et al, New York family physicians, adopt chiropractic terminology in writing on 'Sacroiliac Subluxation: A Common Treatable Cause of Low-Back Pain in Pregnancy'.⁷
- In England Alan Stoddard MD DO writes of 'adjusting' the spine⁸ and osteopathic students at the British School of Osteopathy place new emphasis on high-velocity techniques described as 'adjustment'.
- Is this use of chiropractic terminology made without full understanding of the chiropractic concept? No. In their writings and teachings the two most respected medical leaders in the field of manipulation, Philip Greenman in the US⁹ and Karel Lewit in the Czech Republic,¹⁰ use a neurological model to explain the lesion they are treating. Greenman's text, the most widely read by MDs in North America seeking to understand the role of manipulation, explains that the concepts of "holistic man" and "neurologic man" are fundamental to manual medicine, the two modern founders of which were D.D. Palmer and Andrew Taylor Still. He explains that the 'osteopathic lesion' and the medical 'spinal blockage' are the same as the 'chiropractic subluxation'.¹¹

b) In the words of the Swiss chiropractic leader Ray Sandoz DC "chiropractic does not and should not belong to chiropractors, to MDs, or to anyone else except to the sick ... It is finally a question of who will render the most efficient service with it."¹²

8. Assuming you are a chiropractor, and after thinking it through, how do you react to all of this? When Jiri Dvorak MD, a Swiss neurologist well published in the field of manual medicine, uses the terms 'manual medicine', and 'chiropractic medicine' interchangeably¹³ is that good or bad? There are two sharply divergent perspectives:

- a) This is inappropriate - an MD has no basis to presume that chiropractic care is the equivalent of manual medicine.
 - b) This is highly appropriate - indeed rather exciting. A whole generation of MDs discovering that skilled manipulation and other manual techniques are valuable should be seeing these as part of chiropractic and looking to the chiropractic profession for language, research, education and clinical assistance..
9. In North America today about 7% of the population receives spinal manipulative care, and over 90% of this is given by chiropractors.¹⁴ Because of the high incidence of spine-related pain and the rapidly growing acceptance of spinal manipulation, few would doubt that:

- a) In a few years that figure will at least triple.
- b) Most of this sudden growth of new patients will represent those referred by the medical profession for specialist manipulative services.
- c) The profession that gets the lion's share of that new market will ultimately be the leaders in manual care of spine-related disorders.

There are many reasons why that profession may - and should -

be the chiropractic profession. However it will require a shift in paradigm or 'habit' - from independence to interdependence. This is clearly underway, but must be promoted by chiropractic colleges and associations and be adopted by individual chiropractors. This Report now:

- Gives recent illustrations of the power of a posture of interdependence with medicine.
- Suggests practical steps that can be taken by individual chiropractors.

B. The Power of Interdependence

10. Examples are:

a) **The RAND Study.** The ongoing RAND study entitled 'The Appropriateness of Spinal Manipulation for Low-Back Pain' is the classic example in North America. For the first time the chiropractic profession, through its professional organizations (CCA and ACA) and its research foundations (CCR and FCER) authorized an independent respected corporation under the leadership of medical experts (Paul Shekelle MD and Mark Chassin MD MPH) to study issues vital to the chiropractic profession.

A central part of the study was a multidisciplinary panel, upon which chiropractors were represented - but as a minority (3 of 9). This displayed all of Covey's habits of effectiveness, including synergy and trust. The rewards have far exceeded anything chiropractic could have done alone and:

- Following release of the first RAND reports^{15,16} in late 1991 chiropractic enjoyed unprecedented media exposure and acceptance.
- Ever since there has been a flow-on effect. This includes major articles on chiropractic in the medical literature (e.g. the Annals of Internal Medicine¹⁷ and The Journal of Family Practice)¹⁸ and the popular press. The recent six-page story in the Washington Post entitled 'Chiropractors Come Into the Mainstream',¹⁹ by far the most positive endorsement of chiropractic ever in a respected national newspaper in the US, places central reliance on the RAND study.

The RAND study is also the single most powerful independent endorsement for including spinal manipulation and chiropractic services in a new US national health care plan. RAND's health policy experts have a more direct pipeline to Washington, DC than any chiropractic (or other health professional) advocacy group.

b) **AHCPR Guidelines on Back Pain.** The US government's Agency for Health Care Policy and Research is about to publish a comprehensive literature review and set of clinical guidelines on management of low-back pain. If spinal manipulation is given favourable mention, which seems likely, this will be a marked turnaround from all previous medical guidelines in North America. This will be because the chiropractic profession and its two representatives (Scott Haldeman and Jay Triano) have accepted a cooperative stance and participated in a research and policy environment where they have been prepared to relinquish control and place trust in others.

c) **The British Trial.** The single most important original research ever published for chiropractic was the trial by Meade et al published in the British Medical Journal in 1990.²⁰ This trial was only possible because the British Chiropractic Association was prepared to participate in an interdisciplinary research environment with trust and little control.

The British Medical Research Council was going to research the management of low-back pain - it would readily have looked at other areas if chiropractic was not available. The wisdom of the choice then made by the BCA is now apparent.

C. Steps to be Taken by DCs

11. As Covey teaches the essence is right principles or 'habits' - fundamental attitudes, not techniques. Thus:

- a) Chiropractors must now rest secure, knowing that the value of what they do is widely acknowledged by others in health care (whatever individual biases may be confronted day-to-day) and that chiropractors have demonstrably better education and skills in the field of manual care than any other profession.
- b) On the basis of this security, chiropractors should seek interdependence with others in the health care community, satisfied that this is of long term mutual benefit to everyone. ('win/win').
- c) In seeking interdependence, they must 'seek first to understand rather than to be understood'. Acknowledge that other perspectives are as important as the chiropractic one, and start with meeting the needs of others. For example the perspective of MDs in a group family practice nearby may be:
 - I see many patients with back pain.
 - I have yet to discover an effective course of management for most, especially those with sub-acute or chronic pain.
 - I find this frustrating - what can I do?
 - From what I've read and heard recently spinal manipulation may be worth a try.
 - Chiropractors seem to have the most training and best established practices in this area, but can I find one I can work with? I don't want someone who thinks he/she can treat asthma.

From their perspective these MDs, who have no full understanding of or comfort with chiropractic, require specialist spinal manipulative services not chiropractic. A chiropractor who suggests he/she 'may be able to help with some of these back pain cases', who forwards appropriate literature in support (e.g. the British trial²⁰) and offers the MDs a visit to the clinic to see chiropractic examination and practice, is thinking and acting 'win/win'. Everyone benefits.

A chiropractor whose dominant perspective is that chiropractic is a superior competitive service, and who considers the MDs and their patients misguided and in search of something other than his/her services, will never build a referral relationship. This is a loss for everyone, except the other professional who does receive the referrals. That professional may have lesser understanding and skills of manual care than a chiropractor, but will often produce worthwhile results. That profession will get the future referrals, and ultimately the dominant market share and reputation in manual care.

- d) Consider establishing your practice as part of, or adjacent to, medical and other health care offices. As Woody Allen says "90% of it is being there". A recent survey of DCs and MDs in Canada showed that, where there was a DC situated in a medical mall/complex of offices, every MD surveyed was referring patients.²¹
- e) As a priority in your practice, communicate with the local medical (and nursing, HMO, health insurance, etc) community. Create opportunities to demonstrate your clinical skills - these are far superior to what MDs and others outside the profession imagine.
- f) Make it evident, by your correspondence and attitudes, that you understand the referral relationship - especially letter report responsibilities. (For a detailed review on interprofessional correspondence and reports see the January 1992 (Vol 6 No. 2) issue of this Report).
- g) Listen and learn from other professions in manual care. Be eclectic. Absorb all that has value. Chiropractic may have the predominant position worldwide in manual care - medicine is undeveloped in this area because it did not learn from

chiropractic or its own pioneers. Chiropractors should not repeat this mistake within their own scope of practice. Thus:

- While they have not fared as well as chiropractic manipulation in the literature to date, osteopathic muscle energy techniques are well established, and clearly have value.
- Muscle trigger point work is important.
- McKenzie mechanical therapy, from physical therapy, obviously benefits many patients, is now well established, and chiropractors should know what it offers and where it may be appropriate.

(As a matter of interest in the US the AHCPDR has just given a grant of \$1 million to Daniel Cherkin PhD et al of Seattle for a three year randomized controlled trial to compare chiropractic manipulation and McKenzie mechanical therapy in the treatment of patients with low-back pain. The trial, like the British trial by Meade et al, will not be definitive but will be important. A number of chiropractors in North America have already studied McKenzie techniques and incorporated them in their practices where appropriate. For them the pending research is welcome, and no threat. This should be so for the profession as a whole).

12. Chiropractic colleges have new responsibilities, and must prepare students for a cooperative role. They must teach and instill pride in the history and principles of chiropractic without generating disrespect towards the medical profession and other providers. There should be a focus on what is good in medical practice rather than criticism of what is lacking. Important aspects of the curriculum should now be:

- a) Offering educational exchanges with local medical schools, and including hospital rounds, so that chiropractic and medical students understand each other better.
- b) Interprofessional/managed care skills - particularly recordkeeping, report writing, interprofessional correspondence. The world will judge chiropractic practice primarily by its paper.
- c) Exposure of students to a wide range of manual techniques, including those developed by other professions.

D. Conclusion

13. To be *highly effective* the chiropractic profession must now, as Covey counsels, adopt the *habits of interdependence*. A necessary part of this is comfort with a role that is mutually acceptable to chiropractors and others in the health care system. This, in essence, is that of primary contact neuromusculoskeletal specialist - a role similar to dentistry.

Is this in any way a narrowing of the vision or role of the profession? Quite the opposite. In summary:

- a) For chiropractors the goal is much wider understanding of the potential of chiropractic care, so that as many people as possible may receive and benefit from it.
- b) For this, those who are known to influence the majority of patient choices/decisions - i.e. principally medical doctors - must see chiropractic as having a valuable role within the mainstream delivery of health care.
- c) The path to that understanding must lie on common ground, and upon mutual understanding and respect.
- d) For many reasons that common ground is the chiropractor as a neuromusculoskeletal specialist and skilled spinal manipulation for spinal pain syndromes. Market developments suggest that 20% or more of North Americans - more than three times as many as those currently using chiropractic services - are going to receive their first experience of spinal manipulation during the next few years. It will be very largely for back and neck pain on medical referral.

e) It will be success with these new patients, as perceived by them and their referring MDs, that will determine whether chiropractic retains its predominant position in the manual care marketplace in ten years time.

f) As has always been the case, many of these new patients with pain syndromes will experience wider health benefits. With this larger market share there will be wider appreciation of and research into these wider benefits of chiropractic care.

Acceptance of the full potential of chiropractic care - the chiropractic perspective - will be achieved more quickly by emphasis now on back and neck pain - the public and medical perspective.

To quote Nelson's incisive and colorful commentary on this point in the latest issue of JMPT:

"Chiropractic cannot have it all. We cannot claim concurrently to be generalists in the family practitioner mode, and neuromusculoskeletal specialists and that we achieved all this in 4 years of professional training. It is an affront to common sense to suggest that this is possible. There is no evidence that chiropractors either function as, are trained as, are perceived by the public as, or are recognized by other health professionals as primary care providers.

What are chiropractors? In questions of this sort, it's useful to apply the duck test. The duck test states that if it looks like a duck, if it walks like a duck, and if it quacks like a duck, one is obliged to call it a duck. Applied to this question, if it looks like a neuromusculoskeletal specialist (chiropractic education), if it walks like a neuromusculoskeletal specialist (chiropractic practice), and if it quacks like a neuro musculoskeletal specialist (the public's perception of chiropractic) then it is a neuromusculoskeletal specialist."²²

(For more detailed commentary on chiropractic as a NMS specialty see Wardwell⁴, Nelson²² and the July 1989 issue of this Report).

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Under the continuing leadership of the Congress of Chiropractic State Associations (COCSA), which commissioned the Mercy Guidelines Conference, representatives of COCSA, ACA, ICA, field practitioners at large, and the chiropractic academic and scientific communities met in St. Louis, Missouri, October 23-24, 1993 and agreed upon:

- Formation of a Chiropractic Council on Guidelines and Practice Parameters (CCGPP). This proposal now goes back to all participating organizations for ratification by March 31, 1993.
- A timeline for review of the Mercy Conference Guidelines and development of guidelines in new areas (e.g. soft tissue injuries, primary care, pediatrics).

Structure of the CCGPP

The agreed structure, reflects the two critical realities in the process of developing guidelines. The first is that development of practice guidelines must be, and must be seen to be, under the overall control and direction of the field practitioners who are to be governed by them. The second is that the methods and process to be followed, which are now well established by research and vital to acceptance of any chiropractic guidelines by the outside world, must be developed and monitored by a multidisciplinary panel with appropriate expertise and consumer representation.

Accordingly, it is proposed that the CCGPP shall have:

1. A Board of Directors with 12 fulltime field practitioners and 6 educators/scientists (all DCs - a 2 to 1 ratio in favour of field doctors) and 3 public representatives. 9 of the field DCs will represent founding organizations (e.g. ACA, ICA, COCSA, FCLB) but 3 will be DCs unaffiliated with any of the major organizations. (This gives flexibility to create a truly representative and balanced Board).
2. A Commission of 16 to develop criteria for establishing and disseminating guidelines, and to advise the Board on all aspects of guideline development. This will have a minimum of 30% non-chiropractic membership. One member will be a field practitioner from the Board. Others must represent the following disciplines/skills and all be published in the indexed literature - clinical chiropractic, epidemiology, health economics, statistics, health care ethics, managed care, administration, health policy/services, information resources, insurance/business, literature synthesis, consumer/patient/labour, formal consensus process, clinical decision making, algorithm development, technical editing.

Individual projects to establish or review guidelines may be initiated in two ways. Firstly the Board, as the result of its regular and ongoing consultation with the profession, can start a new consensus process. (e.g. The Board will initiate the first review of the Mercy Conference Guidelines). Secondly, any organization within the chiropractic profession can present a proposal for a guideline project, including subject, funding and suggested participation. The CCGPP would advise as to process (e.g. which groups inside and outside the profession must be represented within the consensus process, etc.) and then give the resulting guidelines its seal of approval as to process if correct process has been followed.

It is important to appreciate that the content or substance of guidelines will be determined by consensus panels, which are separate and different from either the Board or the Commission. These panels, similar to the Board, will have strong field practitioner representation.

The interests of field practitioners will be protected in a further way. Every time the CCGPP and its Commission are presented with a new guidelines project in a specific area (e.g. soft tissue injuries), the Board shall appoint a clinician advisory group to the Commission. This will comprise persons with clinical experience in the relevant area. It will consist of 5-7 members, and the majority must be field chiropractors. Clinicians from other disciplines may be represented as appropriate.

Review of Mercy Guidelines

In December COCSA will once more be issuing a call to all practising chiropractors for submissions on areas of the Mercy Center Guidelines seen to be in need of review - either because of original errors/omissions or in light of new evidence. (If you wish to write now, see the Mercy

Conference Guidelines p.217 for directions). It is expected that consultation will be complete, the CCGPP established, priorities for Mercy review determined, and a consensus panel established by fall 1994.

Conclusion

In the 1990s the issue for chiropractic and other health professions is not whether practice guidelines are necessary - everyone at the St. Louis meeting was unanimous in accepting they were - but how guidelines can be established within a profession in a way that is legitimate and credible to both the profession and the outside world. The key is a correctly structured, central agency which speaks for the profession as a whole, has interdisciplinary and consumer input, and ensures state-of-the-art process.

Field practitioners will be interested at the advice of Dr. Alan Adams of LACC, CCR and the RAND Project. As a participant in St. Louis he noted that a new development in the guideline setting process is acceptance now that draft guidelines should be sent out for some peer review and pilot testing before they are made final.

Participants in St. Louis

Alan Adams DC, Director of Research, LACC; Meredith Bakke DC, Federation of Chiropractic Licensing Boards, Wisconsin; Gerard Clum DC, President, Association of Chiropractic Colleges; R. James Gregg DC, President, International Chiropractors' Association; Ken Harling DC, COCSA, Massachusetts; Charles Herring DC, COCSA, Louisiana; Paul Lambert, President, National Association of Chiropractic Attorneys; Charles Lantz DC, Director of Research, Life Chiropractic College West; Jerome McAndrews DC, VP of Professional Affairs, ACA; R.A. McMichael DC, President, COCSA Ohio; John Martin DC, COCSA Texas; James Peterson DC, COCSA California; Reed Phillips DC, PhD, President, LACC and Council of Chiropractic Education; William Remling DC, New York; Mario Spoto DC, COCSA, Pennsylvania; Leonard Suiter DC, COCSA, Missouri; John Triano DC MA, Texas Back Institute, Chiropractic rep on AHCPR Low Back Pain Panel.

Support Personnel

Daniel Hansen DC, Guidelines Process Consultant, Washington; Mr. David Chapman-Smith, Conference Facilitator; Mr. Don Petersen, Conference Secretary; Mr. Robert P. Sherman, Conference Coordinator.

Observer List

Mark Carroll JD, Florida; Linda A. Edwards, OUM; Richard Flaherty, Leander Products; Darrell E. Fore DC, Kansas; G. Matt Howard III, DC, Indiana; Paul Osterbauer DC, Arizona; Dennis Semlow DC, Michigan; Harold B. Tondera DC, Texas.

New Research on Cervical Facets

'Intra-articular Inclusions of the Cervical Synovial Joints', Mercer S and Bogduk N, Br J Rheumatology (1993); 32:705-710.

'Hidden Cervical Spine Injuries in Traffic Accident Victims with Skull Fractures', Jónsson H et al, J Spinal Disorders (1991); 4(3):251-263.

It remains the general medical fashion to emphasize the disc as the source of neck and back pain. Clearly both the disc and facets (the 3-joint complex) are involved. As was explained by Charles Aprill MD, the Louisiana radiologist who has done prominent cervical spine research and is an editorial board member for the ACA's new Journal of the Neuromusculoskeletal System, when speaking in Toronto last month at the 3rd annual McKenzie International Conference:

- No one has yet published clear evidence linking specific pathology and pain in cervical spine soft tissue injuries.
- The facet joints play a much more prominent role than many people credit.

The new study by Mercer (Pittsburgh, PA) and Bogduk (Newcastle, Australia) in the British Journal of Rheumatology is of interest:

- a) 210 cervical synovial joints from 15 adult spines were studied by dissection to discover the type, positioning and prevalence of intra-articular inclusions in the cervical spine. Cadavers aged 65 years and over were used.
- b) Fat pads occurred regularly in the atlanto-occipital joints but rarely in the facets. Capsular rims occurred occasionally in all joints. Fibro-adipose meniscoid inclusions occurred regularly in all joints (in 174 or 80%).
- c) The authors suggest that the fibro-adipose meniscoids may become disengaged and act as pain provoking loose bodies at the margin of the articular process. The primary source of much acute torticollis may be these meniscoids (called 'extrapment' by the authors rather than 'entrapment' because they have moved from a position inside the joint) rather than the muscle spasm.

In the impressive study by Jónsson et al from Sweden, the first "detailed study of cervical spine injuries and systematic evaluation of the diagnostic accuracy of plain radiography" with respect to whiplash injuries, the cervical spines of 22 victims of fatal traffic accidents were studied:

- With state-of-the-art plain film xrays (AP, lateral, 45° oblique views - an average of 10 films per specimen), and with additional CT scans where the radiographic findings were ambiguous in any way.
- Were then sectioned and filmed in the sagittal plane.

Conclusions included:

- a) Facet joint injuries are commonplace soft tissue injuries in whiplash. They found 69 in these 22 specimens, combining rupture of synovial folds and partial or complete rupture of joint capsules. Most rupture of posterior muscles was in close vicinity to the facet joints.
- b) Virtually none of this extensive soft tissue injury could be seen on state-of-the-art plain film.
- c) In clinical practice "it is well known that emergency plain radiograms are usually negative after whiplash type injury even when the clinical findings are indicative of soft tissue lesions", and "it would seem reasonable to assume that these injuries may be overlooked in clinical situations and that a negative radiographic examination does not exclude cervical spine injuries."
- d) Plain radiograms also failed to show many fractures.

Accordingly the facet joints, which are highly innervated and a rich source of pain and amenable to chiropractic treatment, are a frequent sight of soft tissue injury that is routinely overlooked in standard hospital and medical practice.

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