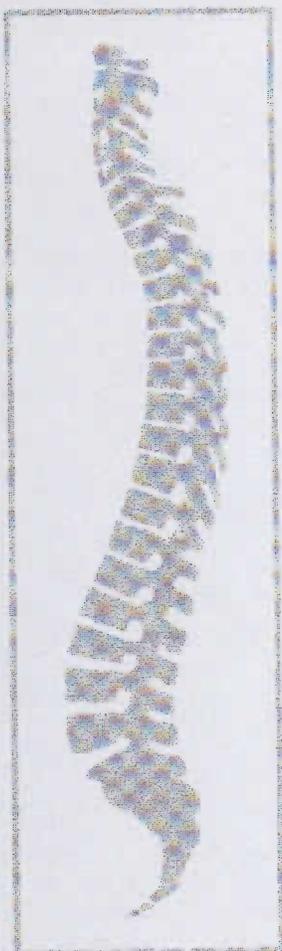


# THE CHIROPRACTIC REPORT

An international review of professional and research issues, published bimonthly  
Editor: David Chapman-Smith, LL.B. (Hons.), FICC (Hon.) March 1995 Vol. 9 No. 2



## Professional Notes

### Long Term Care - A Guidelines Victory

*Lynch v The Halifax Insurance Company*, Ontario Insurance Commission, Arbitration A-00781, December 20, 1994, Ontario, Canada.

In this recent Canadian case Halifax, Mr. Lynch's auto insurer, produced expert medical evidence to argue that monthly chiropractic care four years after Mr. Lynch's accident was unnecessary passive care promoting dependency. Halifax had refused to pay treatment costs during the past year. Mr. Lynch appealed.

In a decision that turned on the distinction between *supportive care* and *preventative/maintenance care* as defined in Canadian and US chiropractic practice guidelines, the Ontario Insurance Commission:

- Analyzed and adopted the relevant chiropractic guidelines.
- Held that Mr. Lynch's ongoing chiropractic care "has reached a state of supportive care, or palliative care given to maintain improvement after maximum medical improvement which is therapeutically necessary, and not preventative/maintenance care or elective care."
- Accepted Mr. Lynch's argument that his continuing use of chiropractic care to manage

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## Authoritative New Guidelines for Management of Back Pain

### US and UK Guidelines Usher in a New Era

*"Back pain has affected human beings throughout recorded history and there is no evidence that the frequency or nature of back pain is any different today than it was in the past. What is new is the scale of chronic disability, work loss and invalidity due to simple backache.*

*Traditional medical treatment has failed to halt this epidemic and may even have contributed to it. There is a clear need to reconsider our whole approach to the management of low back pain and disability."*

#### UK Management Guidelines.<sup>1</sup>

*There are four principal reasons acute low back problems were selected as a subject for guideline development, ... their prevalence, ... cost, ... the increasing evidence that many patients may be receiving care that is inappropriate, ... and a growing body of evidence allowing a systematic evaluation of and conclusions about commonly used assessment and treatment methods."*

#### US Management Guidelines.<sup>2</sup>

### A. Introduction

1. In December 1994 there was simultaneous release of two government-sponsored nationally-based multidisciplinary guidelines for the management of back pain that will dramatically alter traditional medical management. These are:

a) In the US, the Agency for Health Care Policy and Research's Guideline *Acute Low Back Pain in Adults*.<sup>2</sup> Acute is defined as pain for less than three months, but includes both a first attack of back pain and recurring episodes. The Guideline also comments on associated leg pain and chronic pain.

b) In the UK, *Management Guidelines for Back Pain* in a Report on Back Pain<sup>1</sup> by the Clinical

Standards Advisory Group to the UK Health Ministers.

2. Reasons why medical management of patients with back pain will now change include:

a) The US and UK guidelines are comprehensive, evidence-based and broadly consistent - with each other and a third set of guidelines published in Sweden.<sup>3</sup> No professional group can make a credible attack on these documents.

b) There is rejection of management based on bed rest and/or natural remission and/or a 'wait and see' approach, still the basis of most medical management. Such an approach encourages physical and psychological decline, and produces unnecessary chronic pain and disability. Patients with non-specific or mechanical back pain - the great majority - should be encouraged to remain active, even if this causes some pain.

c) Resource intensive work-ups are rejected. A good history and physical examination will isolate the relatively few 'red flag' patients where there may be fracture, cancer or infection. These patients may require imaging, laboratory tests and referrals to medical specialists. Most others do not unless the patient fails to improve under recommended treatments during the first 4-6 weeks.

d) There are only two recommended treatments for patients with non-specific back pain, having regard to the scientific evidence on effectiveness and safety. These are:

- Spinal manipulation, which can now no longer be regarded as unorthodox by the medical profession; and/or
- Non-prescription medications (acetaminophen e.g. Tylenol, or NSAIDs e.g. aspirin).

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**1995 Centennial Celebrations:** Canada: May 31 to June 4, Toronto, Ontario. Information: (416) 781-5656. United States: July 5-9, 1995, Washington DC (incorporating the 1995 World Chiropractic Congress) and September 13-17, 1995, Davenport Iowa. Registrations: 1-800-324-1995.

e) There are recommendations *against* many usual but unproven treatments, some of which are harmful - including many prescription drugs (e.g. oral steroids, anti-depressants, colchicine, opiates for more than two weeks), various physical modalities (e.g. traction, TENS, ultrasound, massage, bio-feed-back), injections (trigger point, ligamentous, facet, and epidural injections unless there is also leg pain that would otherwise justify surgery), and needle acupuncture.

f) Surgery is now seen as valid only in narrowly defined circumstances. For example surgery for stenosis (compressive narrowing of the spine) should not be considered until after three months of pain. Even then it cannot be justified by imaging, often the basis in current surgical practice, but only upon the patient's demonstrated low and unimproving functional status.

3. Initial reaction by major professional groups has generally been strongly supportive. Chiropractic support could have been anticipated since the guidelines vindicate the traditional chiropractic approach to management. In the words of Dr. Louis Sportelli, spokesman for the American Chiropractic Association:

"We endorse (the AHCPR Guideline) completely. A multidisciplinary panel, divorced from politics, analyzed the scientific literature and came to a reasonable conclusion. The public now has information with which to make an informed decision. The Guideline brings common sense to back care. It suggests starting with the most conservative and cost-effective approaches, rather than starting with more radical treatments."

The Guideline, says Sportelli, "suggests that a chiropractor is a logical first choice for primary care .... and will open the minds of family physicians, primary care gatekeepers and the managed care industry to the fact that chiropractic provides a very cost-effective therapeutic approach."

There was also immediate support for the US Guideline from the American College of Physicians, the American Academy of Occupational and Environmental Medicine, the Association of Rehabilitation Nurses, and the American Association of Neurological Surgeons, whose President Dr. Edward Seljeskog, said:

"The Guideline is an important well-documented critical scientific analysis of the effectiveness of back pain treatments. It has debunked several of the very marginal management modalities for back pain and really focused on getting patients better.

We believe the Guideline represents mainstream thought that is generally supported by the scientific literature."

In the US two leading societies for spine surgeons, the North American Spine Society (NASS) and the American Academy of Orthopedic Surgeons (AAOS), withheld endorsement. For chiropractors there is delicious irony in these words from Dr. Edward Handley, AAOS spokesman, representing a group of specialists who have long criticized spinal manipulation as unorthodox and unscientific. Justifying controversial surgical methods without scientific evidence of effectiveness he says:

"My personal view is that the Guideline absolutely reflects what science we know, and it is fair and appropriate. But medicine is an art and not just a science." It must, says Dr. Handley, "not only take into account the scientific literature but also clinical experience and other factors as well."

At the first multidisciplinary meeting in Canada to review the AHCPR Guideline, held by the Institute for the Work and Health in Toronto on February 7, 1995, all relevant specialties and disciplines were represented and there was unanimous agreement that the US Guideline was sound and reflective of the scientific evidence.

4. The more important point to understand, however, is that the reactions of various groups of health professionals

are moot and not that important. Development of guidelines has been a consumer-led response to a common, costly and poorly managed health problem, and these guidelines are going to dictate what forms of care are accepted and paid for by government and private third party payors regardless of what providers say.

5. Chiropractors will want to obtain and review the original guideline documents. So will many patients and all third party payors. This Report:

- provides commentary
- explains where the guidelines can be obtained;
- identifies areas where chiropractic practice will require modification to conform to the Guidelines and;
- reviews the impact of these guidelines on the future of the chiropractic profession.

## B. Overview of Guidelines

6. **Method.** Both the UK and US Guidelines were developed according to established methodology, as used by the RAND Corporation<sup>4</sup> and by the chiropractic profession in the recent development of national practice guidelines in the United States<sup>5</sup> and Canada,<sup>6</sup> and featured:

- a) A detailed review of the international literature. Only well-designed, randomized, controlled clinical trials were accepted as scientific evidence. The same literature review was used for both guidelines processes.
- b) Final guideline development by representative panels of acknowledged experts, with decisions based on two bodies of evidence - the scientific evidence and experienced professional judgement.

Members of the AHCPR panel of 35 and the CSAG Committee of 10 appear in Table 1. Chiropractors were represented on both bodies, Scott Haldeman DC MD PhD and John Triano DC MA in the US and Alan Breen DC PhD in the UK. In addition

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**Editorial Board.** United States: Peter Gale, DC, Chiropractor, Boston Massachusetts, Scott Haldeman, DC, MD, PhD, Neurologist, Santa Ana, California. Reginald Hug, DC, Chiropractor, Birmingham, Alabama. Dana Lawrence, DC, Chiropractor, Chicago, Illinois. Michael Pedigo, DC, Chiropractor, San Leandro, California. Louis Sportelli, DC, Chiropractor, Palmerton, Pennsylvania. Aubrey Swartz, MD, Orthopedic Surgeon, Oakland, California. Canada: J. David Cassidy, DC, PhD, Chiropractor, Saskatoon, Saskatchewan. Donald J. Henderson, DC, B.Sc., FCCS, DACBR Chiropractor, Toronto, Ontario. William Kirkaldy-Willis, MD, FRCS(C), Orthopedic Surgeon, Victoria, British Columbia. Europe: Arne Christensen, DC, FICC, Chiropractor, Odense, Denmark. Australia: Miriam A. Minty, DC, Chiropractor, Perth, W.A. Lindsay Rowe, M.D., B.App.Sc.(Chiro), DACBR, Chiropractic and Medical Radiologist, Newcastle, New South Wales.

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tion the CSAG had a Sounding Board of 34, which included Ian Hutchinson DC, President, British Chiropractic Association.

7. **Publication.** Both guidelines are written in clear language, easily understood by health professionals and the lay reader alike. However, whereas the UK guidelines are an appendix to a technical report on back pain, the US guidelines appear in three documents:

- The full *Clinical Practice Guideline* (160 pages).

- *A Quick Reference Guide for Clinicians.* This is a summary available free to all clinicians.
- *A Patient Guide* titled *Understanding Acute Low Back Problems.* This is a consumer version of the Guideline available to the public without charge through a 1-800 number.

This illustrates the strong consumer orientation to the US Guideline, and means it will be much more widely read and recognized than previous pub-

lications. See Table 2 for ordering information (Page 8).

8. **"Summaries/Charts.** Both guidelines have summaries and management algorithms and tables for clinicians. As examples see:

- a) AHCPR Summary of Recommendations (Figure 1).
- b) CSAG Overview of Guidelines for Acute Back Pain (Figure 2).

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**Table 1**

**AHCPR PANEL MEMBERS (US)**

**CSAG COMMITTEE (UK)**

**Stanley J. Bigos, MD, Chair**  
Seattle, Washington  
*Orthopedic Surgeon*

**Reverend O. Richard Bowyer**  
Fairmont, West Virginia  
*Consumer Representative*

**G. Richard Braen, MD**  
Buffalo, New York  
*Emergency Medicine Physician*

**Kathleen Brown, PhD, RN**  
Birmingham, Alabama  
*Occupational Health Nurse*

**Richard Deyo, MD, MPH**  
Seattle, Washington  
*General Internist*

**Scott Haldeman, DC, MD, PhD**  
Santa Ana, California  
*Neurologist/Chiropractor*

**John L. Hart, DO**  
Columbia, Missouri  
*Physiatrist*

**Ernest W. Johnson, MD**  
Columbia, Ohio  
*Physiatrist*

**Robert Keller, MD**  
Belfast, Maine  
*Orthopedic Surgeon*

**Daniel Kido, MD, FACR**  
St. Louis Missouri  
*Radiologist*

**Matthew H. Liang, MD, MPH**  
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*Rheumatologist*

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*Physical Therapist*

**Margareta Nordin, RPT, DrSci**  
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*Community Health Nurse*

**Malcom H. Pope, DrMedSc, PhD**  
Burlington, Vermont  
*Orthopedic Researcher*

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*Occupational Therapist*

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*Neurosurgeon*

**Jeff Susman, MD**  
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*Family Physician*

**John J. Triano, MA, DC**  
Plano, Texas  
*Chiropractor*

**Lucius C. Tripp, MD, MPH, FACPM**  
Warren, Michigan  
*Neurosurgeon/Occupational Medicine Specialist*

**Dennis C. Turk, PhD**  
Pittsburgh, Pennsylvania  
*Psychologist*

**Clark Watts, MD, JD**  
San Antonio, Texas  
*Neurosurgeon*

**James N. Weinstein, DO**  
Iowa City, Iowa  
*Orthopedic Surgeon*

**Chairman:**  
**Professor M. Rosen**  
*Anaesthetist*  
Cardiff

**Dr. A. Breen**  
*Chiropractor*  
Bournemouth, Dorset

**Dr. W. Hamann**  
*Pain Relief Consultant*  
London

**Dr. P. Harker**  
*Public Health*  
Dorset

**Professor M.I.V. Jayson**  
*Rheumatologist*  
Salford

**Ms. E. Kelly**  
*Physiotherapist*  
London

**Mr. P. Lloyd**  
*Occupational Health Nurse*  
Preston

**Miss E. K. McLean**  
*Nursing Officer*  
Edinburgh

**Dr. C. Sears**  
*General Practitioner*  
Salisbury

**Professor G. Waddell**  
*Orthopedic Surgeon*  
Glasgow

**9. Spinal Manipulation.** This is only defined in the US guideline, as “manual loading of the spine using short or long lever methods (in which) the selected joint is moved to its end range of voluntary motion followed by application of an impulse loading”. This seems to include joint mobilization as well as manipulation, though the scientific evidence favors manipulation. The course of treatment recommended is initially up to four weeks. If there is symptomatic and functional improvement treatment may be continued, if not it should be stopped. This adopts the findings of the RAND Report<sup>4</sup> and rejects the traditional medical approach to manipulation which involves a trial of 2 or 3 treatments only.

See Figure 1 for the US guidelines on manipulation. The UK guidelines are very similar. Strongest recommendation for manipulation is for patients with symptoms for less than one month. Manipulation is also an option for more chronic patients and those with radiculopathies (nerve root pain to the leg). Even for these patients manipulation has as much scientific evidence as, for example, back school or exercise. (See Figure 1).

**C. Implications for Chiropractic Practice**

10. Most chiropractors will not have to make any changes to their management of patients with acute low-back pain. These guidelines endorse their patient-centered, low-tech, biomechanical approach to back pain based on early activity, skilled manipulation and patient motivation. However for some chiropractors these areas are noteworthy:

a) **Imaging.** Some chiropractic technique systems encourage plain film xray examinations and analysis for most adult patients. These guidelines join the US and Canadian chiropractic guidelines in suggesting this is inappropriate. If there is no reason to suspect serious pathology, most patients under age 55 should not initially have plain film xrays, much less MRIs or CT scans. Information that can be learned from routine xrays is not justified having regard to cost, radiation, false positives and false negatives, and minimal influence on the care that will be given anyway.

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**Figure 1**  
**Summary of AHCPR Guideline Recommendations (US)**

The ratings in parentheses indicate the scientific evidence supporting each recommendation according to the following scale:

**A = strong research-based evidence (multiple relevant and high-quality scientific studies).**

**B = moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).**

**C = limited research-based evidence (at least one adequate scientific study in patients with low back pain).**

**D = panel interpretation of evidence not meeting inclusion criteria for research-based evidence.**

The number of studies meeting panel review criteria is noted for each category.

	Recommended	Option	Recommend against*
<b>History and physical exam - 34 studies</b>	Basic history (B) History of cancer/ Infection (B) Signs/symptoms of cauda equina syndrome (C) History of significant trauma (C). Psychosocial history (C). Straight leg raising test (B). Focused neurological exam (B).	Pain drawing and visual analog scale (D).	
<b>Patient Education - 14 studies</b>	Patient education about low back syndrome (B). Back school in occupational settings (C).	Back school in non-occupational settings (C)	
<b>Medication-23 studies</b>	Acetaminophen (C). NSAIDs (B).	Muscle relaxants (C). Opioids, short course(C).	Opioids used >2wks(C).** Phenylbutazone (C) Oral steroids (C). Colchicine (B)* Antidepressants (C).
<b>Physical treatment methods - 42 studies</b>	Manipulation of low back during first month of symptoms (B).	Manipulation for patients with radiculopathy (C). Manipulation for patients with symptoms >1 month(C). Self-application of heat or cold to low back. Shoe insoles (C). Corset for prevention in occupational setting (C).	Manipulation for patients with undiagnosed neurologic deficits (D). Prolonged course of manipulation (D). Traction (B). TENS (C). Biofeedback (C) Shoe lifts (D). Corset for treatment (D).
<b>Injections - 26 studies</b>		Epidural steroid injections for radicular pain to avoid surgery(C).	Epidural injections for back pain without radiculopathy (D). Trigger point injections (C). Ligamentous injections (C) Facet joint injections (C). Needle acupuncture(D).
<b>Bed rest - 4 studies</b>		Bed rest of 2-4 days for severe radiculopathy (D).	Bed rest > 4 days (B).
<b>Activities and exercises - 20 studies</b>	Temporary avoidance of activities that increase mechanical stress on spine (D). Gradual return to normal activities (B). Low-stress aerobic exercise (C). Conditioning exercises for trunk muscles after 2 weeks (C). Exercise quotas (C).		Back-specific exercise machines (D). Therapeutic stretching of back muscles (D).

**Figure 1 (continued)**

	Recommended	Option	Recommend against
<b>Detection of physiologic abnormalities</b> 14 studies	If no improvement after 1 month, consider: Bone scan (C). Needle EMG and H-reflex tests to clarify nerve root dysfunction (C). SEP to assess spinal stenosis (C).		EMG for clinically obvious radiculopathy (D). Surface EMG and F-wave tests (C). Thermography (C).
<b>X-rays of L-S spine</b> 18 studies	When red flags for fracture present (C) When red flags for cancer or infection present (C).		Routine use in first month of symptoms in absence of red flags (B). Routine oblique views (B)
<b>Imaging - 18 studies</b>	CT or MRI when cauda equina tumor, infection, or fracture strongly suspected (C). MRI test of choice for patients with prior back surgery (D). Assure quality criteria for imaging tests (B).	Myelography or CT-myelography for preoperative planning (D).	Use of imaging test before one month in absence of red flags (B). Discography or CT-discography (C).
<b>Surgical considerations</b> 14 studies	Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise after 1 month of conservative therapy (B). Standard discectomy and microdiscectomy of similar efficacy in treatment of herniated disc (B). Chymopapain, used after ruling out allergic sensitivity acceptable but less efficacious than discectomy to treat herniated disc (C).		Disc surgery in patients with back pain alone, no red flags, and no nerve root compression (D). Percutaneous discectomy less efficacious than chymopapain (C). Surgery for spinal stenosis within the first 3 months of symptoms (D). Stenosis surgery when justified by imaging test rather than patient's functional status (D). Spinal fusion during the first 3 months of symptoms in the absence of fracture, dislocation, complications of tumor or infection (C).
<b>Psychosocial factors</b>	Social, economic, and psychological factors can alter patient response to symptoms and treatment (D).		Referral for extensive evaluation/treatment prior to exploring patient expectations or psychosocial factors (D).

\*B or C in this column means the evidence shows ineffectiveness and/or harm ) Editorial notations by  
 \*\* > means "longer than". ) The Chiropractic Report

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**b) Psychosocial Assessment and Rehabilitation.** Chiropractors have generally dealt well, but often informally, with psychosocial factors. These guidelines emphasize the need for formal psychosocial assessment, both initially and more thoroughly at six weeks if the patient is not back to work and/or other activities of daily living. Psychological factors (attitudes and beliefs about back pain; psychological distress and depressive symptoms; ill-

ness behavior) and social factors (family attitudes and reinforcement of disability; work factors - physical demands of the job, job satisfaction, other health and non-health problems causing time off) should be assessed and recorded.

Where the pain and disability are found to be primarily psychosocial, which will increasingly be the case where patients become chronic, multidisciplinary rehabilitation involving close liai-

son with the workplace and comprehensive rehab services is necessary.

**c) Documenting Outcomes.** A patient receiving a course of spinal manipulation should have objective improvement within four weeks, failing which the patient should be referred.

This, again, is consistent with chiropractic guidelines. However this places new importance on documenting improvement, especially in terms of pain relief (e.g. visual analog scale) and increased functional capacity (improved scores on Oswestry Index, Roland Morris or other validated patient questionnaire).

**d) Choice of Language.** The US guidelines divide acute low-back pain into three categories - non-specific, sciatica, and serious spinal conditions. Similarly the UK guidelines use three categories, namely:

- Simple backache - "Mechanical back pain which is musculoskeletal in origin". It may be extremely painful and be associated with referred leg pain but use of the term *simple backache* "provides reassurance that the nerve roots and spinal cord are not compromised and that there is no evidence of more serious spinal pathology".
- Nerve root pain - preferred to sciatica "to emphasize its underlying pathological basis".
- Serious spinal pathology.

Note this advice to consumers and payors on why the above terminology is used:

i) In the UK, "attempts at more precise diagnosis of simple backache based on theories of etiology and pathology are not generally agreed by different specialties and tend to be unhelpful when deciding on management".

ii) In the US an AHCPR handout for patients<sup>7</sup> warns that there is no scientific evidence that the following common diagnoses used to explain back pain either cause it or can benefit from specific treatments:

- |                             |                             |
|-----------------------------|-----------------------------|
| Annular tear                | Adult spondylolysis         |
| Myofascitis                 | Fibromyalgia                |
| Disc syndrome               | Strain                      |
| Spondylosis                 | Lumbar disc disease         |
| Facet syndrome              | Degenerative joint disease  |
| Sprain                      | Osteoarthritis of the spine |
| Disc derangement/disruption | Dislocation                 |
| Subluxation                 |                             |

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Chiropractors would be well advised to consider using the guidelines' simple framework of terms in communications with other health professionals and, even more importantly, third party payors.

e) **Prolonged manipulation.** Both guidelines say little about the duration and frequency of care, whether for medications, physical treatments or other. For manipulation, the essential finding is that a course of manipulation may be continued after four weeks if there is demonstrable improvement.

Note, however, that the AHCPR *Quick Reference Guide for Clinicians* makes a recommendation against a "prolonged course of manipulation". (See Figure 1). This is apparently based on panel interpretation in the absence of any rateable evidence, and there is no definition of 'prolonged' or any supporting discussion in the main Guideline. The point is worthy of note, however, because many readers may see and place their own interpretation on this comment.

Prolonged manipulation may be appropriate or inappropriate, and this subject is dealt with fully in chiropractic practice guidelines. (See Professional Notes, page 1 of this Report, for a recent case applying such guidelines and finding long-term care appropriate). The AHCPR comment is made in and applies to the narrow context of therapeutically necessary care in acute pain patients with simple back pain, with reference to a period in which they are failing to achieve benefit and return to normal activities of daily living.

Outside the context of acute back pain a prolonged course of manipulation may be appropriate for reasons of therapeutic necessity (e.g. used in conjunction with appropriate self-care and keeping a person fully functional on a similar basis to ongoing use of medications) or elective care. In some circumstances, of course, prolonged and/or frequent manipulation will be quite inappropriate.

#### **D. Impact for the Future of Chiropractic**

11. The principal reasons for the remarkable growth of chiropractic this century have been the inability of the medical profession to satisfy patients with simple back pain, and other musculoskeletal pain, and the successes these patients have found when they subsequently turned to chiropractic care. Historian Stuart Moore has documented this in his excellent new text *Chiropractic in America: The History of a Medical Alternative*.<sup>8</sup>

Back pain remains the most common reason patients seek chiropractic care - 40-50% of all chiropractic patients according to most studies - and the majority of these patients has sought medical care first. A recent study in Canada<sup>9</sup> reveals that 67% of chiropractic patients in Ontario have back pain (defined to include neck pain) and that 81% of all chiropractic patients had their problems for more than six months before consulting a chiropractor. In these circumstances it takes no rocket scientist to see that the new US and UK guidelines are a twin-edged sword for the chiropractic profession, because:

a) On one hand they represent the moment in history when it is objectively clear to medical doctors and other health providers that chiropractic management in general, and chiropractic manipulation in particular, are of proven value for patients with back pain. As the UK guideline says, the guidelines refer to low-back pain "but the same principles apply to other regions of the spine."<sup>3</sup>

It is now clearly appropriate to refer patients with musculoskeletal pain for chiropractic care. There should be a substantial increase in the number of patients receiving chiropractic care as the guidelines shake down to street level over the next five years. This process is already underway in most countries.

b) On the other hand chiropractors will now be exposed to significant new competition in the management of back pain. Medical practice will greatly improve. In the US a large national survey by Daniel Cherkin PhD, Richard Deyo MD et al<sup>10</sup> just published in *Spine* and titled *Physician Views About Treating Low Back Pain* confirms that current medical practice is inconsistent with the literature and the new guidelines. For example:

i) Across all the specialties, including family practice, only about 1 in 3 (36%)

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Figure 2

#### **Overview of Early Management Guidelines for Acute Back pain**

##### **Initial consultation**

###### **Diagnostic triage**

- simple backache
- nerve root pain ) urgent
- serious spinal pathology ) referral

##### **Early management strategy:**

- Aims:**
- symptomatic relief of pain
  - prevent disability

##### **Prescribe simple analgesia, NSAIDs**

- avoid narcotics if possible and never more than two weeks

##### **Arrange physical therapy if symptoms last more than a few days**

- manipulation
- active exercise and physical activity
- modifies pain mechanisms, speeds recover

##### **Advise rest only if essential: 1-3 days**

- prolonged bed rest is harmful

##### **Encourage early activity**

- activity is not harmful
- reduces pain
- physical fitness beneficial

##### **Practise psychosocial management; this is fundamental**

- promote positive attitudes to activity and work
- distress and depression

##### **Advise absence from work only if unavoidable; early return to work**

- prolonged sickness absence makes return to work increasingly difficult

##### **Biopsychosocial Assessment at 6 weeks**

chronic pain and remain fully fit for work was the equivalent of continuing use of medication for chronic pain. The OIC arbitrator viewed "Mr. Lynch's choice to pursue occasional chiropractic treatment as a legitimate preference for that type of treatment over, for example, occasional reliance on analgesic medication. The choice of modality of treatment is for Mr. Lynch and his health care providers."

- On the facts of this case, expressly rejected the argument that the ongoing supportive care promoted dependency. Mr. Lynch was fit, capable and reasonable, and the chiropractic care supplemented his self-care and kept him at work. The insurer was held liable for past and future supportive care.

There have been other occasions where chiropractic guidelines have been misquoted or distorted by insurers and used to restrict chiropractic care. However this decision, now an important precedent, shows that chiropractic protocols of management can be successfully defended if things are done properly - establishing a literature base, valid guidelines, and standard terminology and methods within the profession.

Mr. Lynch's case would never have been successful prior to the establishment of guidelines, but now illustrates the practical importance of the concept of *supportive care*.

#### **A New Chiropractic Journal**

*Topics in Clinical Chiropractic*, a new quarterly chiropractic journal published by Aspen, is well worth a trial subscription. (In North America \$63.00 per annum. Call 1-800-638-8437, or write to Aspen Publishers Inc., 7201 McKinney Circle, Frederick MD, 21701).

Editor is Bob Mootz DC DABCO FICC, Associate Medical Director for Chiropractic, Department of Labor and Industries, State of Washington. Each issue presents several articles and clinical materials on one topic. The most recent issue, December 1994 (Vol 4 No. 1), explained how to use quality practice strategies in traditional practice, managed care and interdisciplinary team practice. It includes:

- Clear algorithms by Dan Hansen DC FICC summarizing frequency and duration of care according to the Mercy Center Guidelines - useful in explaining your practice to other professionals and payors.

- Useful algorithms by Daniel Nelson MS DC DABCO explaining passive care and active care under chiropractic management.

- An article by Mootz and Hansen explaining how to use and benefit from algorithms.

- Articles on patient satisfaction (with a chiropractic satisfaction questionnaire), chronic patients, interdisciplinary care and managed care.

The four topics in 1995 are performing primary care assessments in chiropractic, care of the cervical spine, strategies for coping with health care reform, and nutrition in chiropractic practice.

#### **Orthopractic Update**

The orthopractic movement, in which long-term chiropractic antagonist Dr. Murray Katz of Montreal tried to rally medical and physical therapy forces into a new political and clinical grouping against chiropractic, has been dealt a major blow by the withdrawal of the largest international movement in PT manual care - the McKenzie Institute International.

By letter dated January 9, 1995 Robin McKenzie PT, once himself a critic of chiropractic, rejects orthopractic as "a vitriolic vendetta" and a "witch-hunt" against chiropractic that can only frustrate the cooperation between the professions that is today necessary in the public interest.

We should be "building bridges not digging trenches", says McKenzie and promoting an interdisciplinary rational approach that includes chiropractors. McKenzie withdraws his personal support "as well as my personal endorsement (of orthopractic) to members of the McKenzie Institute worldwide."

#### **Manga Report Update**

The 1993 Manga Report, by health economists from the University of Ottawa and commis-

sioned by the Ontario Ministry of Health, found chiropractic management of back pain patients to be superior to medical care in terms of effectiveness, cost-effectiveness, safety and patient satisfaction. The Report recommended a shift in policy in Canada "to encourage and prefer chiropractic services in the management of low-back pain" and concluded this would save several hundred millions of dollars per annum. (See *The Chiropractic Report, Sept 1993 Vol. 7 No. 6*).

The new US and UK guidelines discussed in this issue provide compelling support for the Manga Report's conclusions which, because of their outspokenness, attracted much criticism from other health professionals. What has happened in Ontario?

The Minister of Health referred the Manga Report to a Chiropractic Services Review Committee, chaired by a former Minister of Health and containing senior representatives of the Ministry of Health and the Ontario Chiropractic Association. In a consensus report recently filed by this Committee:

"The Committee accepts the basic findings of the Manga Report", supports its recommendations, and then makes many recommendations of its own to remove financial and other "barriers to access" to ensure that "the citizens of Ontario have improved and genuine freedom of choice of chiropractic services".

CSRC recommendations include funding chiropractic education in a university setting, additional private and public funding for chiropractic care, improving the direct access of chiropractic patients to radiology and laboratory diagnostic services, and government funding of clinical outcomes research in chiropractic management of low-back pain, neck pain and headache. (Copies of the CSRC Report (98 pages) are available from The Chiropractic Report on written request with payment of \$20.00. Mailing address: 3080 Yonge Street, Suite 3002, Toronto, Ontario M4N 3N1, Canada.

Alternatively call 416-484-9601 or fax 416-484-9665 giving details of Mastercard or VISA).

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of MDs believe there is any value in spinal manipulation - probably less than 1 in 4 when you exclude doctors of osteopathy (83%) and specialists in physical medicine (63%).

ii) The majority of US physicians believe in the effectiveness of treatments not recommended in the AHCPR guidelines - most popular treatments being physical therapy (81%), bedrest for more than three days (72%) and trigger point injections (64%).

Timothy Carey MD MPH, asked to provide editorial comment on this study, concludes candidly that "given the current enthusiasm for guidelines, and the demonstrated lack of practitioner consensus, (medical doctors) *may soon find their practice restricted*".<sup>11</sup>

Experience suggests that relatively few MDs will have the time and inclination to gain formal training and enter fulltime practice in the field of spinal manipulation. However many physical thera-

pists/physiotherapists will pour new energy into education and practice. Spinal manipulation, hitherto viewed as unorthodox and unworthy by medicine in the UK and the US, will now be accepted. Third party payors will ensure that this is so. To retain professional leadership chiropractic must:

- Continue to lead in the three areas of educational standards, practice standards and research.

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• Be readily available - in professional, financial and geographical terms - for referrals. Most back pain patients will continue to consult family physicians or, increasingly, nurse practitioners or other gatekeepers. Their referrals over the next 10 years will largely determine which profession is the market leader in manual care in 20 years -and ever thereafter.

Much could be said here. Suffice to say that if chiropractors understand the health care system, and have the willingness and patience to prove themselves first to the medical community on the narrow ground of back pain - presently the only common ground available to the two professions - there is every reason to believe that chiropractic will retain its pre-eminence in manual care in the future.

First, a history of medical distrust and chiropractic reaction must be replaced with mutual trust and cooperation. These new guidelines, consumer and third party pressures, and many other current developments promise this can now happen quickly. Then, with that trust established, there will finally be opportunity for the full potential of chiropractic principles of care to be demonstrated and accepted.

One must be prepared to start with the thin edge of the wedge. Or, in the words of the wise and respected orthopedic researcher William Kirkaldy-Willis MD, who has for some years predicted a bright future for the chiropractic profession, "if you have big plans, be prepared to start in a small way."<sup>12</sup>

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