THE CHIROPRACTIC REPORT

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Managed Care - The Right Attitude

"A day of accounting for professions throughout the United States is at hand. If there is a problem for chiropractors, the only profession now that has an untapped pool of potential new customers (if I thought there were thousands of corporations out there that did not have legal services I would leap for joy), it may be one of adaptation or one of attitude.

Throughout history talented people have had to adapt. The Fearless Buggy Whip Corporation was astounded with the advent of the horseless carriage. Those who stood around and griped went bankrupt or became marginalized. Those who said "I must adapt", opened up new car dealerships or gasoline stations .... and enhanced their economic well being. The nation benefited as well.

How many of you have thought about the possibility of joining a group practice with medical physicians, with neurologists, orthopaedic surgeons? Horrors! Some of the purists in chiropractic would shudder at the idea. I do not. The public would not. What are you afraid of? Chiropractors have to learn to adapt. Some of you have."
George P. McAndrews, *Wilk Case* attorney, ACA General Counsel.[1]

A. Introduction

1. Managed care, a business strategy for controlling the costs and quality of health care services, swept across the US between 1990 and 1995. By the year 2000 less than 3% of insured health services will be outside managed care.[2]

This Report, read internationally in three languages (English, French and Japanese), has not previously discussed managed care (MC) because of its apparent marginal relevance outside the US. However now, with even greater precision, MC is sweeping into countries with publicly funded health care systems.

Two years ago Canadian chiropractors and medical doctors, paid on a fee-for-service model by a government-funded system with legal protection of patient freedom of choice, felt immune from MC. Public debt, reduced government funding, and escalating auto insurance and workers' compensation costs have changed all of that. The government, employers and insurers are following the US experience. In Ontario for example:

a) New auto insurance law will require all health professionals to file a treatment plan. Methods and frequency of care must conform with the Quebec Task Force Guidelines for whiplash, failing which the insurer may refer the claim to a streamlined early interdisciplinary review process. Major insurers, such as Cooperators, want to move to a preferred provider network.[3]

b) Magna International, a major auto parts manufacturer, is taking its 10,500 employees and their families out of the fee-for-service inefficient public system. Magna will provide all health services in its own managed care plan. This will be funded by the government (a global sum based on number of people and the current cost of their health services) and Magna (costs currently paid under its employee benefits program). Chiropractors, medical doctors and others will be salaried, but with a guaranteed practice and various benefits and incentives. Chiropractors will have a gatekeeper role. Magna reckons to deliver better care with significant cost savings.

2. There are similar developments in the UK with regional purchasing of National Health Service contracts, and chiropractors used within multidisciplinary teams providing the contracted services. Because of the speed of modern communications, and the international reach of large insurers and employers, MC is now of relevance and importance to all chiropractors.

3. With admirable understatement US chiropractic commentators McElheran and Sollecito observe that "most chiro-

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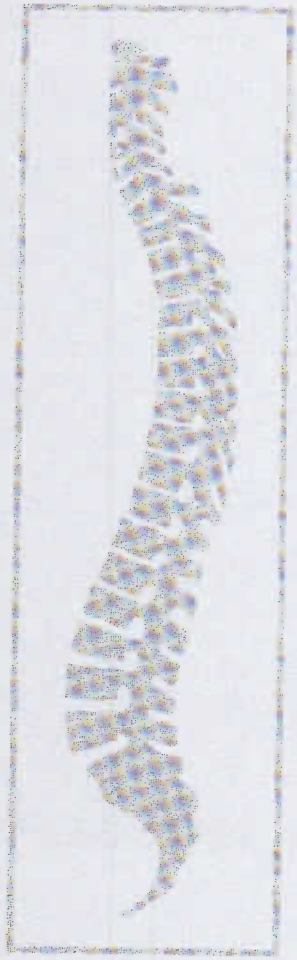

Professional Notes

Manipulation by PTs and MDs - New Legal Prohibitions

There have been two new rulings of great significance to the chiropractic profession. In California following joint submissions from the California Chiropractic Association and the American Chiropractic Association:

- The Attorney General has delivered a formal legal interpretation of state law declaring that "a physical therapist may not directly manipulate or adjust the spine or any other bony structure." Based on this opinion the Health Care Financing Administration (HCFA), the federal agency monitoring the US Medicare program for seniors, has ruled that California managed care plans providing services under contract to Medicare may not offer spinal manipulation services by PTs.

And now in Kansas Attorney General Carla Stovall, in a February 20, 1996 opinion sought by the Kansas Chiropractic Association, has ruled that under state law:

- Chiropractic manipulation is a manual maneuver during which the three joint complex is suddenly carried beyond the normal physiological range of movement without exceeding the boundaries of anatomical integrity. (She expressly accepts the definition of David Cassidy DC and William Kirkaldy-Willis MD appearing in *Managing Low-Back Pain* ed Kirkaldy-Willis, 2nd edition 1988, 287).

- That "chiropractic manual manipulation as taught in accredited schools of chiropractic is not within the

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1996 International Meetings: European Chiropractors' Union Annual Convention, May 16 -18, 1996, Geneva, Switzerland. *Contact:* Anne Kemp, ECU Secretary, 9 Cross Deep Gardens, Twickenham, Middlesex, TW1 4QZ, Tel: (44)(0)181 891 2546, Fax: (44)(0)181 744 2902. FCER's International Conference on Spinal Manipulation, October 17 - 19, 1996, Bournemouth, England. *Contact:* Emma Davis, FCER, 1701 Clarendon Boulevard, Arlington, VA 22209 U.S.A.

practors are not enthusiastic about MC concepts that literally reverse the logic by which they previously practised."[4] Whether they are enthusiastic or not is irrelevant of course. They, and all health practitioners, are faced with an inevitable market process. Choices are:

a) Resist and wither on the vine.

b) Adapt and, because of chiropractic's great market advantages in this new world, establish a dramatic new rate of acceptance and use of chiropractic services.

MC focuses first on cost - it is managed cost rather than managed care. Then, as the US experience shows, plans and networks that offer quality - which includes the availability of chiropractic services - begin to dominate. Having taken great losses in membership Kaiser Permanente is now including chiropractic services because the marketplace has spoken. As Arthur White MD orthopedic surgeon and Medical Director, San Francisco Spine Institute says, the evidence for best management of spinal problems is such that "the chiropractor is in an ideal position to be the primary manager ..... certainly in a better position than is the MD."[5]

B. The Right Attitude

4. Definitions of terms and different forms of managed care appear in Figure 1. The elements of complete managed care are in Figure 2.

However these details are relatively unimportant for the chiropractor seeking to understand managed care, accept it, and then develop the skills which offer new opportunities. The key, as George McAndrews says, is *The Right Attitude*. This was the name of his address to the American Chiropractic Association's annual convention last July.[1] Here are the basic concepts that need to be understood and accepted by chiropractors to develop the right attitude to work successfully in the new health/managed care marketplace.

Historical Context

5. Throughout the affluent 1960s to 1980s health care costs grew at well beyond the rate of the population and inflation in the industrialized world. In general health professionals, and especially the dominant dental and medical professions, lived remote from market realities with minimal concern for measured results/outcomes, minimal accountability to the ultimate payor, and no incentive for economy.

MC is the broadly based natural market response in a new era of government debt, international business competitiveness, and slow economic growth. It is powered by those who pay, and there is no way that health professionals will now escape market realities from which they have previously been shielded.

Loss of Autonomy - Balance of Interests

6. Those who pay for health care now say that, if the patient pays privately, you as the health care provider are autonomous and the patient/provider relationship is still privileged. However if we pay, the privileged relationship is a myth. And by the year 2000 we will be paying for services for 95% of the market. Your health care services are now marketplace transactions in which all stakeholders' interests must be addressed - there must be a balance drawn between the goals of each of the patient, the provider and the payor. This means everyone should be willing - not forced, but willing - to compromise.

This is perhaps the pivotal point for health professionals. They see their services as much more than one consumer option, and are not accustomed to integration, compromise and corporate goals bigger than their professional services. Health professionals must now understand the history, reflect on market realities, and accept that it is right and inevitable that a health provider is not entitled to be autonomous when a third party is paying. *There must be risk and benefit sharing for all parties/stakeholders.* The issue is not whether there should be evidence-based, goal-oriented, time-limited treatment plans and other quality control mechanisms. The issues are what the negotiated terms of these quality controls will be - and who will deliver the care.

Managed Cost v Managed Care

7. Given the history, one should expect the pendulum to swing heavily to simple cost containment as MC arrives. Cost is what is driving the process. Therefore there are:

a) Dollar limits on services, per service and annually, with patient co-payments.

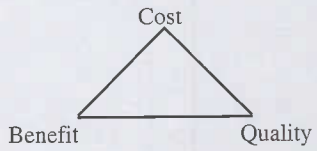
b) Gatekeepers, restricting freedom of choice, with financial incentives to reduce diagnostic testing and referral to specialists.

These things are managed cost, not managed care. As is now seen in the US, the natural history of MC is that the marketplace forces the pendulum to swing back towards quality. After a few years:

a) **Consumer reaction**. Patients rebel against reduced quality and choice. Competition in the marketplace means that MC plans have to adapt.

b) **Cost**. It becomes evident, as in all markets (e.g. cheap clothing or construction), that lack of quality ends up being more expensive. Patients do not get timely, effective necessary care, which leads to greater use of resources, more chronic problems, and greater disability costs. Some patients and provider groups complain and litigate - administration costs grow.

In the marketplace *managed care* (MC) replaces *managed cost*. The essential interdependent model of MC is:



Marketing - the Need for Integration

8. Individual chiropractors may feel no need to join a provider group or net-

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work, arguing that they provide quality services. Managed care may affect others, not them. Hundreds of chiropractors in states such as Minnesota and California, who felt secure but were finally driven to integration with a chiropractic or interdisciplinary provider group by astounding patient losses, provide stark evidence of the fallacy of this thinking. Here is why:

a) A feature of MC is large purchasers of health care services - insurance companies, employers, groups of employers, government-funded plans or regional health councils, which represent thousands or millions of patients.

b) These purchasers do not have the time, funds or inclination to analyze which providers deliver quality and which do not, and then monitor all the individuals chosen. For obvious reasons they prefer to deal with provider networks which have done their own credentialling and provide a guarantee of ongoing quality control and performance. This is the same as General Motors getting certain car parts from 2 or 3 major suppliers rather than hundreds of small family businesses. Patients may be happy with you, an excellent chiropractor, but must now choose a network DC if the cost is to be covered by their employment benefits plan.

c) Other market disadvantages for individual chiropractors under managed care are competing with networks on marketing and price. An individual does not have the marketing expertise and resources, and solo practice provides a much higher overhead than the average overhead within a group - which has economies of scale on administration, staff, equipment, marketing costs, etc.

d) In some markets being part of a large provider network or group is now not sufficient. Purchasers do not want *component care* (i.e. chiropractic services or medical services or acute care services or rehabilitation or hospital services) but total health care through a *vertically integrated* MC plan. Employers like Magna for example, prefer to deal with or create a provider organization that meets all health care needs of the employee group in a way that provides complete coordination of delivery, administration and cost.

Old Battles and Strange Bedfellows

9. The chiropractic profession has faced, and in many jurisdictions still faces, firm opposition and turf protection from political medicine and its allies. One most promising aspect of MC is that it is not concerned with these old battles. It is governed by market principles of quality and cost, not by anti-competitive professional interests.

If the evidence is, as government commissioned health economists in Canada have recently reported,[6] that chiropractic management of low-back pain is the most effective and cost-effective and produces highest patient satisfaction, then an employer or medical group setting up a competitive MC organization will sooner or later be forced to include chiropractic services. If the evidence favors management that includes spinal manipulation for soft-tissue cervical whiplash injuries, as it does,[9] the MC organization will be forced to include those best trained in spinal manipulation.

Any health provider who is not cooperative with other disciplines, who is not patient-centered, is fighting new market realities and is at risk. Rehabilitation services jointly managed and operated by MDs, chiropractors and PTs, who would have been strange bedfellows 10 years ago, are much more appealing to patients and purchasers.

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Figure 1

GLOSSARY OF MODERN MANAGED CARE TERMS

Managed Care
- A method of delivering, supervising, and coordinating health care so as to control costs and maintain quality.

The system works in many organizational guises, including HMOs, PPOs, IPAs, and managed health insurance indemnity plans.

Capitation
- A reimbursement method that pays a set fee per patient per month in exchange for all health care.
- This type of approach puts health professionals and hospitals at financial risk.
- In some systems, primary care providers may manage the capitation fee, setting aside a portion of it to pay specialists and hospitals. This process is called subcapitation.

Covered lives
- In capitated systems, the total patient base.

Discounted fee-for-service
- A reimbursement system commonly used by PPOs in which health professionals agree to provide care to a health plan's patients at a discount from the customary fee.
- The discount may be further reduced by a "withhold," a sum that the payor deducts from the initial payment and withholds until the end of the year, when it is reimbursed to providers only if they meet cost-saving goals.

Gatekeeper
- A health care provider, commonly a primary care-specialist, who supervises all aspects of a patient's care and who must authorize care from all other providers (except in emergencies) before it can be rendered. This is a common feature of HMOs.

Health maintenance organizations (HMOs)
- A prepaid health plan in which professionals are paid a fixed fee to treat patients covered by the plan (eg, capitation).

HMOs may employ health professionals as salaried staff members or they may contract with a specific group (closed panel) or with any health professional in a community who can accept capitation (open panel) or similar arrangements.

Preferred provider organizations (PPOs)
- An organization that contracts with "preferred" providers who agree to provide health care to subscribers for a discounted fee.
- Some PPOs require health professionals to put part of their discounted fee into a "risk pool." They get all or part of their money back if their charges do not exceed an annual limit.

Independent practice associations (IPAs)
- A legal entity that holds managed care contracts. The IPA contracts with health providers to provide care on a fee-for-service or capitation basis.
- IPAs are often sponsored by medical societies to help physicians in solo practice contract for managed care.

Point of service plans (POS)
- A health plan that allows patients to seek treatment at a member HMO or...
- to consult doctors outside the plan for a higher deductible for example, 70% reimbursement rather than 100%.

Vertically integrated system
- A system that provides primary care, specialty care, and hospital care under one umbrella. Such systems are helpful in attracting managed care contracts, and most experts believe all health care providers will eventually organize themselves this way. Also called an integrated delivery system.

Adapted from Coile RC (1993) - see Reference 2.

A Pause to Test Your Attitude

10. At this point consider Dr. John Smith a chiropractor, who has been approached by AB Insurance Company, XY Corporation or ZZ Regional Government Health Plan for inclusion in a managed care plan. Essential points he makes in documentation or at interview are:

- There is now excellent evidence supporting the effectiveness, cost-effectiveness and appropriateness of chiropractic management, particularly for patients with the highly prevalent problems of back pain, neck pain and headache.
- Each patient is different and it is difficult to give clear indications in advance as to duration and frequency of care.
- These matters will be based on my professional judgement and I am prepared to do reassessments and reports on a basis I consider reasonable.
- Most patients will likely need some form of ongoing preventive care on principles well recognized within the chiropractic profession. I anticipate this will be understood by your claims personnel and that my professional judgement on such matters will not be challenged just because the patient is symptom free.

Dr. Maria Gelarti, who has also been approached, responds:

- I represent a network of 40 chiropractors in the city, with geographical spread that matches your population base.
- The great majority of the services we offer are used by patients with neuromusculo-skeletal disorders such as back pain, neck pain and headache. There is excellent evidence of the effectiveness, cost-effectiveness and appropriateness of chiropractic services for these patients.
- For most effective care and best results such patients should be seen by chiropractors in the acute phase if possible. Direct access greatly facilitates this.
- In our network we expect patients to recover within six weeks and 15 visits on average on the attached treatment plan and protocols, unless there is one of the following complicating factors. We guarantee that average and cost, and will offer any additional necessary treatments without cost.
- Outcomes will be measured and reported every 2-4 weeks using the following accepted methods for pain and functional limitations.
- Data will be supplied in the following format for easy interpretation, or in such other manner as you wish.
- We are concerned about efficient integration with your other health care and hospital services. This is how we integrate at present under two other contracts that are working successfully. We welcome your proposals.

Which of these doctors has the right attitude? Which will win the contract?

Figure 2
COMPONENTS OF MANAGED CARE AND THEIR IMPACT ON PROVIDERS

Managed care has several components. The more components a program contains the more managed is the care provided. A comprehensive managed care program affects health care providers as follows:

1. Management and Administrative Processes
   - effective overall management of the providers office
   - streamlined administrative processes that permit inquiries from payors to be handled promptly and effectively
   - electronic transmission of claims and funds
2. Utilization Management and Review
   - utilization management and control of service access
   - utilization review of services
   - case management
   - preferred provider networks
3. Information Systems
   - integrated information systems capability
   - computerized offices with e-mail and electronic communications
   - electronic patient records accessibility
4. Quality Assurance and Evaluation
   - continuous quality evaluation and improvement
   - quality control of services
   - standards for care delivery
   - outcome measurement and evaluation of effectiveness
   - performance review of providers

Which is more like you?

C. Chiropractic in Managed Care

11. MC, which involves major changes in basic assumptions and practice methods for all health professionals, obviously presents large challenges. On the other hand it presents the chiropractic profession, if chiropractors are willing and able to respond to the marketplace, with an unprecedented opportunity for acceptance and growth. Reasons include:

a) Acute spinal pain (back and neck) and primary headache are the second and third most common symptoms (after respiratory disorders) for which patients seek health care services.

b) These patients represent the great majority of chiropractic practice, but the various studies indicate that chiropractors see only approximately 10% of this population.

c) The scientific evidence, and now government-sponsored interdisciplinary guidelines based on this evidence, notably the US AHCPR Guideline[7] and the UK CSAG Guideline[8] (back pain) and the Quebec Task Force Guideline[9] (neck pain, headache and other symptoms of whiplash), support chiropractic management as a first line of treatment in terms of effectiveness, cost-effectiveness and patient satisfaction.

d) The chiropractic profession, unlike others, now has evidence-based national guidelines for practice. These provide the basis for the documentation, treatment plans, objective assessments and reports that are required by MC.

Take, for example, objective measurement of results/outcomes. MC will require this every 2-4 weeks, and for patients with musculoskeletal pain and headache is most interested in measurement of function - ability to perform activities of daily living. The chiropractic profession has helped to develop and is using the most appropriate outcome instruments (e.g. Revised Oswestry Questionnaire for back pain, and the Neck Pain Disability Index for neck pain).

For these reasons it is reasonable to assume that, as MC balances cost and quality after the initial brutal shake-up, chiropractic services will be increasingly sought after and will be used by a much larger segment of the public. Here are two examples of current developments and new opportunities.

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Back Pain - Workers' Compensation in Oklahoma

12. Workers' compensation schemes are a form of managed care, traditionally only loosely and poorly managed. That is changing in North America, sometimes with current treating professionals subjected to new evidence-based guidelines (partial MC) and sometimes with operations contracted out to private managed care plans (fuller MC). In Oklahoma:

a) There has not been a good basis for cooperation and referral of patients between MDs and chiropractors. The medical malpractice carrier PLICO has had a policy obstructing referrals. Interdisciplinary cooperation has not progressed as quickly as in other parts of the United States.

b) In 1995 the state workers' compensation authorities consulted with a Physicians Advisory Committee on Low-Back Pain to provide specific practice guidelines. Because there are US national guidelines established by the chiropractic profession (Mercy Center 1992[10]) and a government-sponsored multidisciplinary panel (AHCPR, DHHS, 1994[7]) there was chiropractic participation. The new workers' compensation guidelines, adopted in September 1995, are consistent with the Mercy Center and AHCPR guidelines - necessarily, since all these guidelines are evidence-based and identify spinal manipulation as an important component of management. The guideline for acute injuries provides for:

i) A treatment regime of 3-5 sessions per week for up to two weeks, then with declining frequency to discharge.

ii) Typical treatment range of 5-18 visits.

iii) Optimum duration of management of 2-4 months.

iv) Reassessment for positive functional results every 2-4 weeks.

c) The implementation of these guidelines has automatically created a new basis for cooperation between MDs and chiropractors. It is now not possible for PLICO or other trade associations to obstruct cooperation, and there has already been an increase in referrals of patients by MDs to chiropractors.[11]

Neck Pain - Automobile Insurance in Ontario

13. In Ontario, as elsewhere, there has been much medical misunderstanding of the risk/benefit ratio of cervical manipulation, with relatively few whiplash injury patients who have chosen medical care being referred for chiropractic management. Under evidence-based managed care this is now changing as follows:

a) Guidelines based on current scientific evidence have now been established by the chiropractic profession (Canadian Chiropractic Association 1994[12]) and a multidisciplinary international panel of experts sponsored by the government-administered auto insurance plan in Quebec (Quebec Task Force Report 1995[9]).

b) These guidelines show that the scientific evidence supporting all forms of management is not strong, but that there is better evidence for manual treatments and early return to activities than anything else. It is fair to say that the Quebec Task Force Report establishes guidelines that give priority to chiropractic forms of management - specifically activation (including manipulation, mobilization, postural advice, and exercise) as opposed to rest, reliance on prescription medications, use of collars and other supports beyond 72 hours, and passive machine therapies.

c) Last month the Quebec guidelines were adopted by the Ontario Insurance Commission,[13] the government agency regulating the auto insurers who provide legislated no-fault health benefits for all auto accident victims. Under new draft legislation about to become law, all primary health care providers, including chiropractors, must provide treatment plans consistent with the guidelines.

d) Managed care is arriving, and insurers want full managed care soon. The new limitations on all providers, including chiropractors, are evident. On the other hand spinal manipulation and chiropractic management have a greatly enhanced role within the system. Chiropractors have an assured and growing market share, and a fresh basis for greatly increased medical acceptance and referral.

D. Conclusion

14. The times they are a'changing. The American Chiropractic Network (ACN), the biggest US independent practice association (IPA) of chiropractors, is based in Minnesota and represents over 5000 DCs from California to New York. Its most recent acquisition, a managed care contract purchased in New York in February, is for the provision of all physical medicine services (chiropractic, medical and physical therapy) for one million people/enrollees. In some of its markets, says ACN Director of Chiropractic Services, Richard Donahue DC, ACN has already seen a 40% increase in utilization of chiropractic services.

Chiropractic Network Services (CNS), one of several strong regional chiropractic IPAs now going national, is based in Seattle, Washington with 220 DCs serving 1.2 million covered lives through 11 payor contracts in that state.

In Canada Active Injury Management (AIM), a chiropractic MC group led by Lu Barbuto DC, has recently been purchased by Extendicare Inc. which had gross business of $1.4 billion in 1995 in health services in Canada, the US and the UK.

Another sign of the changing times is that the academic program at the ICA's annual convention in Orlando next month, co-sponsored by Palmer College, features speakers from medicine and other disciplines on *Strategies for Success in Managed Care.*

To close with further words from McAndrews, the son and brother of chiropractors from Palmer, and the father of a chiropractic student at Cleveland, chiropractors must respond to the marketplace, and:

"..... talent indicates how great you can be, motivation indicates how great you want to be, but only *attitude* tells you how great you *will be.*"

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Professional Notes: *continued from page 1*

scope of practice of medicine" as set forth in the Medical Practice Act.

- That "the legislature clearly intended the distinctions between healing arts branches not be obliterated" and that the law "prohibits a licensee from invading in the field of practice of any branch in the which the licensee is not licensed to practise." Accordingly the prohibition against MDs practising manipulation as defined is to be printed in the Kansas Statutes Book adjacent to the Medical Practice Act.

Importantly, this prohibition appears to apply to PTs as well as MDs. These new legal rulings will serve to highlight the simple point long argued by the chiropractic profession that standard education for MDs and PTs provides no adequate basis for the safe and effective practice of spinal manipulation.

Cervicogenic Headache - "Chiropractors were Right"

There is much new interesting research on cervicogenic headache. Last year Niels Nilsson DC MD PhD presented a study from Europe showing that cervicogenic headache (headache caused by neck problems) was as common as migraine. (Nilsson N (1995), *The Prevalence of Cervicogenic Headache in a Random Population Sample of 20-59 Year Olds,* Spine 20(17)1884-1888.) Now:

1. **Italy**. A chiropractic and medical research team from the Headache Center, Department of Medicine, University "La Sapienza", Rome, has studied management of cervicogenic headache by chiropractic manipulation. Their results suggest that "cervicogenic headache should be treated with spinal manipulation therapy (SMT) before the recommendation of invasive techniques." (Martelletti P, LaTour D et al (1995) *Spectrum of Pathophysiological Disorders in Cervicogenic Headache and Its Therapeutic Indications*, JNMS 3(4):182-187). Details are:

- 36 consecutive patients with cervicogenic headache were given a 7 day washout period from analgesics and anti-inflammatory medications. They then received a course of 12 cervical manipulations, 3 times weekly for 4 weeks, using Diversified technique.
- Patients were allowed to resume taking medication at the beginning of treatment. Outcomes measured at the end of 4 weeks treatment, and 4 weeks after the last treatment, were frequency, duration and intensity of headaches as recorded in a daily diary; and drug consumption as recorded in the diary.
- A decline in the pain index and drug consumption began immediately, and remained significantly lowered at 4 weeks and after 4 weeks follow-up.

2. **North America**. In December 1995 in Canada's largest daily newspaper Peter Rothbart MD, a Toronto anaesthetist and pain specialist, quoted new research from Syracuse University, New York giving new medical understanding that for many headaches "the key to the problem is the trigeminal nerve in the head" which descends to the upper levels of the spinal cord and neck and "can be pinched by problems with the bones and neck."

Rothbart acknowledges, and this was the headline for the prominent article - that "chiropractors were right - many headaches are caused by damaged structures in the neck and scientific evidence proves it."

Rothbart, who candidly acknowledges that MDs "haven't been much more advanced than Greek physicians were 2000 years ago" and must now understand that many headaches previously thought to be tension headache or migraine are "rooted in neck problems", estimates that about 80% of the patients seen at his large headache clinic in Toronto could be diagnosed for tension headache but in fact have cervicogenic headache. Where there is a structural problem that will respond to spinal manipulation Rothbart refers the patients for chiropractic care, for other problems such as disc degeneration he uses nerve block injections. (*Toronto Star* Life Section, pg. 1, Thursday December 28, 1995).

3. **North America**. There is more to cervicogenic headache, of course, than just the trigeminal nerve and its branches. Pikus and Phillips, neurosurgeons from Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire, have just produced a good description of the various structures likely involved, together with a summary of the history of cervicogenic headache. (Pikus HJ, Phillips JM (1995) *Characteristics of Patients Successfully Treated for Cervicogenic Headache by Surgical Decompression of the Second Cervical Root*, Headache 35:621-629).

They emphasize the importance of the C2 nerve root and ganglion, demonstrated for them by a 90% success rates in a prospective series of 27 patients receiving microsurgical decompression of this nerve root and ganglion. They support the view of Nikolai Bogduk MD PhD , in a recent article in JMPT, that a unified theory of cervicogenic headache has to acknowledge many cervical structures - all the structures innervated by the first three cervical nerves including joints, muscular and ligamentous structures, and vertebral artery.

4. **England**. In a paper in *Cephalalgia* Pearce, a Yorkshire neurologist, reports (Pearce JMS (1995) *Cervicogenic Headache: A Personal View*, Cephalalgia 15:463-469):

- In a consecutive series of 127 of his patients over age 50 presenting with headaches, approximately half (41.7%) had cervicogenic headache using International Headache Society criteria.
- He quotes another recent study of 383 patients diagnosed as having migraine - on IHS criteria 48% had cervicogenic headache.
- He concludes that "despite attempts at anatomical refinement of diagnosis, treatment remains empirical," and as a neurologist acknowledges "we have much to learn about the important role of the neck in the genesis of headaches."