Clinical Guidelines for Chiropractic Practice in Canada: using guidelines to enhance patient management

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First may I say how pleased that I am to be asked by the association to discuss the utilization of the guidelines and patient management.

When I think of the guidelines and the role that they will play in the future development of our profession I cannot help but think of the fable of two little old men. This is a story of the two little old men who were taking their nightly walk in the moonlight down by the castle. As they walked by the swamp they noticed a little frog sitting on a lily pad. The little frog said to the first man "If you will pick me up and kiss me, I will turn into a beautiful princess and I will show you an evening of such thrills, excitement and passion like you have never known before in your life." The first little old man bent over gently and lifted the frog from the lily pad and put it into his pocket. The second little old man said. "Aren't you going to kiss her?" The first one answered , "No. Just having a talking frog is enough for me."

This story reminds me of the guidelines because of the initial excitement and enthusiasm that emerged from the conference that conceived them. Their true value will be over the long term. For as we approach the centennial of our founding, we are going to be able to emerge from that swamp of obscurity, internal bickering, paranoia and clumsiness and come into the light, and we will arrive on fertile soil as a more clearly identifiable profession which has accepted responsibility and accountability.

In a perfect world there would be no need for guidelines. In a perfect world we all would have graduated from a college that would have given us all the answers of diagnosis, therapeusis, and prophylaxes. But we're not living in a perfect world and we're not in a perfect profession. We have the pseudo religious fanatics at one end and the unyielding scientists (data fascists) at the other end. But to the credit of the guidelines its strongest point is that they give realistic parameters to the vast majority of our patients; on the other hand there are limitations of application to patients in a broad base practice.

Just having to go through the process of producing these guidelines has been a worth while exercise. An exercise in trying to fuse together the fact that the science of chiropractic is knowing what to do; the art of chiropractic is knowing when and how to do it. An exercise in fusing that which is known, (the science) with the art which is the collective clinical experience of the participants. This consensus method has produced what I consider a remarkable document. But this document has not only its strong points it also has obvious weaknesses. And understanding these weaknesses will help us identify our future research priorities.

The reality is that the guidelines were established this way because the scientific literature is developed and written on a symptom centred model, a model based on the pathophysiology rather than a patient centred model which is based on a biopsychosocial model. In other words we have produced a reductionistic guide for a holistic profession. This was necessary because we still have to communicate with the world of Science and third party payers, in order to eventually grow to our deserved status.

I treat a chiropractor who has been practising for forty-six years and when he read the guidelines he said "What's all the fuss about? This is exactly how I have been doing it since the beginning."

The guidelines are in position and they were done by us for us not them, as in the case of the W.C.B. and O.H.I.P. I believe the future is ours if we can build from this solid foundation.

If there are people in our profession who as a result of the guidelines are worried about their incomes, in my opinion they better start looking more closely at their outcomes. For they are not utilizing the full potential of their science in the interest of their patients.

I think that one of the greatest weaknesses in the guidelines and one which hasn't been made clear is the fact that they have been based on the available hard scientific data and to a great extent this data is related to low back pain. Low back pain is where the research is and hence the greatest amount of data. Once again this tends to limit the broad base practice. Now I must say that the principles of treating any syndrome are exactly the same-come to a diagnosis, work out a realistic treatment plan, and apply that plan and judge your results on the basis of meaningful expectations and clinical reality by honestly evaluating outcomes. I don't believe any ethical practitioner could ever get into difficulty following this program regardless of the syndrome that he is treating but the time frames may not be realistic.

Now more specifically about the guidelines and their application: The initial clinical examination should establish an accurate record of reliable information based on a complete history. Remember, listen to the patient, they are telling you the diagnosis. The most salient factors that you have to establish can be done by applying the SOCRATES principle. (Figure 1) A family history when indicated should also be recorded. Sir William Osler said "Half of us are blind, few of us feel, all of us are deaf" I strongly suggest the utilization of

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FIGURE 1 SOCRATES

SUBJECTIVE
OBJECTIVE
COURSE
RELIEVING FACTORS
AGGRAVATING FACTORS
TREATMENTS
EXAMINATIONS
SIGNS

pain drawings and questionnaires and visual analogue scales which measure pain. I personally like the Oswestry index and the neck pain index as developed by Vernon and Mior which measures function and when indicated the Beck Inventory to establish levels of depression. These are excellent as baselines in assessing outcomes. Continue to ask questions until you have got a clear picture. Watch out for those red flags, persistent mid dorsal pain, dizziness, night pain, unexplained weight loss etc.

When it comes to the examination stand back and look, look, look. A good chiropractor is a biology watcher; their posture during the consultation, how they arise from a chair, their gait, their posture in front of a plumb line, etc. Force yourself to look a little bit longer before you continue your physical examination. We must obviously do the routine orthopaedic, neurologic evaluations that are accepted and standard procedures. Of course any other areas that require special consideration on the basis of your history will be evaluated. Other tests to establish the statics and dynamics of the locomotor system such as palpation, muscle length and strength etc. must be performed. This is done in order to be able to access the syndrome that we are dealing with. The syndrome will arise as a result of that local site which is responsible for the abhorrent function and/or pain. This may be localized to a specific tissue or a sub system of sufficiently distinct delineation anatomically or pathologically. This is the lesion. Once we have established the lesion like any other practitioner we the chiropractor must establish the spacial ecology or the broader status of the static and dynamic of the locomotor system. Only after reaching these two decisions - these two diagnoses can you identify the syndrome that is going to be treated. Remember it is the patient that has the pain that we are treating not the pain that has the patient – this is what makes chiropractic unique. You must be cognizant of the temporal factors involved in the process because this patient is in the midst of an ongoing process – Where do you enter the process? The chiropractor must be aware of the developmental factors leading to the spinal lesion and the mechanisms by which the body has adapted in response to the symptomatic lesion. All of these must be considered in the selection of the treatment planned and in our eventual approach to rehabilitation.

I may add here that in your evaluation any instrumentation that can quantify or act as a base line to assess outcomes of care are worthwhile. I use a four quadrant weight scale and a plumb line to great advantage and I detail abnormal movement patterns such as loss of lumbo pelvic rhythm in flexion, loss of the C curve and/or lack of the shift of the pelvis in lateral bending. Interestingly enough the guidelines rate the plumb line as promising and only of class three evidence. This is one of the points that I would like to see changed at the next guidelines conference and I have every intention of supplying them with the information which would place the use of a plumb line with class one evidence. I would challenge each and every one of you to do the same thing for any of your sacred cows, for example, diagnostic procedures or the value of re x-ray etc.

Again look for the red flags in your examination. Things like bulging of the sternum, masses in the neck, possible abdominal aneurism in patients over fifty with back pain, inappropriate motion patterns related to pain and instability etc.

Explain to the patient as you are going through your examination procedure:
- reflexes
- muscle weakness
- muscle shortening
- palpation findings (fixations).

The report of findings and proposed treatment plan must be formulated in such a way as to correlate the symptomatology with your examination findings. This is where you communicate in order to prevent having to litigate. This is where we have to allay the fears of the apprehensive patient and lets not kid ourselves, most patients are apprehensive. The consent forms will be discussed by Dr. Carey and if you have read the latest edition of The Canadian Chiropractic Protection Association, you will realize that this is becoming more and more important. I just wish to say that the consent form should not be a negative thing. I think that it can be one of the most positive educational opportunities for chiropractic if we explain the comparative safety of our procedures. Everyone knows that there are side effects to drugs and potential complications to surgery. Why should we be shy about explaining potential complications to our treatment. Explain that we are doing these tests and examinations to minimize these complications and that their chances of dying from a chiropractic manipulation is less than dying from a bee sting or being struck by lightening.

All techniques are good and all techniques are bad. The question is when to use what and on whom. These guidelines will put the practitioner who only uses one technique or one method on his medal and it may indeed force him or her to face the reality of the limitations of his or her approach.

Let's take a look at what the guidelines say about treating these people. For example an uncomplicated acute case two trial courses of two weeks each using alternative manual procedures was recommended and then that you discontinue if there is no evidence of a demonstrable improvement over this time frame. I have some difficulty with the limiting term of manual procedures because I know, on occasion, that I use

non manual procedures. But this recommendation tends to give the impression that we are just one modality in the long list of modalities in physical medicine in spite of the fact that chapter ten (on management) delineates a wide spectrum of techniques. There is a major difference between a twelve year old who wakes up with an acute torticollis and a sixty-five year old who has been involved in a serious acceleration, deceleration injury. But even in the second case, one would expect some positive outcome after a four week period. Any clinician who exceeds the guidelines is certainly entitled to defend such an outcome given a rational clinical explanation. For there is no substitute for clinical judgement; but I think we all appreciate the fact that regardless of how severe a whiplash injury is if you can not show some demonstrable positive change over a four week period then you have missed some very serious pathology such as a retropharyngeal abscess, a compression fracture, or possibly secondary gain motive etc. This case should be referred. In these uncomplicated acute cases the guidelines indicate that there should be a return to the pre episode status in most cases in six to eight weeks. I agree with this but in the case of our sixty five year old gentleman who is involved in the car accident I would certainly expect continuation of treatment passed eight weeks.

The guidelines define a chronic condition as one with an onset of more than three months prior to the consultation. The recommendations then suggest that we shift from passive to active care as progress warrants. This obviously will reduce disability, eliminate the possibility of dependency and chronicity. It is recommended that after a trial therapy session of manual procedures of two weeks with a reassessment without improvement and an alternate approach with a maximum of four weeks the patient should be discharged or referred. It is expected that the patient should achieve maximum therapeutic benefit within six to sixteen weeks. The guidelines are flexible enough to allow for acute exacerbations which will modify the treatment frequency. The guidelines are also flexible enough to consider complicating factors such as spinal anomalies, pathologies, occupational stresses etc. and these could multiply our therapeutic time by a factor of 1.5 or 2. I believe this concept is right even though it is predicated on a flimsy study based on low back pain. The guidelines refer to four previous episodes as being a predictor. Now these four episodes may be minor or only one previous episode may have occurred and this one resulted in three months hospitalization - this is the type of problem that we face when we deal with the data fascists. (The average family has 2.3 children). Supportive care is considered when a trial period of withdrawal of treatment results in a significant deterioration of clinical status and I have no disagreement with this approach, for this is the way that we establish frequency for supportive care.

Responsible clinical procedures, I'm sure, will give us the same or similar outcome. We must remember that if we can only show outcomes improve you have a free hand to continue to help even the most chronic patient. We must, however, remember that if we are going to deviate from these practice guidelines there has to be some scientific clinical rational which is documented to justify this deviation. This is why we must keep excellent records on a treatment to treatment basis, not just a major reassessment after two weeks. I like the concept of S.O.A.P. because this does require an assessment of the patient's status each and every time you treat it. We must be accountable and therefore we as a profession cannot exist without some kind of credible quality assurance guidelines.

Another thought at the end of sixteen weeks it is recommended that we refer the patient; where? to whom? ... The reality in the city of Toronto if you want to get an orthopaedic or neurologic consultation it will take three to six months. Are you going to send him or her back to his or her general practitioner – not until you have at least informed the doctor that you have been treating this patient for what appeared to be a bio mechanical problem without results and therefore you believe additional investigation or pain management or psychological assessment etc is in order. I usually get cooperation from the G.P. especially if I give a detailed status report of the patient – this also furthers good inter professional relationships.

If the G.P. does not cooperate or there isn't one, discuss the problem with the patient and set up the referral yourself. The other alternative is to discharge the patient simply by explaining that your trial treatment indicates that their problem isn't in your province. I think that we have a moral responsibility not to abandon the patient and leave them in limbo for three months while waiting for a specialists appointment. Take advantage of the time to direct some active rehab and/or other modality for this patient even if it only means getting them into a therapeutic pool with aquatic exercises or daily walking routine. During this period I think that it behooves you to see or phone the patient for supportive therapy at least once a month even if it is only for moral support and to check for any rapid deterioration in their condition which may constitute an emergency.

I believe in preventive/maintenance care and that it should be discretionary and elective on the part of the patient. We do not have hard evidence that promotion of wellness by early identification and correction of neuromusculoskeletal disorders will help preempt symptoms and disability. But when coupled with education on the topics such as exercise, spinal hygiene, good bio mechanics relative to the life style, stress reduction and nutrition we are fulfilling our full responsibility of health practitioners. I am not married to the once a month concept – I often use it – however, as I see many of my young healthy patients on a once a year basis.

I believe these guidelines are a good beginning and if we follow the process for their evolution we will be one step closer to the full development of our profession and before the next one hundred years has elapsed we may even establish a more complete appreciation and understanding of our scope of practice.

To those who say that it cannot be done, I say to you, "Step aside and don't hinder those that are doing it."