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The determinants of chiropractors being providers of appropriate manipulative health care in Australia

Phillip S Ebrall, BAppSc (Chiropractic)*

The objective of this paper is to introduce the descriptor "appropriate" for the process of delivering manipulative health care (MHC), and to identify and describe the determinants of chiropractors being providers of such care. Information from government publications, curriculum requirements, and Chiropractors' Association of Australia policy and direction was qualitatively assessed within the context of the public health arena in Victoria, Australia. The information suggested that appropriate strategies exist to facilitate the provision of appropriate MHC. The strategies are seen as either being an entry level or ongoing maintenance requirement. The entry level strategies are essentially (i) the legislative provisions of government which, in the case of chiropractic and osteopathy in Victoria, Australia, confer specific responsibility and guardianship for manipulation, and (ii) the competencies instilled during the professional education process. The maintenance strategies are more diverse and exist within the critical mass of a professional association and are integrated with the research environment through critical questioning and critical review of the outcomes of professional intervention. The most powerful maintenance strategy to date seems to be the "standards of practice" concept, achieved by consensus and providing a blueprint for the delivery of the most appropriate MHC. The considerations presented in this analysis demonstrate that the chiropractic profession is holding a position of strength and leadership, a position which must be noted by those with a genuine interest in ensuring the safe delivery of MHC services to the consumer.
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KEYWORDS: chiropractic; quality-assurance, health-care; curriculum; legislation.

Cet article vise à introduire le descripteur «approprié» dans le processus de prestation des soins de santé manuels de même qu'à établir et à décrire les déterminants des chiropraticiens en tant que fournisseurs de ce type de soins. On a évalué la qualité de l'information contenue dans les publications du gouvernement, les exigences du programme d'études ainsi que les règles et la direction de la Chiropractors' Association of Australia dans le contexte des soins de santé publique à Victoria, en Australie. L'information recueillie indique qu'il existe des soins de santé manuels et des stratégies qui facilitent la prestation des soins appropriés. On considère que ces stratégies sont soit des stratégies de départ soit des stratégies de traitement permanent. Les stratégies de départ représentent essentiellement (i) les dispositions législatives du gouvernement qui, dans le cas de la chiropratique et de l'ostéopathie à Victoria, en Australie, confèrent aux professionnels la responsabilité précise et l'exclusivité des manipulations, et (ii) les compétences acquises pendant la formation professionnelle. Les stratégies de traitement sont plus variées et existent à l'intérieur de la masse critique d'une association professionnelle; elles sont intégrées au domaine de recherche grâce à un questionnement critique et à une révision des objectifs des interventions professionnelles. Jusqu'à ce ce jour, la stratégie de traitement la plus efficace semble être la notion de «normes de pratique» obtenue par consensus et qui fournit une base à la prestation de soins de santé manuels les plus appropriés. Les informations présentées dans cette analyse montrent que la chiropratique occupe une position de force et de chef de file; les personnes qui manifestent un intérêt réel dans la prestation prudente des soins de santé manuels doivent reconnaître cette position.
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MOTS CLÉS : chiropratique, vérification de la qualité, soins de santé, progamme d'études, législation.

* Chair, Clinical Practice Committee, Chiropractors' Association of Australia.
Coordinator, Undergraduate Chiropractic program, School of Chiropractic and Osteopathy, RMIT Melbourne.
Address: Dr. Phillip S. Ebrall, 80 Charles Street, Northcote 3070 Australia.

Introduction

The development and implementation of standards of practice by the consensus method is currently an issue of importance for the chiropractic profession worldwide.[1] One impetus has been identified as the need for the chiropractic profession to demonstrate the maturity of a health care profession which is capable of setting its own practice parameters in lieu of having them imposed by external bodies,[2] a reflection of the socialization of health care.

Other health service delivery professions, notably nursing, have embraced a range of mechanisms to ensure a high standard of practice. Foremost among these is the process of Quality Assurance (QA), the process by which an output is measured for consistency. It began in the industrial sector as a reflection of the complications and intricacies of mass production and was originally concerned with improving product performance in order to maintain or gain market share.[3]

The underlying premise of QA in the context of health care is the minimization of errors in the delivery of a service or services. The process recognizes that as the number of people involved with service delivery increases, so does the potential for error, with a concomitant decline in the quality of service provided.

Chiropractic services are largely privately purchased services made at the personal discretion of the consumer,[4] delivered in the ambulatory setting of either sole provider or partnership practice.[5] In this environment the QA process becomes less applicable, however the need for quality care appropriate to the patient, remains.

One favourable outcome of this disposition is the profession's ability to see quality care in the most pure form in which "quality" is what the consumer gets out of the chiropractic encounter and is willing to pay for.[6] "Quality of Care" thus becomes the parallel of "appropriate care" as defined by the Australian National Health Strategy, adapted for chiropractic as being the safe delivery of that standard of care which best encompasses the consumer's expectations of health and the benefits of treatment, at acceptable cost.[7]

The challenge to chiropractic as a profession is the development of processes to ensure both the enhancement and continuance of appropriate care, especially in light of an increasing accountability to third party payers. This paper attempts to add to the current "standards of practice" debate by discussing those processes attendant to what becomes, in effect, the delivery by chiropractors of the most appropriate manipulative health care (MHC).

The "appropriate care" process

The processes which contribute to appropriate care can be initially set at two levels:

i the entry level, being those strategies which ensure persons entering the profession do so with a predetermined level of knowledge, skill and competence; and

ii the maintenance strategies, being those mechanisms which ensure persons who practice over time retain competencies, perform to uniform standards, and critically review their performance and outcomes.

Maintenance strategies revolve around the professional associations and the research community. They ideally reflect the development of new knowledge as presented through the peer-review process of scientific meetings and publications.

Entry level strategies are enshrined in the enabling legislation and the educational institutions. The intimate relationship between the entry level strategies of statutory determinants and curriculum development has recently been elaborated by Gatterman and Vear.[8]

A division can be thought to exist between the two levels (entry and maintenance) on the basis that entry level strategies essentially reduce error in the form of inappropriate care resulting from inadequate knowledge, while maintenance strategies essentially reduce violation in the form of inappropriate care resulting from defective attitude. Violations may be further reduced by increasing peer conformity to standards of practice.

The legislative entry level strategy

Manipulative health care (MHC) is legally practised in the Australian state of Victoria by chiropractors, osteopaths, physiotherapists and medical practitioners. However, only one group, chiropractors and osteopaths, have the entitlement to manipulate by inclusion within an Act that includes a specific legislative requirement to address manipulative skills. The other two groups, physiotherapists and medical practitioners, have default entitlement by exclusion from a related Act (namely the Chiropractors and Osteopaths Registration Act).

The legislative control of MHC in Victoria came about in May 1978 through the enactment of the Chiropractors and Osteopaths Registration Act. It is through this Act that the government of the day made a clear but subtle distinction with respect to MHC by defining chiropractic and osteopathy in terms of the application of manipulation for the purpose of "curing, alleviating or preventing a physical disability or abnormality".[9]

This distinction, seen as a statutory determinant by Gatterman and Vear, uses the process of legislative inclusion to firmly place the legal guardianship of MHC upon registered chiropractors and osteopaths, and is thus a key entry level strategy for ensuring the delivery of appropriate care.

Whilst the resultant, anomalous bias is favourable to chiropractors, it does nothing to protect all consumers or ensure the provision of manipulative services of equal quality and safety. The ideal environment in which to attain appropriate care would be one in which all providers of a particular service subscribe to common mechanisms.

In order to register for practice in Victoria, a chiropractor must meet the regulatory requirement of being a graduate of an accredited chiropractic college with an approved curriculum,[10,11] thus empowering the second entry level strategy.

The educational entry level strategy

Chiropractors are educated with remarkable international consensus regarding the standard which students must reach before graduation. Australia is now a world leader in chiropractic education by virtue of each chiropractic program being housed within a university, with the inherent implications in respect to the quality of education.

Each Australian program must meet or exceed accreditation standards at three levels:

1 internally, by assessment against the rigid internal standards of the University itself;
2 externally, by assessment against the standards applied by the Government that safeguard the quality of teaching in Government funded programs; and
3 externally, by assessment against the international requirements for curricula as monitored by the Australian Council for Chiropractic and Osteopathy (ACCO), which holds reciprocity with the three other national accrediting agencies, namely the United States Council on Chiropractic Education (CCE), the Canadian Council on Chiropractic Education (CCCE), and the European Council on Chiropractic Education (ECCE).

The course in chiropractic education at Royal Melbourne Institute of Technology, a University incorporating the former Phillip Institute of Technology, has been repeatedly assessed and subsequently accredited by virtue of it meeting or exceeding all standards and guidelines. It is a matter of record that the program is a preeminent qualification within Australia for practitioners engaged in manipulative science.[12]

On the other hand, there is no similarly complex educational standard for others who wish to manipulate. For example, a physiotherapist may choose to practice manipulation after he or she has graduated from a four year BAppSc degree program in physiotherapy. The new graduate can apply manipulation to their patients without any significant formal training in MHC, under a registration act that makes no reference to manipulative skills. In cases where a graduate physiotherapist has undertaken an additional post-graduate course in manipulative therapy in Victoria, the combined, total equivalent hours still amount to only two-thirds (67%) of those contained within the undergraduate chiropractic program.[13,14]

A similar lack of educational accountability exists with medical practitioners. Once registered in Victoria, a medical practitioner can manipulate without any specific training in manipulation, and without being required to demonstrate competency with manipulative skills. It should be of some concern that payment for such perfunctory manipulation is made from the public purse.[15] Whilst it is optimistically hoped that, in Australia, medical practitioners who opt to manipulate would affiliate with the Australian Association for Musculoskeletal Medicine and pursue appropriate post-graduate training, this is not a prerequisite for rendering manipulation to unsuspecting patients.

A developing strategy

The chiropractic curriculum has been designed to produce primary contact health care practitioners with, among other key attributes, the ability to perform differential diagnosis. This important component of the undergraduate program means that persons who become registered as a chiropractor or an osteopath become one of only two groups of primary contact health practitioners with the broad based diagnostic skills required for the accurate assessment of the patient's total health status. The other remaining group is comprised of persons registered as medical practitioners. In addition, incomparable training in manipulative skills further renders the chiropractor or osteopath as being uniquely able to diagnose musculoskeletal disorders and to determine the suitability or otherwise of the patient for treatment by manipulation.

Educational institutions must therefore, develop strategies for assessing and measuring student performance against the required competencies.[16] To facilitate this type of assessment, exhaustive documention is being made of the required clinical competencies. This initiative originated with CCE (USA), where the impetus is in measuring the effectiveness of education through competency based outcomes assessment, and has been comprehensively developed under federal government funding in Australia by the ACCO.[16]

The expectations are that the introduction of competency based assessment will significantly strengthen the undergraduate education process. This type of assessment may also be applicable to those graduate practitioners wishing to expand into the government funded health arena.

The professional association as a maintenance strategy

Maintenance strategies are designed to:

1 maintain the competencies demonstrated at the time of entry;
2 enhance those skills across a broader clinical environment;
3 develop new skills commensurate with developing technology and changing social expectations; and
4 critically review the relevant activity.

Maintenance strategies can be developed pursuant to the attainment of a critical mass of graduates in any one discipline. Achieving critical mass makes it possible to establish a professional organization of an introspective nature, with the power and ability to look at itself and assess its members' strengths and weaknesses.

Chiropractic associations have existed for over fifty years, and all seem to have issued guidelines for basic practice standards and professional ethics as rudimentary maintenance strategies. Other such strategies include concepts such as continuing education, and mandatory requirements for association membership such as professional indemnity insurance.

Recently, various associations have published very detailed standards of practice. Most noteably are the Mercy Center document[17] and on a smaller scale, one from the Board of the Manitoba Chiropractic Association. The latter document touches on the heart of a chiropractor's ability to practice effec-

tively by limiting the number of patients that may be seen in any one week, much like airlines limit the number of hours a pilot may fly.[18]

Professional associations are the ideal arena for most maintenance strategies on the basis of a profession being charged with the responsibility to govern itself.[19,20] To date, the contemporary emphasis on "standards of practice" can be seen as the most sincere attempt to achieve a consensus document that clearly delineates chiropractic professional behaviour. The Clinical Practice Committee of the Chiropractors' Association of Australia is currently addressing a number of pertinent practice issues. It is one of several committees charged with the responsibility to refine and recommend "standards of practice" to the profession on a national basis. Chiropractors who decline membership of this Australian Association in particular must be seen by health authorities as refusing to participate in the maintenance process, and therefore lacking the accountability required for participation within the broader third party payer and community health arena.

The critical review process as a maintenance strategy

In recognition of the responsibility that comes with the legal guardianship of manipulation, the chiropractic profession has embraced the issue of developing standards of practice through critical review and the consensus process.[8,22]

An essential part of the process is to raise the standard of appropriate care through critical evaluation of each contributing component. The aim of this evaluation is to individually refine it into a logical process, capable of validation within the constraints of science.[21] A maintenance program without critical evaluation does not have validity, and without a direction towards improving the quality of care, it has only limited relevance in today's environment.

The outcomes of intervention are now measured in the patient's value terms, namely whether or not the intervention decreases pain, increases function and the ability to work, and increases the ability to perform the activities of daily living. In this context critical review is essential, more so now all providers of health services are being held accountable to demonstrate that what is done to the patient in the name of health care is actually of benefit to the patient.

The maintenance strategy of critical review is dependent on critical questioning, and those asking the questions in the field of health care are now more often the third party payers and the recipients, rather than the providers. The preferred way to achieve acceptable answers to appropriate questioning is through analysis by the scientific method of that which can be measured.

Within chiropractic, many questions are still being driven by the providers themselves through their professional associations and educational institutions, an amalgamation of most of the strategies designed to achieve appropriate care.

The leadership position of chiropractic

The chiropractic profession has taken a leadership position with respect to all processes which result in appropriate and safe MHC. What is now required is a lateral shift in thinking by insurers and rehabilitation providers, from the existing framework of the medical practitioner as the diagnostician whose opinion is law, and the physiotherapist whose traditional treatment is seen as all encompassing for musculoskeletal disorders, to a new paradigm which places greater reliance on chiropractors as the most accountable providers of the most appropriate MHC.

Through the appointment of chiropractors to government and third party advisory panels, the solid gains in the quality of MHC through improved standards of practice will be accessible to the broader health care community. The mentality of trying to contain manipulation totally within a medical framework is redundant, although still practised by Government as recently as November, 1992.[23]

The standards of practice adopted by chiropractors for MHC should set the minimum standard for any practitioner who wishes to embrace manipulative methods within his or her practice. To ignore the work of the chiropractic profession with respect to ensuring the most appropriate MHC would be to attempt to duplicate an intricate and costly process at the expense of limited community resources. It becomes evident that chiropractic's considerable investment in assuring quality of care for patients receiving manipulation can in fact be very cost effective for adoption by the various health care communities.

Conclusion

This paper has discussed the provision of appropriate MHC in terms of the strategies which exist to facilitate its delivery. The strategies are seen as either being an entry level or ongoing maintenance requirement. The entry level strategies are essentially (i) the legislative provisions of government which, in the case of chiropractic and osteopathy in Victoria, confer specific responsibility and guardianship for manipulation, and (ii) the competencies instilled during the professional education process.

Maintenance strategies are more diverse and exist within the critical mass of a professional association. They are integrated with the research environment through critical questioning and critical review of the outcomes of professional intervention. The most powerful maintenance strategy to date seems to be the "standards of practice" concept, achieved by consensus and providing a blueprint for the delivery of the most appropriate MHC. The global environment which has stimulated the review of these strategies is that of the third party payer and of a government concerned with the provision of appropriate health services within budgetary limitations.

The considerations presented in this paper contend that the chiropractic profession is in a position of strength and leader-

ship, a position which must be acknowledged by those with a genuine interest in ensuring the safe delivery of MHC services to the consumer. The quality of MHC provided by chiropractors represents a community resource too valuable to be ignored. To do so would be to deny the patient the most appropriate MHC from a profession which is at the leading edge of the quality process.

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