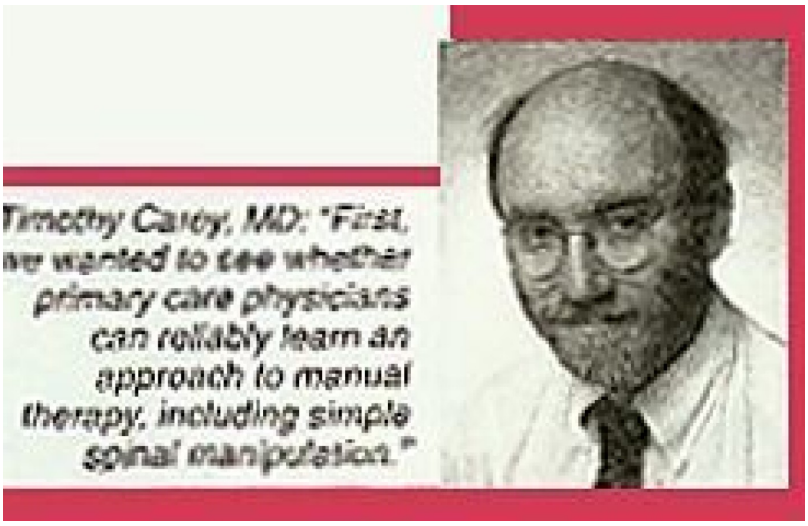
Dynamic Chiropractic



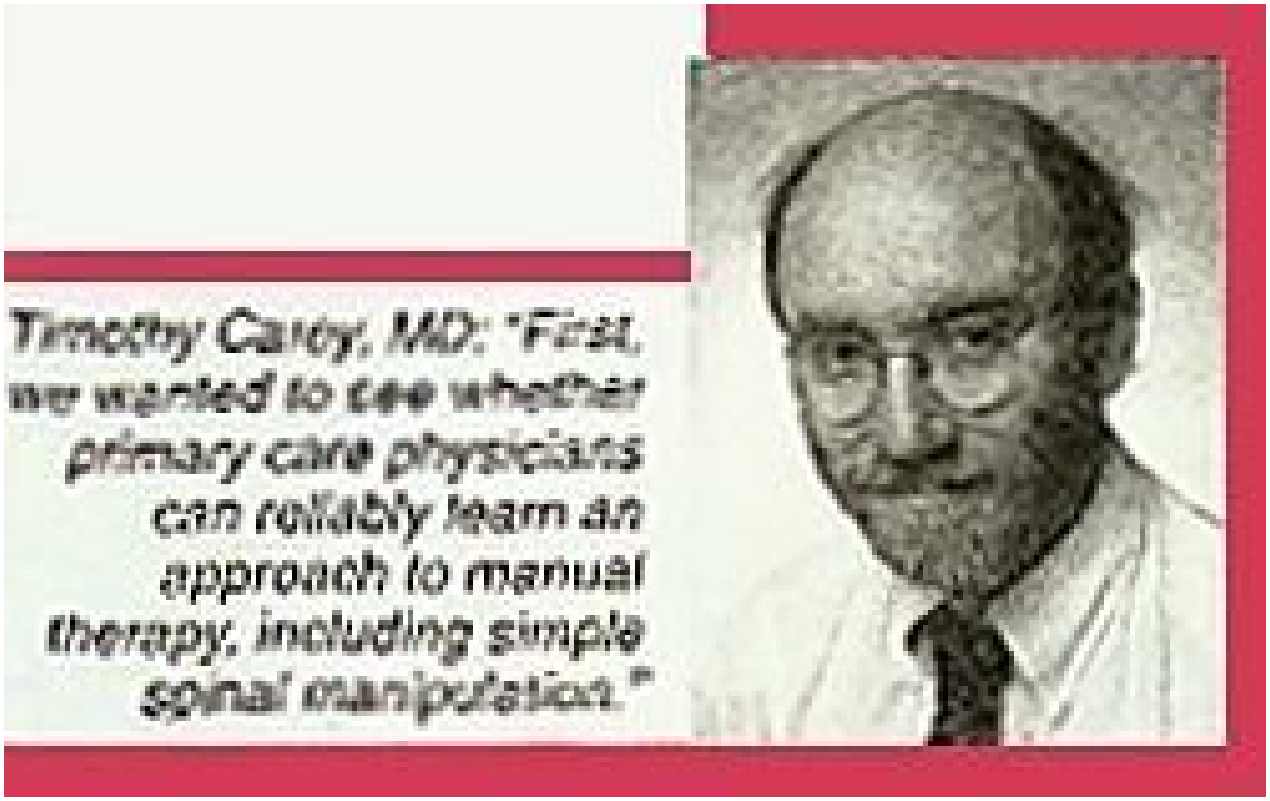
PHILOSOPHY

Should MDs Be Taught to Manipulate?

Editorial Staff

That's just one of the questions being asked in a randomized trial being conducted by noted researcher, Timothy Carey, MD. In an exclusive interview, Dr. Carey explains what the study involves and its goals.

"DC": Dr. Carey, you are the principal investigator of the study, "Integration of Manual Therapy in Primary Care with Acute Low Back Pain." Would you give us an overview of the study?



Dr. Carey: This is a three-and-a-half year project which we started slightly over a year ago through the Shepps Center for Health Services at University of North Carolina, Chapel Hill. The study has two overall questions. First, we wanted to see whether primary care physicians can reliably learn an approach to manual therapy, including simple spinal manipulation. Then we wanted to see whether use of simple spinal manipulative therapy could improve the clinical outcomes for patients with acute low back pain when applied in this setting. We developed a standardized curriculum of simple manual therapy drawing from both osteopathic and chiropractic traditions. We wanted to be clear that we were not teaching primary care doctors how to be osteopaths or chiropractors. We have implemented this curriculum in training 33 physicians from primary care disciplines in North Carolina. We are now testing the training with the physicians in a randomized trial using either manual therapy or an educational intervention in their mechanical low back pain patients.

"The three areas we focused on were three muscle energy techniques, and two very simple high velocity, low amplitude techniques for the sacroiliac and lumbar areas."

"DC": How long were the physicians trained, and how was that training conducted?

Dr. Carey: The training consisted of two one-day sessions spaced about two months apart, and then a refresher session. We also developed a training videotape and an extensive syllabus, which again was developed for the training to be quite specific. The training followed the continuing medical education model which allopathic physicians are accustomed to: two to three days training in a new therapy. The analogy that we used was training physicians to learn other new techniques, such as sigmoidoscopy, joint injection, or other types of techniques that they may use.

"DC": Obviously, this two-day program couldn't cover all the various techniques available for manual therapy.

Dr. Carey: Absolutely not.

"DC": What areas did you focus on?

Dr. Carey: The three areas we focused on were three muscle energy techniques, and two very simple high velocity, low amplitude techniques for the sacroiliac and lumbar areas. One of the reasons we chose these relatively simple techniques is that we found that they were relatively easy for the physicians to learn and that they could perform those techniques reproducibly.

"DC": What was the basis for diagnosis before the technique was performed?

Dr. Carey: We trained the physicians to do a standard back diagnosis derived from the Agency for Health Care Policy and Research guidelines, which is a fairly allopathic tradition -- looking for red flags, serious causes of back pain, etc. And then we also used manual therapy type diagnosis -- looking for areas of motion restriction.

"DC": Similar to motion palpation?

Dr. Carey: Yes.

"DC": If a chiropractor were to look at this, he/she might feel that the teaching of MDs both how to diagnose and manipulate in a two-day program was making light of chiropractic practice. How do you feel about that?

"Well, the physicians are not being taught chiropractic. They are being taught a manual therapy technique."

Dr. Carey: Well, the physicians are not being taught chiropractic. They are being taught a manual therapy technique. I think for someone to practice chiropractic they should be trained in the underpinnings and the extensive knowledge base that's involved in teaching someone to be a chiropractor. The analogy that we've used is learning joint injection techniques of the knee by a primary care provider does not make someone into a rheumatologist. That takes two years of fellowship-based training to become a fully qualified rheumatologist, however, we've known from many years of experience that physicians are capable of adequately treating inflammatory disorders of the knee within a certain scope by using injection techniques of the knee. But that doesn't make them a rheumatologist. We have had chiropractors observe our training sessions and they felt that we are not making light of it.

Short training courses in manual therapy for MDs are currently conducted in a number of sites around the United States, ranging from four hours to one week. Our purpose is to evaluate training programs of this type that are currently ongoing, not to take an advocacy position that this is the way to go. The purpose of our study is to determine whether this is an appropriate technique for educating primary care providers. They're currently being taught it now in these other courses, so the question in our minds is, "Can they learn it reliably?"; secondly, "Will their patients be better off for it?"

"DC": How do you feel this training will impact the triage that these primary care physicians will do when they see a low back problem?

Dr. Carey: That's one of the questions we want to find out, how will it be incorporated into their daily practice? So, in addition to the formal part of the study where patients are being randomized to the manual therapy arm or the educational arm, we're also interviewing the physicians periodically over a three year period to see how learning this new approach to mechanical back pain is affecting all of their patients -- those who are in the study as well as those who are outside of the study. We are particularly interested in issues like: "How does learning the terminology and a few basic concepts behind manual therapy change their relationship with manual therapists in their community?" We're interviewing the physicians periodically on these issues. For example: Will they develop different referral relationships with doctors of chiropractic or physical therapists or doctors of osteopathy in their community? Anecdotally, some of the physicians have told us that they now have a common language, so that they can discuss certain types of mechanical back pain with their colleagues in those other professions.

"DC": When you are talking to some of these physicians, are you getting any kind of understanding regarding what their feeling is about doing a procedure or technique that not too many years ago was thought to be, at the very least, totally ineffective?

"How does learning the terminology and a few basic concepts behind manual therapy change their relationship with manual therapists in their community?"

Dr. Carey: The training programs were very interesting. I think the primary care physicians we work with had become aware of the studies and guidelines and recommendations regarding spinal manipulative therapy. They enrolled in the project because they were interested in those areas, so these are the physicians who are interested in these areas. We found that after they had some practice with hands-on manual evaluation and therapy that sometimes there was a light bulb going on over the head and they'd say, "Oh yeah, that's how the back works." But again, that's the training portion, and what we're trying to evaluate in the study is how this training is going to play out in actual practice. Many types of medical educational training have great training experiences and then the physicians may find these types of therapy difficult to incorporate into practices. Issues of patient positioning, table height, and incorporating manual therapy into the increasingly

pressured primary care practice are areas that could be barriers to incorporation of manual therapy into primary care. These are the things we want to find out.

"DC": Speaking of that, the average allopathic table is significantly higher than the average chiropractic table. How did you get around this?

Dr. Carey: We gave each of them a step, which was wide enough that they could position their legs. A few doctors brought portable tables. We found we had to spend a lot of time during the training talking about very practical issues. One of the developers of the training, Dr. Paul Evans, told me that there were really three components of the training. One was changing the way they assess the back, moving from a relatively basic assessment (looking for only major issues) to a more detailed assessment -- that's a paradigm shift. The second issue is to learn the techniques. The third is how to incorporate those techniques into their practice. So learning the technique, while a significant part of training, is really only one part it. You can't divorce it, we feel, from learning the assessment techniques and learning the incorporation.

"DC": How did the physicians feel about some of the risks that they've probably read about or maybe even a few horror stories they may have heard about spinal manipulation?

Dr. Carey: We talked about that in some detail. All of the patients enrolling in the study signed consents, and we had long talks with the physicians about that. There's risk to any medical procedure, certainly, and there have been reported risks to spinal manipulation. However, the best assessments of those risks I believe were from Dr. Paul Shekelle's work that was published in the Annals of Internal Medicine in the early '90s and risks are in the order of probably events per million. That is less than the risk associated with using some of the medications allopathic physicians use every day. So while there is risk, we feel that those risks are very low when performed in appropriate patients. I believe, there was only one physician who started the training who didn't complete it but it wasn't because of his discomfort. Now again, these were not random physicians. These were physicians who we invited into the training who accepted the training. So they had a level of interest in back pain and manual therapy that was greater than that of the average primary care provider. But we found that the acceptance was really quite good.

"DC": We recognize that you are not through with this study and that there are a number of things that you can't really share until you get to the end. Is there anything you can share, either that you have observed or anecdotally, that would provide a better understanding of where you are now?

Dr. Carey: We're in the middle of patient randomization. Obviously we can't analyze the data until we're done with the randomization process and we follow the patients through several months of follow up. So far we're very pleased with how the mechanics of the study have gone. We're pleased that these 33 physicians wanted to try something somewhat new in their practice. We're very happy with the curriculum development process and several members of the chiropractic profession have reviewed some of these materials and that's been a fun learning experience for us. The acceptance of the patients seems to be reasonably well. We're actually a little bit ahead of our targeted goals so we hope that within one to two years we will have completed the study and be able to have some results.

"DC": Is there anything else you would like to add?

Dr. Carey: Only that it has been a very enjoyable study to do. Again, I want to emphasize that we are evaluating a type of training that is already out there. I think of that of being a little bit analogous to evaluating a new procedure before it becomes widely applied. In the case of manual therapy it is not a new procedure. It's a very old procedure, but it's being used in a somewhat new

way. Before training allopathic physicians becomes incorporated in a wide number of continuing medical education programs or into residency programs, the feeling of our group is that this should be evaluated in a scientifically rigorous and valid way. The reason we developed our own curriculum was that we felt that there was not a standardized curriculum out there that we could easily apply. The curricula were very idiosyncratic, with each professor developing a different course, with terminology that was somewhat inaccessible to allopathic providers.

"DC": Thank you, Dr. Carey.

MAY 1996