Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Chiropractic Works in a Medical Model

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In May 2009, the English agency National Institute for Health and Clinical Excellence (NICE) produced a guideline you're probably not aware of here in the U.S.: *Low Back Pain: Early Management of Persistent Non-Specific Low Back Pain*.[1] In terms of its recommendations concerning "persistent" low back pain, the English guideline is not unlike the *Acute Low Back Problems in Adults* guideline produced by the Agency for Health Care Policy and Research (AHCPR; now known as the AHRQ) some 15 years earlier.[2]

- "Manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms." – AHCPR
- "Consider offering a course of manual therapy, including spinal manipulation, comprising up to a maximum of nine sessions over a period of up to 12 weeks." – NICE

Inspired by the NICE guideline, a group of London researchers put the guideline to the test.[3] This was not just an academic exercise, according to the authors: "Chronic pain currently affects 7.8 million people in the UK and it has been estimated that back pain alone costs the economy #12.3 billion per year. A survey of adults registered with GPs in the UK found that 38% of respondents were affected by musculoskeletal (MSK) pain. Dealing with MSK problems places a heavy burden on primary care services and resources." (In the U.S., the projected annual cost of back pain exceeds $100 billion.)

The researchers worked with a large medical practice (or "GP surgery," as they call it) in central London with about "11,500 registered patients." While not in keeping with the NICE guidelines allowing nine sessions, "patients could receive up to 6 treatments. Appointment making was integrated into the practice's computer-based reception system, so that patients could book their sessions in the normal way via the practice reception (in person or by telephone). Decisions about patients' treatments were not constrained by any research protocol, but were delegated to the practitioners who were free to treat as they would in everyday practice."

After comparing the pre- and post-questionnaires, the researchers found the following:

- "The most common places participants experienced pain were their lower backs (53.7%), shoulders (43.9%) and necks (37.4%)."
- "79.7% were taking pain medication."
- Comparisons between pre- and post-treatment for the primary outcome measure revealed a highly statistically significant improvement in MSK problems.
- "Comparisons between other study variables pre- and post-treatment revealed a statistically significant improvement in health-related QoL (Quality of Life)" and "a statistically significant reduction in medication use."
- "Some patients reported improvements in other physical health conditions, for example decreased headaches, menstruation pain and improved energy levels."
- "Other patients felt they had experienced improvements in their psychological well-being."
- "Patients appreciated having the (manual therapy) service at their GP practice, it was a convenient location and a familiar environment. They trusted a service provided through

their GP practice, and felt reassured that their GP would know details about their... treatment."
- Ninety-one percent of participants said that they would use manual therapy again at their GP's clinic.
- "This figure fell to only 30.8% who would use it privately, this was principally because of the cost of treatment."
- Almost 25 percent had problems getting their manual therapy because the providers were so popular.
- "GPs particularly valued having the service on site, this meant they were aware that their patients were having CAM treatment and were able to access details of patient appointments on the practice's computerised system and communicate with CAM practitioners easily. GPs also welcomed the relatively short waiting time for appointments and having an extra referral option."
- "Our results reveal patients are enthusiastic about the benefits of CAM treatments for pain when expertly delivered. ... The current study shows how high patient approval and demand for effective CAM services can have unexpected results. One drawback of the service was that patients wanted *more* CAM provision than originally estimated. Ideally there should be a degree of flexibility of CAM therapists to provide more or less appointments depending on patient demand."
- "Our findings suggest that it is possible for a GP ... to quickly adapt to incorporate a CAM pain service."
- "It demonstrates that it is possible to introduce treatment modalities into a GP surgery for patient benefit, even when the underlying philosophy differs to that of biomedicine."

Needless to say, there is lots of good news from this study. Patients who had perhaps never seen a doctor of chiropractic were exposed to manipulation, experienced significant benefit, reduced their dependence on drugs, saw other ailments improve and were left wanting more.

The drawbacks are few, but require consideration. In the medical setting, manipulation was seen as a means to primarily reduce pain, increase function and decrease reliance upon pain medication. It is likely that the GPs would have a better appreciation of chiropractic's benefits over time, but that would require more interaction.

Another drawback if chiropractic were included into such a model is the challenges related to practicing in a medical environment. It's not like running your own practice. That said, I have talked to DCs who serve in the military clinics across the country; most of them like it, are well-integrated into the health care system, have developed great working relationships with the other providers, are greatly appreciated for what they bring to the table and are very busy.

Perhaps the worst drawback to this study is the fact that the manipulation was delivered by osteopaths, not doctors of chiropractic. For whatever reason, DCs were not included. But that fact shouldn't be allowed to shut us out here. It would take less than two years to replicate this study in the U.S. In doing so, a model could be developed that would open the door for DCs and medical providers to work together in a shared environment for the benefit of millions of patients.

Admittedly, this is not the usual model for a chiropractic practice. But thus far, little we have done as a profession has moved us from seeing the small percentage of the population we currently see as patients.

With few exceptions (me being one of them), most people see their medical doctor once a year. Most medical doctors have a very poor track record managing musculoskeletal ailments. Having a DC in their clinic, one who is in tune with treatment protocols and intra-clinic communication / documentation, would likely be a win-win.

This model could open the door to the rest of the patient population, because I believe that *chiropractic works*, even in a medical model.

References

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