Dynamic Chiropractic

WHIPLASH / NECK PAIN

Guidelines and Gridlines Revisited

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Some time back, I wrote an article titled "Of Guidelines and Gridlines." It is online (www.chiroweb.com/archives/18/24/05.html). In that editorial piece, I exhorted practitioners to read the existing guidelines, and to know what they include and do not include, because they are often misunderstood, misquoted and misused. Practitioners might misuse them by claiming to third-party payers that their services are in accordance with guidelines when, strictly speaking, they are not. Whether this is done innocently, out of ignorance, based on unreliable hearsay, or purposely and deceptively is irrelevant; it is wrong.

Similarly, it is common for physicians performing peer reviews of their fellow practitioners' work to misquote or misuse guidelines as a basis for concluding that the reviewed practitioners' work was substandard, outside of reasonable practice guidelines, excessive, etc.

Since most of these documents tend to be rather weighty, most practitioners (and peer reviewers) have not read them, which leaves an entire profession ripe for both of the scenarios I just mentioned. Hence my efforts to encourage practitioners who use them (and those who are subject to them) to actually assimilate them.

If you read the original paper, you might recall that I mentioned, in the special case of treating whiplash victims, that the Quebec Task Force on Whiplash-Associated Disorders1 is often used to deny reimbursement for services by insurance companies and their peer-review panels. In truth, as I pointed out, the QTF-WAD "guidelines" are relevant only to individuals who are not working; i.e., on temporary, total disability. If the patient is at work or school, these guidelines simply do not apply, period.

I also mentioned that the *Mercy Guidelines* did not have anything to say about whiplash injuries, and that they could actually be interpreted to allow adequate treatment in most cases. Moreover, certain statements made by the authors of this document could also be interpreted to mean that the document itself was to be used by practitioners as a guide to care - not for peer-review purposes.

Then there is the *Olson Guidelines*, consisting of a 159-page document authored by Richard E. Olson, DC, published by Data Management Ventures, Inc. I don't really know how these were developed, who subscribes to them, or how widely they are used, but apparently at least some state associations and/or state boards do use them for peer review, and perhaps also for disciplinary purposes. Having obtained this document, I note that Dr. Olson only mentions "whiplash" three times: twice in reference to PT modalities, and once in a somewhat vague reference to manipulation. In no case does he discuss treatment frequency or duration in reference to whiplash injuries.

If you use the same arithmetic I do, we have zero guidelines with any specific utility or practical applicability to the lion's share of whiplash injuries - unless, of course, you count the guidelines I developed in 1992, at the time I developed the whiplash grading system. These guidelines deal with both the frequency and duration of care rendered by chiropractic physicians for whiplash trauma,

and have been with us for a decade, without any opposing guidelines.

The Canadian Chiropractic Association published a guide to the management of whiplash for practitioners that apparently was promulgated to most of the DCs practicing in that country. While a direct endorsement was not given, the guidelines were, nevertheless, part of that book. As of this writing, several U.S. states also have boldly adopted these guidelines, including Alaska; Ohio; Utah; Colorado; Kentucky; Arkansas; Washington; North Carolina; and Oklahoma. Several other states are in the process of deciding whether to adopt. I discussed the subject of adoption of these guidelines in an article titled "Guidelines for the Management of CAD Trauma - Use Them." (www.chiroweb.com/archives/16/09/01.html)

Having spoken directly with many state boards of examiners and chiropractic associations, I am aware of the reservations in adopting any guidelines. Here are the chief concerns:

(a) "Our lawyers tell us not to adopt anything." This is great advice for lawyers to give. After all, nobody gets in trouble for telling his or her clients to do nothing. Why assume a risk if you don't have to? (That also happens to be the general apathetic philosophy that is currently killing the practice of personal injury law, and remarkably, most attorneys are too shortsighted to see the writing on the wall - but that's another tale entirely.)

(b) Some feel the guidelines will allow for increased treatment frequencies and duration and jeopardize the current state of reimbursement for chiropractic treatment. Let me disabuse the second issue, since the first one worked its way out already. My guideline neither "allows" nor "prescribes" any particular treatment not already permitted under existing, albeit unwritten, principles of ethical practice. The guidelines tell you, for example, that when the patient becomes asymptomatic or has returned to his or her pre-injury status, the patient should be released - regardless of the duration of care described in the guideline. I see neither a variance from the usual guiding principals of good treatment, nor any tangible risk of increasing treatment profiles. On the contrary; currently there is no definitive way of dealing with overly long treatment durations or frequencies. Both sides classically slug it out, often with no clear winner or agreement, regardless of the outcome. This is expensive and, if anything, is what gives us a bad name.

In fact, proper use of my guidelines will probably result in a slight general decrease in treatment. They were originally adopted by the state examining board in Oklahoma, specifically for the purposes of controlling the rogue elements of the profession. After all, it is generally viewed as true that 10 percent of the profession creates 90 percent of the controversy, often padding their own bank accounts in the process. This is true of players on both sides of the fence. Why should the profession allow itself to be abused by this minority? When will we collectively decide enough is enough?

The real purpose of this article is to call attention to the risk engendered out of ignorance. Whoever you are - peer reviewer, payer or treater - you stand to lose when you are ignorant of these documents. The unfortunate upshot of all this is the abandonment of the very guidelines that offer to help us rise up from the quagmire of personal slugfests. Take *Mercy* as a great example: When this set of guidelines is mentioned, many doctors reflexively curl their lips in contempt. They view it as a vile, dubious work of academics perched too high in their ivory towers to remain tethered to *terra firma* reality. Again, most of these practitioners readily admit they have never read the document. Their reaction is really not so much to what the document said, as it is to what others have said that it said - a sad little case of professional "post office." In a blind uproar, several associations have rejected *Mercy* out-of-hand and in pure ignorance (and now are loath to adopt any guidelines). They hire attorneys who advocate reasoned inaction.

It has come to my attention that my guidelines are being abused. I have heard from state board examiners here and there that some field practitioners are claiming their treatment is in accordance with the "Croft Guidelines." In some cases, this abuse includes using multiple PT modalities in addition to the treatment rendered; in other cases, it involves the use of systematic diagnostic modalities. In truth, my guidelines deal only with the issues of frequency and duration in accordance with the WAD grade. They do not make recommendations for the type of care rendered or for which modalities - or how many - might be appropriate, and I do not recommend multiple modalities in my training programs. While appropriate in some cases, more than two PT modalities typically should not be required. I also do not advocate any diagnostic modality in all cases.

By dint of the fact that these questions were raised, it is clear that the examiners themselves were also blind to how the guidelines were intended to be used, and as I chastened them, they should never accept any statements about any guidelines unchallenged. My chief concern is abuse of these guidelines by a minority of practitioners who might find it irresistible to shelter all of their personal management schemes under the umbrella of the "Croft CAD Treatment Guidelines." This practice will threaten their adoption by some states, and may result in their rejection by those already adopting them. Fortunately, my guidelines do not require the equivalent of reading *War and Peace*. They're just a few pages; let's not abuse them.

The good news is this: If we as a profession simply don't have the time, inclination, or intestinal fortitude to develop and ratify our own guidelines, someone else will surely do it for us. The bad news is that if we don't do it, someone else will surely do it for us. Case in point: New Jersey and the "Care Paths" that were developed at the behest of - get this - the Insurance and Banking Commission. I still find that amusing, although it has not been funny to the state's practitioners, who hired the accounting firm of PriceWaterhouseCoopers to develop this set of dubious algorithms ("care paths") for medical care. Sound like fiction? Sorry - it's true. According to a piece in *Smart Business Magazine*, the Securities and Exchange Commission later reported that partners at the firm routinely violated rules forbidding them from owning equity in companies they were auditing. "Thirty-one of PriceWaterhouseCoopers' 43 partners committed at least one violation, as did six of the 11 partners responsible for enforcing the investment and securities rules. In all, the SEC probe uncovered 8,064 violations: five partners were dismissed in the aftermath." Their approach to the Care Paths was a *fait accompli*.

It is gratifying to see that some states have taken the affirmative move to adopt. All states should adopt guidelines and adhere to them, and all practitioners and peer reviewers should abide by them whenever possible. Misrepresenting guidelines should not be tolerated by any parties.

Download the articles mentioned above; they might save you some money and trouble. Even if your state association hasn't adopted them yet, you can. After all, there are no competing guidelines.

References

1. Spitzer WO, Skovron ML, Salmi LR, Cassidy JD, Duranceau J, Suissa S, Zeiss E: Scientific monograph of the Quebec Task Force on Whiplash-Associated Disorders: redefining "whiplash" and its management. *Spine* (Supplement) 1995;20(8S):1S-73S.

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