Dynamic Chiropractic

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ABS Fall Symposium: The Brave New World of Managed Care, Part II

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Editor's note: This is Part II of Dr. Cooperstein's report of the American Back Society's Beverly Hills Fall Symposium (Nov. 30-Dec. 3, 1994) which focused on "Back Pain in an Era of Health Care Reform." Part I appeared in the Feb. 27, 1995 issue.

Exemplary Chiropractic Workshop

Every ABS meeting includes a chiropractic workshop that theoretically acquaints allied professionals with the clinical practice of chiropractic. In the past I have been somewhat disappointed with most of these workshops, because the faculty have tended to dissipate their scarce time defining a bunch of words and theorizing about what manipulation does, in spite of the fact that at least half of the audience are chiropractors and already familiar with this material. I was delighted to attend an excellent workshop presentation by Drs. John Scaringe and David Peterson, who skipped all the fluff and went straight to the heart of the matter: how clinical history and exam procedures, functional anatomy, and biomechanical considerations dictate appropriate and hopefully optimal manual interventions. They wasted none of their scarce time globally defending or advertising chiropractic care, opting instead present two detailed cases. They used them as a vehicle to highlight how a smart chiropractor applies critical thinking to the clinical setting. Congratulations to doctors Scaringe and Peterson, and to the panel of advisors to the ACA Council on Technique, to which they belong.

The Economics of Managed Care

In another afternoon workshop Schumarry Chao, MD, MBA, and Emma Orr, MBA, discussed the macroeconomics and microeconomics, respectively, of managed care. More people should have attended this utterly fascinating and important presentation, much of which was concerned with the inexorable rise of capitation. Briefly, in a capitation plan, the contracting physicians agree with a payer organization to treat a given population for a certain number of diagnostic entities at a pre-negotiated price and according to certain other provisions. This amounts to that physician taking on an HMO-like character, assuming the risk traditionally born by the payer, who is more than willing to pay a set fee for physician services and obtain much greater control and predictability over future costs.

Chiropractors may be able to ignore the consequences of managed care for a few more years, but during that time managed care will certainly not ignore them. Their fees, billing patterns, visit frequencies, diagnoses, and other practice characteristics are being tracked. This will come back to haunt them when and if they decide it is time to play ball with the evil insurance companies, whom they currently either fight or avoid. As these companies become increasingly adept at shifting risk to the physicians through capitation agreements, these physicians will become more exposed to financial disaster as they hastily sign on to plans they had hoped to escape, unable to understand the fine print.

Reflex Sympathetic Dystrophy

It has never been clear to me why most of the chiropractic colleges under emphasize electrodiagnosis, at least in their undergraduate programs. It wouldn't be such a problem if the chiropractic profession had historically regarded the nervous system with the same relative, if polite, diffidence that it affords other organ systems. However, we have staked far too much on "nerve interference" to maintain the same distance from EMG and SEPs as we do from EKG and Western Blot. Although we are probably not about to perform needle EMGs, we should at least be eminently able to interpret the findings of the neurologists with whom we often co-manage cases.

I am always reminded of this hole in my chiropractic education when neurologist Ken Nudleman gives a talk at an ABS meeting. He often discusses the most interesting, clinically relevant, and (for me) noninterpretable subjects. This time he discussed reflex sympathetic dystrophy (RSD) syndrome associated with back pain, including the electrodiagnostic findings. The diagnosis is often unclear, and perhaps commonly overdone. The patient reports a persistent, burning pain in an extremity, sometime after an injury, a failed back surgery, or perhaps as a spontaneous occurrence. There is neuropathic pain, skin hypersensitivity, an increased vascular response to cold, and denervation hypersensitivity. An infrared thermogram shows an area of coldness, while the patient avoids weight-bearing on an affected leg which may furthermore show evidence of muscular atrophy. RSD should not be mistaken for Raynaud's phenomenon or IVD syndrome.

Results of the RAND Study

Dr. Alan Adams recounted the five year history of the RAND Corporation's involvement in evaluating the appropriateness of spinal manipulation for head, neck, and back pain. The process began with a systematic review of the literature, leading to a meta-analysis of RCTs of spinal manipulation that was published in the October 1992 issue of the Annals of Internal Medicine. (Meta-analysis is a powerful and innovative statistical technique that permits the amalgamation and interpretation of data gathered in separate trials, subject to certain inclusion criteria, so that inferences may be drawn that could not otherwise be drawn from any one of the individual studies.) Next, the investigators prepared an exhaustive list of possible indications for SMT. Finally, two expert panels were convened to make recommendations on the appropriateness of SMT for treating these indications, one panel being all chiropractic and the other multidisciplinary. These panels produced the two well known RAND studies: The Appropriateness of Spinal Manipulation for Low-Back Pain: Project Overview and Literature Review, and The Appropriateness of Spinal Manipulation for Low-Back Pain: Indications and Ratings by a Multidisciplinary Expert Panel. This same type of consensus process has more recently evaluated the role SMT should play in the treatment of head and neck pain.

The RAND reports have often been very poorly interpreted by some individuals, both within and without the chiropractic community. Noting (correctly so) that these reports are limited to examining the appropriateness of SMT for low back pain, these individuals then come to the illogical and perfectly absurd conclusion that these reports recommend limiting SMT to the treatment of low back pain. In a development that should prevent this genre of misinterpretation in the future, the RAND Corporation has readied for publication a new report concerning the appropriateness of SMT for the treatment of headache and neck pain, based on a literature review that involved hundreds of articles and another meta-analysis of identified RCTs. As in the case of the previous studies on low back pain, the results are very favorable for manipulative treatment. Part of the report concerns the risk of complications associated with SMT of the neck, which is found to be vanishingly small.

Later during the panel session Dr. Adams was to field a rather poorly worded question, which in effect challenged him to defend SMT in spite of the fact that it is purported to be of "short-term value." Apart from the fact that no one who recommended or accepted the use of NSAIDs for back pain was required to defend their short-term value, even noting the often serious gastric side-effects of NSAIDs, what makes this type of question particularly disturbing is that once again the RAND reports and the Mercy Guidelines are misinterpreted. If SMT is validated to be effective for short-term benefits, it does not follow that it is invalidated for long-term benefits. Although the data is so far lacking, lack of evidence only rarely implies evidence of lack. I can understand why opponents and skeptics of SMT would interpret these reports so erroneously, but prefer not to dwell upon the low-minded motivations of those within our own milieu who knowingly perpetrate this same anti-RAND, anti-Mercy disinformation. Their scorched earth antics will sow entirely unnecessary disunity and enlarge chiropractic vulnerability for some time to come.

Cost Effective Interdisciplinary Care

The widespread consensus that back pain is a multifactorial problem has led to a parallel belief that the treatment should be multidisciplinary. Patients are referred to Dr. DeFoyd's multidisciplinary spine center in Texas after there has been a failure to improve in a family doctor setting. It is not always easy to get the individuals in a multispecialty group to collaborate well, given the conflicting terminologies, world views, and historically-entrenched professional rivalries. Nevertheless, Dr. DeFoyd described a cost-effective interdisciplinary protocol in just such a multidisciplinary setting for the management of back pain.

Re-privatizing Health Care in Calgary

Dr. Stephen Miller is involved entrepreneurially in re-privatizing health care in Calgary, Alberta, Canada. He claims that problems in the fabled one-payer system (e.g., three MR centers to serve two million people, three of six hospitals closing) have created a niche for such reprivatization, although the government is doing is best to prevent it. Echoing a point that has been made in previous ABS meetings, Dr. Miller pointed out that effort expended by the patient, not his functional capacity, is the primary predictor of treatment success. In other words, the hippest of back doctors is the specialist in "motivational medicine."

There is an enormous increase in the societal cost of low back pain, without there being any change in the overall incidence of back injuries. Back patients in technological societies increasingly tend to demonstrate what has been called illness behavior, in which there is a large psychosocial component having to do with job dissatisfaction, hostility towards the government and the medical system as such, family problems, substance abuse, and much more. According to Waddell, although low back pain is ancient, low back disability is very modern. Modern treatment methods in and of themselves may be a primary cause of this change, with surgery and bed rest leading the list. What does not appear to be changing is the incidence of back disease, the underlying pathological substrate over which the illness behavior is draped.

VBAs and Science: Myths Dispelled

Drs. Scott Haldeman, Marion McGregor, and Frank Kohlbeck are currently involved in the most intensive study of its kind on risk factors for vertebrobasilar artery accidents, with special emphasis on the inferences regarding possible vascular complications of cervical spinal manipulation. The initial literature search produced 689 titles, of which 256 featured such vascular accidents as their major

focus. Of these, 179 met certain inclusion criteria, yielding 552 case reports from which 370 could be culled for analytical purposes. When these cases were assigned to etiological categories post-manipulation, major trauma, minor trauma, and spontaneous certain initial impressions emerge:

Cervical manipulation could not be etiologically distinguished from "trivial trauma," such as playing badminton, as a risk factor for vertebrobasilar injury.

No risk factors (DJD, oral contraceptives, age, etc.) could be identified.

No clear value could be ascribed to common screening procedures, such as George's test.

The implications of this work-in-progress are obvious. I hope those within our milieu whose drum-beating on this subject is so loud that it rivals Consumer Reports will quiet down a bit. The risk really is on the order of "one in a million."

Ankylosing Spondylitis

Dr. Metzger, acknowledged expert on anklyosing spondylitis, brought us up-to-date on how it is seen relative to the other HLA-B27 seronegative arthropathies. In fact, AS is no longer considered to be a diagnosis distinct from other possibilities, but an umbrella that includes psoriatic arthritis, Reiter's syndrome, Marie-Strumpell disease, etc. It is an auto-immune granulomatous inflammation of discs and other histologically related tissues, which accounts for the widespread enthesopathic developments that are associated with it. The genetic predisposition is confirmed by its greater likelihood of occurrence among Native Americans as compared with Caucasians, and lesser likelihood among Africans as compared with either of the other groups.

Managing the Acute Spinal Patient

In describing his approach to managing the acute spinal patient, the first point Gary Jacob, DC, made is that not all acute spinal conditions are associated with inflammation. Then, he went on to attack the notion that acute onset spinal conditions are always inflammatory. Eventually he took strong issue with the "inflamed spine model." (By then I thought I knew what he was getting at.) Dr. Jacob wants acute onset spinal conditions to be mechanically treated, "in direct contrast to the a priori notion of many [whom?] concerning an inflammatory chemical nature for acute spinal conditions that mandates rest and medication." He finds great success in treating such conditions with exercise, progressive resistance, McKenzie methods, manipulation, and other mechanical means. Despite having situated himself in a sort of protest position, one in which the opposing medical straw dogs could not be located, Dr. Jacobs just wound up engendering a protest from the chiropractors present who objected to his notion that a sprained, swollen extremity should not be manipulated.

Historical Recognition of Chiropractic

Dr. Reed Phillips, president of Los Angeles Chiropractic College, painted in broad strokes the history of the chiropractic profession's efforts to achieve recognition and develop a standardized, high quality approach to health care. The early years were marked by the development of terminology clearly distinguished from medical usage, to avoid (often unsuccessfully) going to jail for practicing medicine without a license. The next phase of development witnessed chiropractors obtaining licensure from the state boards, predicated upon training in the basic science. The federal recognition of the CCE in 1974 was clearly a watershed event, reminiscent of the role the Flexner report played in elevating the

quality of medical schools earlier in the century. Parity with other professions in terms of insurance equality quickly followed, setting the stage for the development of practice guidelines, a process that began in the late 1980s and continues today.

Symposium Themes

The Elusiveness of Objective Factors

No one needs to be reminded that the search for anatomic and mechanical factors related to back pain, and for objective parameters that change during treatment, has not yielded much. However reluctantly, those who had preferred to objectively measure the merits of different treatment have shifted emphasis from these factors to that of clinical outcome. Outcome is largely measured by "soft" measures, such as return to work, patient satisfaction, and pain assessment questionnaires. If a provider can establish that care is effective, then the search for the elusive "hard factors" becomes correspondingly less pressing. Indeed, clinical testing is not warranted if the outcome of the test is unlikely to influence the care of the patient.

Validity Is Not Enough

Objectivity in a test is useless if the data acquired is not relevant to the patient's functional impairment. (For example, the demonstration of reliability in x-ray line marking may be devoid of clinical significance.) Even when valid, particular diagnostic tests may not be necessary if the signs and symptoms are already clear enough. Tests that are unlikely to change the treatment, even if positive, are not indicated. According to Dr. Haldeman, "thermography did not survive" because the results are abnormal in 35 percent of asymptomatics, and what's more, thermography does not change the treatment approach.

Technical Excellence Is Not Enough

Gone are the days where brilliant doctors could indulge in self-congratulatory mutual admiration societies on the basis of brilliant diagnoses and challenging technical achievements. Society is equally unimpressed by the surgeon who pulls off a trans-specific heart transplant and the chiropractor who achieves the perfect audible, unless their respective procedures measurably improve the quality of their patient's life. No one will pay for a brilliant diagnosis, the appropriate therapy, and a miserable functional outcome. Chiropractors will no longer be reimbursed for improving ROM, evening up the legs, or aligning the spine, if they remain incognizant of "soft factors" like symptoms and functional outcome. The doctor may be very happy to have "cleared the patient," but society will take no special pleasure in inscribing on the patient's tombstone the following epitaph: "John Smith, loving husband and father, and devoted chiropractic patient, died writhing in agony and unable to work, but his legs were even and his range of motion was, well, passable."

Chiropractors: Slow to Acknowledge Treatment Failure?

Medical doctors, insurance administrators, and others are prepared to concede -- whether spitefully, patronizingly, or even graciously at times -- that SMT is clinically appropriate. Some may concede that chiropractor is the expert in SMT, and even acknowledge that chiropractic care is more than just SMT. Although these are clearly welcome developments, they do not augur a new era of massive chiropractic acceptance. On the contrary, what these detractors-turned-advocates are now saying is that chiropractors are poor at case management, and are unable to acknowledge treatment failure.

They just don't know when to call it quits for given patients. Maybe some other grouping of health care professionals should be trained to perform this wonderful treatment called manipulation ...

Prophylaxis on the Run?

The usual schizophrenia was present. Some speakers reminded us that "the natural history of back pain is that it is largely self-resolving in a few month," while others retorted "but not the back problem, which requires ongoing prophylactic and therapeutic intervention." This time, the disagreement surfaced in a more contemporary way, tinged with economic overtones. The advocates of limited care pointed out that the goal of treatment must be to end treatment. Therefore, it is difficult at best to discern what diagnostic factors would warrant the care of individuals not currently suffering from back pain. Call it maintenance care, call it preventative care, call it what you will -- but don't send the case manager a bill for it. After several symposia stressing back wellness care, It seemed to me that this time the advocates of prophylaxis were on the run.

Technique Wars and Patient Selection

Appearances notwithstanding, chiropractors have enjoyed monopoly on technique wars. The surgeons were hard at work, arguing the relative merits and disadvantages of the various cervical surgical techniques: laminectomy, microdiscectomy (posterior or anterior approach, with or without interbody fusion), percutaneous discectomy, chymopapain. Or would a neuroaugmentative (nerve-blocking) technique suffice? In this discussion and others, the quite civilized impression arose that some patients would benefit more from a given procedure, and others from a different one. The three most important considerations in predicting the outcome of a clinical procedure are (1) patient selection, (2) patient selection, and (3) patient selection. I have known some chiropractors who never seem to weary of pitting named techniques in the abstract against one another -- Gonstead vs. AK vs. SOT -- instead of raising the fundamental question -- which procedure, applied to which patient, by which doctor, at which stage of the case, with what desired outcome, as assessed by what particular outcome measure? Market forces, not any scientific imperative, are driving the doctor professions away from proprietary procedures which have not been demonstrated to be valid, toward a basic package of generally accepted methods. If one thing is certain, it is that we chiropractors are going to practice in a more generic way in the future. It's not that we as individuals don't have any choices: we can have ourselves booted into this situation kicking and screaming, or we can adjust to socioeconomic realities in a more responsible, graceful way.

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