Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Ethical Pragmatic Skepticism

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One of the new buzzwords in health care is the term "evidenced-based practice" (EBP). Within our profession, some tout EBP as the wave of the future; others see it as the death knell to chiropractic care, because "We can't really research chiropractic; besides, we know it works, so why do research?" A third group contends that if we were to practice evidence-based chiropractic, the only patients we could treat would be those with a limited number of conditions for which we have a large body of evidence of our effectiveness (e.g., acute low back pain).

EBP is a wave that is already rolling in. Chiropractic will only die if the evidence shows it is not clinically effective. Those who think EBP must be limited to conditions for which treatment is supported by a large body of evidence - specifically, randomized controlled clinical trials (RCTs) - lack an understanding of the pillars of EBP. It is not slavish devotion to the RCT or "cookbook" health care[1] but a system of care based on three basic tenets:

- use of the best available external clinical evidence derived from systematic research;
- use of the individual doctor's clinical expertise; and
- taking into account the patient's predicaments, rights and preferences in making clinical decisions about his or her health care.[1]

What is meant by "best available external clinical evidence" is basic science research, particularly patient-centered clinical research. What research should be considered? The type that evaluates the reliability and validity of diagnostic procedures, the power of prognostic indicators and the efficacy and safety of treatments.[2]

Within this model of EBP, what do we do about patients with conditions for which there is insufficient evidence about chiropractic's effectiveness? This is where ethical pragmatic skepticism comes into play.

Ethics

Two of our duties to patients are beneficence and nonmaleficence - to help the patient, and not to harm (or to prevent harm to) the patient (*primum non nocere*). Obviously, our goal in treating a patient is to bring about a positive clinical result, to make him or her feel better; to be healthier. Such an outcome is consistent with our duty of beneficence. Unfortunately, we are not able to help everyone who seeks our clinical expertise. Research has shown that a trial course of treatment may be the only way to determine a diagnosis, and thus the appropriateness of a treatment.[3] A real predicament develops when one continues to treat a patient with a method that does not result in a positive clinical response. Ineffective treatment is a violation of our nonmaleficence duty, in that it results in multiple harms to the patient. Continuing with care that does not benefit a patient harms him or her by wasting time and money and preventing the finding of effective treatment. The dilemma: How do we know we

are, or are not, helping a patient?

Pragmatism

As I've noted, some say that if there is no evidence for a treatment, one should not use it. This is an extreme approach to the use of EBP; one must be a bit more pragmatic. By "pragmatic," I mean that when confronted with a patient with some health problem for which there is a lack of evidence of an effective treatment, we still need to try to help the patient. This follows Carl Sagan's dictum, "Absence of evidence is not evidence of absence." The pragmatic approach is to provide the patient with a reasonable treatment that our training, reading, and experience suggest may be helpful and not harmful.

Skepticism

Skepticism is the notion that authorities have no inherent infallibility or omniscience, because we have accepted them as authorities. Science would not exist without this philosophical construct; otherwise, our knowledge would be limited to what past authorities have espoused.

The skeptic says, "Prove it to me. Prove that this treatment, which lacks compelling evidence of clinical effectiveness, is working for this patient." We should all question that which we fervently believe. In particular, our profession has a rich oral history of clinical effectiveness; many conditions have not documented such effectiveness in well-designed clinical research, and we need to be skeptical about this oral history. In other words, we also should be mindful of another Sagan quote: "I believe that the extraordinary should certainly be pursued. But extraordinary claims require extraordinary evidence." It is not reasonable to treat syphilis with an adjustment, for it is an extraordinary claim that an adjustment is effective treatment for this condition.

The psychology of the doctor-patient relationship is such that patients often say they are better when their condition has, in fact, not improved or (worse, yet) has worsened. The skeptic in me would love RCTs to provide that extraordinary evidence, but lacking this, the skeptic in me demands, at the minimum, the use of outcome measures to see if the treatment does help the patient.

Putting It All Together

When we have a patient we need to treat pragmatically, we should choose a treatment that is both reasonable (not extreme) and unlikely to be harmful. Because we want to prevent the harm of clinical inefficacy, and we have some element of skepticism, we should monitor the patient's clinical progress by using previously validated, reliable clinical outcome measures. I recommend Yeomans'[4] text to learn more about outcomes assessments, which I submit we should use because it is our ethical duty.

References

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