

Chapter 3

Choice of Chiropractic Technique: Doctor's Right Under State Laws

Technique Issues in Chiropractic Regulation

Technique in chiropractic is well understood by chiropractic practitioners, educators and researchers, and might be generally defined as, "Any of a number of physical or mechanical chiropractic procedures used in the treatment 'care' of patients."¹ Despite the virtually universal use of the term in educational, research and clinical application and effectiveness literature, a more specific statutory definition is hard to come by, partly because technique is so closely tied to the chiropractic adjustment procedure, which is very specifically defined in a host of sources, including clinical practice guidelines, research and the law.

The International Chiropractors Association (ICA) defines the adjustment as, "a specific directional thrust that sets a vertebra into motion with the intent to improve or correct vertebral malposition or to improve its juxtaposition segmentally in relationship to its articular mates thus reducing or correcting the neuroforaminal/neural canal encroachment factors inherent in the chiropractic vertebral subluxation complex."² Similar to a number of other US state statutes, Idaho law defines the chiropractic adjustment in great detail: "Adjustment" means the application of a precisely controlled force applied by hand or by mechanical device to a specific focal point on the anatomy for the express purpose of creating a desired angular movement in skeletal joint structures in order to eliminate or decrease interference with neural transmission and correct or attempt to correct subluxation complex."³ Most US state laws include a specific focus on the spine. For example, Georgia law even itemizes the anatomical segments of specific concern to the chiropractic profession to include, "...the ilium, sacrum, and coccyx..."⁴ How the attending doctor applies that adjustment is "technique."

The adjustment and/or manipulation of the spine and its adjacent structures represents the essence of chiropractic patient care as established by US state, Canadian provincial and numerous national statutes. No less than 38 US state statutes employ the term "adjustment" in reference to the procedures applied by the doctor of chiropractic. "Most state statutes are very specific regarding the authority of the doctor of chiropractic to apply the adjustment and/or manipulation process to the area of the human spine and its articulations, but direction and limitations as to the techniques for administration of those procedures are very rare and when it does appear, very vague."⁵

Like statutes and regulations, educational standards are similarly lacking in definition concerning the specifics of technique. The Council on Chiropractic Education's (CCE) *Standards for Doctors of Chiropractic Programs*⁶ makes only passing reference to "technique" in the list of substantive subjects in which colleges must provide instruction in its curriculum section. CCE's *Commission on Accreditation Manual*⁷ makes no mention of technique at all, and the CCE's *Commission on Accreditation Self Study and Report Guide*⁸ simply reproduces the reference to technique contained in the Standards, along with the rest of the curriculum requirements.

This is not to be interpreted as a shortcoming, but evidence that technique need not generally be a concern to the regulatory process, and an expression of confidence that technique is more than adequately addressed in the teaching and testing processes. The lack of specific directives in statutes and regulations can rightfully be interpreted as a statement of faith in and acceptance of the job chiropractic educational institutions do in instructing chiropractic students in technique. As evidence of this conclusion, statutes and regulations frequently contain references to procedures taught in accredited colleges or college post-graduate programs. Procedures that are so taught are considered to be established, normal and customary. Chiropractic college catalogs provide extensive detail on technique instruction, with, for example, Palmer College of Chiropractic, Davenport, Iowa, listing 15

doctors of chiropractic on their technique faculty,⁹ and offering courses on a wide range of named techniques. Other CCE accredited college catalogues likewise contain a major emphasis on technique instruction, with some modest differences in the techniques emphasized.

The standardized licensure examination process maintained by the National Board of Chiropractic Examiners (NBCE) is another element in the process of validating that doctors of chiropractic are adequately trained in technique. According to the NBCE, *“The Part IV practical exam, which utilizes an Objective Structured Clinical Examination methodology, was developed by the NBCE at the request of the Federation of Chiropractic Licensing Boards (FCLB). The Part IV examination tests individuals in three major areas including x-ray interpretation & diagnosis, chiropractic technique and case management. Results of the Part IV exam may be utilized by state licensing authorities in lieu of their practical examinations for licensure.”*¹⁰

Technique falls within the realm of what is frequently and correctly referred to as the “art” of chiropractic. Indeed, chiropractic sociologist Dr. Walter Wardwell, in his extensively researched work, *Chiropractic: History and Evolution of a New Profession*, categorized “art” and “technique” in his index as terms refereeing to the same concept.¹¹ The art of chiropractic centers on the abilities and judgment of the attending doctor to evaluate the needs of each unique patient, and apply appropriate procedures with the goal of safe, optimal care. Laws and regulations have been careful to recognize and preserve the judgment of the attending doctor, and the protection of that judgment is a key goal of professional organizations. ICA’s clinical practice protocols specifically address this matter in the context of the choice of technique. Those protocols state: *“Doctors of chiropractic should be free to apply any chiropractic technique in which they are appropriately trained, to meet the needs of the patient.” The choice of technique is an integral part of the discretion reserved to the judgment of the attending doctor.”*¹²

The list of well-known chiropractic techniques is long,¹³⁻¹⁴ but comprised of procedures many of which are very similar, with slight variants resulting from an individual practitioner seeking to improve or modify one technique, and then placing a new name on it. This is sometimes done to distinguish clear clinical differences, but also done for marketing purposes, often to then promote a seminar or publication seeking to teach the “new” technique. Most techniques apply a standard range of directional thrust procedures,¹⁵ all time-proven to present no exceptional danger or risk to the patient. In recent years, technology has begun to play a greater role, both in the delivery of the adjustment,¹⁶⁻¹⁷ as well as the diagnostic procedures guiding the doctor’s clinical decision-making.

The literature on named techniques has largely been driven by technique innovators. Such innovators as Dr. Donald Harrison, Dr. Deed Harrison, Dr. Arlan Fuhr and others, have been a significant source of new research in this vital area. Their research findings and studies have also been increasingly peer-reviewed and indexed, correcting a longstanding issue with technique literature.¹⁸ Preliminary exploratory steps have been undertaken to develop a means by which the safety, effectiveness and acceptance of chiropractic techniques might be arrayed and further research applied.¹⁹⁻²⁰ This is clearly one of chiropractic’s most important and most exciting research frontiers.

It will be many decades before a research record of sufficient quality and volume, as well as that of all-important comprehensiveness, will exist that would allow for any sort of credible evidence-based categorization of techniques. In the meantime, techniques will remain hard to define with exactitude, continue to be applied differently by practitioners and often mixed in the unique application of the provider, depending on the needs of the patient. However, given the absence of widespread patient complaints, concerns or injury, combined with powerful patient satisfaction statistics and a growing record of clinical effectiveness, it would seem that the current mix of techniques, taught by chiropractic colleagues, postgraduate programs and developed by individual innovators, has served the public well, and not done the profession any harm.

The actual “approval” or other recognition of specific lists of acceptable techniques by regulatory boards is not the standard approach to chiropractic regulation and is, in fact, a very rare matter. As has been related, most statutes define chiropractic procedures the doctor is authorized to apply in very general terms. In the instances in recent years where a new technique has emerged and

caught the attention of a regulatory body, the issue of the experimental nature or scientific validity of the procedure has largely been at the heart of the process and, despite some contentious and often litigious encounters, boards in North America have, by and large, been effective in absorbing emerging processes with a responsible openness. The actions of such boards in resolving technique issues have not generally been a matter of “recognizing” or “approving” techniques, but rather of resolving actions or complaints against specific practitioners based on allegations of an unscientific, experimental or unusual nature of the procedure.

Most formal statutes and regulations do not contain a basis for specific technique approval by regulatory boards. For example, in the State of California in the United States, the statute which governs chiropractic²¹ does not mention the term “technique” once. The regulations of the California Board of Chiropractic Examiners²² uses the terms “technique” and “techniques” 18 times throughout its 61 pages, without ever defining specifically what is meant. Most references dealing with chiropractic education and standard procedures are expressed in a manner that indicates that the term “technique” was understood and/or to be relegated to the educational process. This does not mean that the State of California does not consider technique unessential or unimportant; quite the contrary as that state’s annual 12-hour continuing education requirement stipulates that 4 of the 12 hours must be in technique. Once again, it is logical to conclude that policy makers have confidence that such matters are adequately addressed in the educational and postgraduate realms.

Any regulatory board considering pursuing authority to regulate technique should ask, first and foremost, is there evidence of the need for such authority? There is a strong case to be made that in the absence of specific, documented problems, such boards should have no appropriate technique role at all. This is the universal consensus found among the current and former regulatory board members from 19 jurisdictions interviewed on this subject.²³ When asked, “*Should state or provincial boards seek an active role in approving acceptable or appropriate chiropractic techniques, in the absence of any specific legal charge to do so?*” all respondents answering, answered, “No.” (Among the jurisdictions represented in this questionnaire were Arkansas, California, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maine, Manitoba, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, North Carolina, Ontario, Pennsylvania, Florida, and Vermont).

Comments offered by those interviewed, subsequent to answering that question, included observations on the good job educational institutions were doing in training chiropractic graduates in the selection and application of appropriate techniques, the rapid growth of technology and new measuring and adjusting devices, a strong desire not to see innovation stifled in the regulatory process, and most frequent of all in comments offered, a desire to maintain the primacy of the judgment of the attending doctor in technique decision making.

Approval by a regulatory body of a given technique would also imply that objective measures and means exist to allow the imposition of specific definitions and terms of application. Neither the research record nor a significant and positive body of regulatory experience has been able to identify or establish such a validation matrix for technique. In the absence of any consensus technique matrix, the imposition of limiting technique rules would simply be impossible to police or regulate. This is especially problematic since what may be reflected in a patient record, even one prepared and maintained at the highest standard of clinical record keeping, may not necessarily relate the exact technique details applied.

It is understandable how it has been difficult for regulatory boards to determine how they should approach their responsibilities regarding technique issues in the absence of specific statutory or regulatory guidance. Cooperstein and Gleberzon wisely observed, in referring to the attempted regulation of technique, that, “It is self-evident that considerable divisiveness can result from standards of care produced by a regulatory body that are not congruent with the professional practice activities of its members or that are at odds with patient interests.”²⁴

There are, however, clear and responsible common-sense criteria which regulatory bodies might consider when addressing questions related to chiropractic technique. These criteria include but are not necessarily limited to the following:

- **RISK:** Most techniques have some inherent risk from unforeseen complications, even when properly applied by a fully trained professional. There are, however, obvious signposts indicating exceptional risk when extraordinary force is applied, mechanical equipment is utilized or if and when a static appliance is involved or a potentially unstable surface or platform is utilized. ICA's practice protocols address this matter head on, stating, "*The chiropractor shall not use any mode of care which has been demonstrated by critical scientific study and field experience to be unsafe or ineffective in addressing vertebral subluxation and other malpositioned articulations and structures.*"²⁵ Any technique innovation that has obvious signs of unusual risk merits the evaluation of a regulatory board, the objective being exploration of the process to the satisfaction of the board that risk factors have been addressed.
- **COMPLEXITY:** Any technique that employs a series of steps, devices, patient compliance requirements such as removing clothing or wearing any appliance, brace or similar external component, complicated equipment, or staff other than the attending doctor him or her self merits examination as to matters of patient safety, patient dignity and clinical appropriateness. Appropriate and adequate training issues are also important when issues of complexity are present.
- **MECHANICAL DEVICES:** In recent years, a number of traction, mechanical thrust, spinal decompression, atmospheric, laser and other electrically powered devices have appeared in the chiropractic marketplace. Such devices often have the potential of applying injurious torque or force if not properly utilized by the attending doctor. The issues of appropriate training in the use of such devices, the proper installation, maintenance and adequate safety protocols all merit regulatory board attention. Also, legitimate questions may be raised as to whether a new device is within the intended scope of the law.
- **UNUSUAL CLAIMS:** No ethical practitioner will make claims of superiority of his or her care. This element is captured in many state regulations. As an example, Arizona's official rules specifically state that providers, "...may not infer that one technique is superior to another, or that the chiropractor is somehow superior to others because he/she uses that procedure,"²⁶ The State of Oregon is presently considering legislation that would similarly prohibit, "The advertising of techniques or modalities to infer or imply superiority of treatment or diagnosis by the use thereof that cannot be conclusively proven to the satisfaction of the board."²⁷ Nor would any ethical provider promise a cure or offer false hope to any patient. Any technique that is represented to the public to have unusual or exceptional curative powers should be viewed with immediate suspicion. The issue is likely to be an inappropriate marketing activity on the part of the provider, rather than a potential problem with the technique itself, but such elements merit swift exploration and appropriate corrective action on the part of a regulatory board.
- **FREQUENCY AND DURATION:** A technique that requires unusual frequency, not based on unusual or exceptional patient needs, or an exceptional duration of application, merits board evaluation. Reasonable, well-documented parameters of frequency and duration of care exist in a number of published guidelines. The research record also continues to expand in these areas, and all regulators have a legitimate role in ensuring that a supposed technique innovation is not, in fact, a mask for economic exploitation. This requires objectivity, sensitivity and documentation on a level that exceeds most other elements in a board's technique evaluation as it has the potential to grow into a civil issue or worse.

- **PATIENT RESPONSE:** If a regulatory board receives an unusual number of inquiries regarding the application of a specific technique, asking about its acceptance, background, safety, cost or other elements that signal exceptional consumer concern, a regulatory body should have in place a means to investigate the doctor and procedure in question on an informal, non-punitive basis. Such consumer enquiries are rare, and the fact that a number of patients would take the time and go to the trouble to contact a regulatory board on such an issue is significant. This should not inherently signal anything inappropriate or dangerous, but would merit objective review.

In recent years, the emergence of insurance and other third-party payment protocols and requirements has begun to impact regulatory board thinking. This is, in almost all instances, not a positive development for the patient or the practitioner. Boards must be very careful to scrupulously avoid acting against providers on issues not specifically detailed in statute or formal rule, based on allegations that a doctor's behavior, including choices of technique, do not meet an insurance company's protocol requirements. Boards must jealously guard their unique civil authority and never allow that authority to be usurped or driven by private economic concerns.

Boards must also guard against any bias resulting from their preference for the curriculum of any specific educational institution, clinical approach or specific technique innovator. The mission to protect the public should not extend to the limitation of innovation or the limiting of consumer choice or doctors' options. All of these factors should always be subject to objectivity, reason and a profound commitment to fairness. When these factors are applied, any regulatory board will find their mission in respect to technique a positive one, not a divisive and painful endeavor that detracts from what a board should be focusing on.

Regulatory bodies responsible for the protection of the public and enforcement of the published and formal rules for the practice of chiropractic should be cautious and very specific with regard to any action they take on the issue of the selection, use or approval of specific chiropractic techniques, or punitive actions against practitioners for their technique choices. This is because the range of established techniques is large and growing, innovation in the technique arena should not be impeded, discouraged or penalized, and because the needs of each patient are unique and the judgment of the attending doctor must be allowed to be freely and appropriately applied without concern for arbitrary scrutiny because of the choice of techniques.

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