



Complete Summary

GUIDELINE TITLE

Vertebral subluxation in chiropractic practice.

BIBLIOGRAPHIC SOURCE(S)

Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2003. 201 p. (Clinical practice guideline; no. 1). [1100 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 1998. 120 p.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Vertebral subluxation

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Chiropractic

INTENDED USERS

Chiropractors

GUIDELINE OBJECTIVE(S)

To provide the doctor of chiropractic with a "user friendly" compendium of recommendations based upon the best available evidence

TARGET POPULATION

Adults, adolescents and children who are candidates for chiropractic care

INTERVENTIONS AND PRACTICES CONSIDERED

History and chiropractic examination, instrumentation, radiographic and other imaging, clinical impression and assessment, reassessment and outcomes assessment, modes of adjustive care, duration of care, care of children, maternal care, patient safety, professional development, patient privacy

MAJOR OUTCOMES CONSIDERED

Detection and correction or stabilization of vertebral subluxation(s)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Updating and Revision of the 1998 Guidelines

In the spring of 2002 during the annual meeting of the Council on Chiropractic Practice, the Guidelines Committee was reconstituted, a Project Manager was appointed, and the further structure of the review, updating, and revision was discussed and planned. A nearly identical process was used for the updating and revision. The Project Manager, who serves as Chair of the Guidelines Committee, assembled a panel of area experts who assisted in the search for literature, the subsequent gathering of that literature, and its critical assessment.

As in the original process an "Abstraction Form" was utilized, and suggestions for changes in the Ratings, Recommendations, and Commentary were sought from

this panel and the Guidelines Committee as a whole. The literature and other evidence utilized in the update spanned the time period between 1996–2003. The panel relied heavily on the peer reviewed chiropractic literature as well as the general biomedical literature where applicable.

A detailed search of the guideline development methodology literature published since 1995 was undertaken by members of the guidelines committee and pertinent concepts and procedures incorporated into the process.

The literature was searched utilizing MANTIS, CINAHL, The Index to Chiropractic Literature, Medline, and individual electronic journal searches such as the *Journal of Manipulative and Physiological Therapeutics* and the *Journal of Vertebral Subluxation Research*. Hand and stack searches were also employed to assure the most extensive gathering of relevant literature.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Categories of Evidence

E: Expert opinion based on clinical experience, basic science rationale, and/or individual case studies. Where appropriate, this category includes legal opinions.

L: Literature support in the form of reliability and validity studies, observational studies, "pre-post" studies, and/or multiple case studies. Where appropriate, this category includes case law.

C: Controlled studies, including randomized and non-randomized clinical trials of acceptable quality.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Existing recommendations from the first (1998) edition were circulated to panel members for review and given the additional evidence compiled for the 2003 revision. New recommendations, prepared by subject experts, were also circulated to panel members with summaries of the supportive evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Established. Accepted as appropriate for use in chiropractic practice for the indications and applications stated.

Investigational. Further study is warranted. Evidence is equivocal or insufficient to justify a rating of "established."

Inappropriate. Insufficient favorable evidence exists to support the use of this procedure in chiropractic practice.

COST ANALYSIS

Effects of Chiropractic on Health Care Costs

Studies suggest that chiropractic care may result in significant savings of health care dollars. An analysis of an insurance database compared persons receiving chiropractic care with non-chiropractic patients. The study consisted of senior citizens over 75 years of age. It was reported that the persons receiving chiropractic care reported better overall health, spent fewer days in hospitals and nursing homes, used fewer prescription drugs, and were more active than the non-chiropractic patients. The chiropractic patients reported 21% less time in hospitals over the previous 3 years.

Another study surveyed 311 chiropractic patients, aged 65 years and older, who had received chiropractic care for 5 years or longer. Chiropractic patients, when compared with US citizens of the same age, spent only 31% of the national average for health care services. There was a 50% reduction in medical provider visits. The health habits of patients receiving maintenance care were better overall than the general population, including decreased use of cigarettes and decreased use of nonprescription drugs.

These are but two recent studies demonstrating improved health outcomes and reduced costs associated with chiropractic care. In other studies chiropractic care in general and chiropractic care directed at reduction of vertebral subluxation has demonstrated positive effects on physiological outcome measures.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The significant difference for the 2003 update and revision was the use of an online review process. Essentially, the final draft of the guidelines revision was placed in a secure online Forum where reviewers were required to provide a LOGON and PASSWORD to enter and access the draft. Once the individual reviewed the draft they then filled out an online form with any recommendations or changes. Their response was immediately routed to the Project Manager for review and any needed action.

Recommendations for additions or changes to the draft based on this review were then circulated electronically to the Panel for feedback.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the Recommendation Ratings and Categories of Evidence are provided at the end of the "Major Recommendations" field.

History and Chiropractic Examination

Case History

Recommendation

A thorough case history should precede the initiation of chiropractic care. The elements of this history should include general information, reason for seeking chiropractic care, onset and duration of any symptomatic problem, family history, past health history, occupational history, and social history.

Rating: Established

Evidence: E, L

Chiropractic Examination

Recommendation

The initial chiropractic examination shall include a case history and an assessment for the presence of vertebral subluxation, which, if present, is to be noted with regard to location and character. A review of systems may be conducted at the discretion of the practitioner, consistent with individual training and applicable state laws.

Reassessments may be conducted periodically throughout a course of chiropractic care to assess patient progress. Such reassessments typically emphasize re-examination of findings which were positive on the previous examination, although need not be limited to same. Reassessment is also indicated in the case of trauma or change in the clinical status of a patient.

Rating: Established

Evidence: E, L

Instrumentation

Recommendation

Instrumentation is indicated for the qualitative and/or quantitative assessment of the biomechanical and physiological components of vertebral subluxation. When using instrumentation, baseline values should be determined prior to the initiation of care.

Rating: Established

Evidence E, L

Postural Analysis

Sub-Recommendation

Postural analysis using plumb line devices, computerized and non-computerized instruments may be used to evaluate changes in posture associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Bilateral and Four-Quadrant Weight Scales

Sub-Recommendation

Bilateral and four-quadrant weight scales may be used to determine the weight distribution asymmetries indicative of spinal abnormalities.

Rating: Established

Evidence: E, L

Moiré Contourography

Sub-Recommendation

Moiré contourography may be used to provide a photographic record of changes in body contour associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Inclinometry

Inclinometry may be used as a means of measuring motion against a constant vertical component of gravity as a reference. Changes in ranges of spinal motion may be associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Goniometry

Sub-Recommendation

Goniometry, computer associated or not, may be used to measure joint motion. Inclinometry is superior to goniometry when standardized procedures are employed.

Rating: Established

Evidence: E, L

Algometry

Sub-Recommendation

Algometry may be used to measure pressure-pain threshold. Changes in sensory function associated with vertebral subluxation may produce changes in pressure-pain thresholds.

Rating: Established

Evidence: E, L

Current Perception Threshold (CPT) Testing

Sub-Recommendation

Current perception threshold devices may be used for the quantitative assessment of sensory nerve function. Alterations in sensory nerve function may be associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Electroencephalography (EEG)

Sub-Recommendation

Electroencephalographic techniques, including brain mapping and spectral analysis, may be used to assess the effects of vertebral subluxation and chiropractic adjustment associated with brain function.

Rating: Established

Evidence: E, L

Somatosensory Evoked Potentials (SSEP)

Sub-Recommendation

Somatosensory evoked potentials may be used for localizing neurological dysfunction associated with vertebral subluxations.

Rating: Established

Evidence: E, L

Skin Temperature Instrumentation

Sub-Recommendation

Temperature reading devices employing thermocouples, infrared thermometry, or thermography (liquid crystal, telethermography, multiple infrared [IR] detector, etc.) may be used to detect temperature changes in spinal and paraspinal tissues related to vertebral subluxation.

Rating: Established

Evidence: E, L

Surface Electromyography

Sub-Recommendation

Surface electrode electromyography, using hand-held electrodes or affixed electrodes, may be used for recording changes in the electrical activity of muscles associated with vertebral subluxations.

Rating: Established

Evidence: E, L, C

Muscle Strength Testing

Sub-Recommendation

Muscle strength and endurance testing may be used to ascertain and track muscle force generation and neuromuscular status. Clinically, it may be useful to quantify

differences in strength between limbs or bodily segments. The evaluation of strength may be characterized by the experienced examiner based on various technologies. Manual, mechanized, and computerized muscle testing may be used to determine changes in the strength and other characteristics of muscles. These changes may be a result or a cause of alterations of function at various levels of the neuromuscular system and/or any other system related to the patient. Such changes may be associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Questionnaires

Sub-Recommendation

Questionnaires may be used in the assessment of the performance of activities of daily living, pain perception, patient satisfaction, general health outcomes, patient perception outcomes, mental health outcomes, and overall quality of life throughout a course of chiropractic care. Questionnaires provide important information, but should not be used as a substitute for physical indicators of the presence and character of vertebral subluxations.

Rating: Established

Evidence: E, L

Heart Rate Variability

Sub-Recommendation

Heart rate variability may be used to assess autonomic dysfunction associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Radiographic and Other Imaging

Recommendation

Diagnostic imaging procedures may be utilized to characterize the biomechanical manifestations of vertebral subluxation and to determine the presence of conditions which affect the safety and appropriateness of chiropractic care.

Plain Film Radiography

Sub-Recommendation

Plain film radiography is indicated to provide information concerning the structural integrity of the spine, skull, and pelvis; the misalignment component of the vertebral subluxation; the foraminal alteration component of the vertebral subluxation; and the postural status of the spinal column. Imaging procedures, including post-adjustment radiography, should be performed only when clinically necessary. It is common for lines of mensuration to be drawn on radiographs to assess subluxation and alignment. These procedures may be done by hand, or the chiropractor may utilize computerized radiographic digitization procedures.

Rating: Established

Evidence: E, L

Dosage and Shielding

Sub-Recommendation

Imaging procedures employing ionizing radiation should be performed consistent with the principles of obtaining films of high quality with minimal radiation. This may include the use of gonad shielding, compensating filters, and appropriate film-screen combinations.

Rating: Established

Evidence: E, L

Videofluoroscopy

Sub-Recommendation

Videofluoroscopy may be employed to provide motion views of the spine when abnormal motion patterns are clinically suspected. Videofluoroscopy may be valuable in detecting and characterizing spinal kinesio pathology associated with vertebral subluxation.

Rating: Established

Evidence: E, L

Magnetic Resonance Imaging (MRI)

Sub-Recommendation

Magnetic resonance imaging may be employed to assess suspected neoplastic, infectious, and degenerative conditions of the spine and related tissues as well as the stages of subluxation degeneration. Its use is generally restricted to instances where the desired information cannot be obtained by less costly procedures.

Rating: Established

Evidence: E, L

Computed Tomography (CT)

Sub-Recommendation

CT imaging may be employed to assess osseous and soft tissue pathology in the spine and contiguous tissues. Its use is generally restricted to instances where the desired information cannot be obtained by less costly procedures.

Spinal Ultrasonography

Sub-Recommendation

Spinal ultrasonography may be used to evaluate the size of the spinal canal and to detect pathology in the soft tissues surrounding the spine. Its applications in the assessment of the facet inflammation and nerve root inflammation remain investigational at this time.

Rating: Established for determining spinal canal size.
Investigational for facet and nerve root inflammation.

Evidence: E, L

Radioisotope Scanning (Nuclear Medicine Studies)

Sub-Recommendation

Radioisotope scans performed by qualified medical personnel may be used by a chiropractor to determine the extent and distribution of pathological processes which may affect the safety and appropriateness of chiropractic care when this information cannot be obtained by less invasive means.

Rating: Established

Evidence: E, L

Radiographic Digitizing Analysis

Sub-Recommendation

Computerized x-ray analysis may be used by chiropractors to objectively analyze the biomechanical and misalignment improprieties related to vertebral subluxation. Clinical necessity is justified for assessing the degree of insult and the effect upon the patient's health and future well-being by way of impairment rating.

Rating: Established

Evidence: E, L

Clinical Impression and Assessment

Recommendation

Practitioners should develop a method of patient assessment which includes a sufficient diversity of findings to support the clinical impression as related to vertebral subluxation. In this regard, it is considered inappropriate to render an opinion regarding the appropriateness of chiropractic care without a chiropractic assessment, including a physical examination of the patient by a licensed chiropractor. When management of patient care is carried out in the collaborative setting, the chiropractor, as a primary contact health care provider, is the only professional qualified to determine the appropriateness of chiropractic care. The unique role of the chiropractor is separate from other health disciplines and should be clarified for both the patient and other practitioners. The patient assessment, specific to the technique practiced by the chiropractor, should minimally include a biomechanical and neurophysiological component. It is inappropriate to make a retrospective determination of the clinical need for care rendered prior to the assessment.

Rating: Established

Evidence: E, L

Record Keeping

Sub-Recommendation

Since record-keeping practices may be technique/method specific and may depend on the practice objective of the practitioner, chiropractors should develop a method of reporting the care they provide to their patients that is consistent with their practice objectives. Record-keeping systems for practitioners who limit their care to the analysis and correction of vertebral subluxation should minimally reflect the segments/regions adjusted and the techniques or methods employed if they are not self-evident. Other pertinent information may be included on an as-needed basis.

Note: This Sub-recommendation is in no way meant to contradict other recommendations made in these Guidelines that address issues related to Outcome Assessment, History and Examination, Duration of Care, and Instrumentation.

Rating: Established

Evidence: E, L

Peer Review & Chiropractic Necessity

Sub-Recommendation

The purpose of chiropractic peer review is to determine if the services rendered to the patient were necessary from a chiropractic perspective.

The general standard for necessary care is any care, therapeutic treatment, or services reasonably expected to improve, restore, or prevent the progression of any illness, injury, disease, disability, defect, condition, or the functioning of any body member. This is understood to include care provided to detect the existence of vertebral subluxation and the care provided to reduce or correct it.

Rating: Established

Evidence: E, L

Reassessment and Outcomes Assessment

Recommendation

Determination of the patient's progress must be made on a per-visit and periodic basis. This process provides quantitative and qualitative information regarding the patient's progress, which is utilized to determine the frequency and duration of chiropractic care. Per-visit reassessment should include at least one analytical procedure previously used. This chosen testing procedure should be performed each time the patient receives chiropractic care.

Concomitant with this process, the effectiveness of patient care may also be monitored through the development of an outcomes assessment plan. Such a plan may utilize data from the patient examination, assessment, and reassessment procedures. Patient-reported quality of life instruments, mental health surveys, and general health surveys are encouraged as part of the outcomes assessment plan. The analysis of data from these sources may be used to change or support continuation of a particular regimen of patient care and/or change or continue the operational procedures of the practice.

Rating: Established

Evidence: E, L

Modes of Adjustive Care

Recommendation

Adjusting procedures should be selected which are determined by the practitioner to be safe and effective for the individual patient. No mode of care should be used which has been demonstrated by critical scientific study and field experience to be unsafe or ineffective in the correction of vertebral subluxation.

Rating: Established

Evidence: E, L

Duration of Care for Correction of Vertebral Subluxation

Recommendation

Since the duration of care for correction of vertebral subluxation is patient specific, frequency of visits should be based upon the reduction and eventual resolution of indicators of vertebral subluxation. Since neither the scientific nor clinical literature provides any compelling evidence that substantiates or correlates any specific time period for the correction of vertebral subluxation, this recommendation has several components which are expressed as follows:

- a. Based on the variety of assessments utilized in the chiropractic profession, the quantity of indicators may vary, thus affecting the periodicity of their appearance and disappearance, which is tantamount to correction of vertebral subluxation.
- b. Vertebral subluxation, not being a singular episodic event, such as a strain or sprain, may be corrected but reappear, which necessitates careful monitoring and results in a wide variation in the number of adjustments required to affect a longer-term correction.
- c. Based on the integrity of the spine in terms of degree and extent of degeneration, the frequency of assessments and the necessity for corrective adjustments may vary considerably.
- d. Because the duration of care is being considered relative to the correction of vertebral subluxation, it is independent of clinical manifestations of specific dysfunctions, diseases, or syndromes. Treatment protocols and duration of care for these conditions are addressed in other guidelines, which may be appropriate for any practitioner whose clinical interests include alleviation of such conditions.

Rating: Established

Evidence: E, L

Chiropractic Care of Children

Recommendation

Since vertebral subluxation may affect individuals at any age, chiropractic care may be indicated at any time after birth. As with any age group, however, care must be taken to select adjustment methods most appropriate to the patient's stage of development and overall spinal integrity. Parental education by the subluxation-centered chiropractor concerning the importance of evaluating children for the presence of vertebral subluxation is encouraged.

Rating: Established

Evidence: E, L

Maternal Care

Recommendation

A woman's body experiences numerous biomechanical adaptations and physiological changes during pregnancy. These changes may have an adverse affect on her neuromusculoskeletal system.

Because of these physiological and biomechanical compensations, practitioner care must be taken to select the specific analysis and adjustment most appropriate for the complex changes during the various stages of pregnancy.

The increased potential for spinal instability in the mother and the resulting subluxations in the woman's spine throughout pregnancy affect the health and well-being of both her and her baby. This warrants regular chiropractic check ups in all women throughout pregnancy.

Patient education pertinent to chiropractic care in pregnancy is encouraged.

Rating: Established

Evidence: E, L

Patient Safety

Recommendation

Patient safety encompasses the entire spectrum of care offered by the chiropractor. Consequently, it is important to define at the onset, the nature of the practice as well as the limits of care to be offered. Minimally this should include a "Terms of Acceptance" document between the practitioner and the patient. Additionally, all aspects of clinical practice should be carefully chosen to offer the patient the greatest advantage with the minimum of risk.

Rating: Established

Evidence: E, L

Professional Development

Recommendation

The science, art, and philosophy of chiropractic, and hence its practice, continue to expand in understanding and development. Continuing professional development, as in all responsible health professions, is a necessary component of maintaining a high standard for both the practitioner and the profession. Continuing development should be directed to areas germane to each individual practice, including, but not limited to, credentialing, continuing education programs, participation in professional organizations, technique protocols and application, radiographic and other imaging, instrumentation, philosophy, research, practice liability issues, legal issues, and ethics.

Since all state licensing jurisdictions are ultimately responsible for patient health and safety, these guidelines recommend that all subjects congruent with state law be considered appropriate for continuing education credits in respective states.

Rating: Established

Evidence: E, L

Patient Privacy

Recommendation

Respecting patients' right of privacy has always been both an ethical and a legal duty. New federal regulations place specific, enforceable obligations on most chiropractors and their employees. Knowledge of and compliance with these regulations is essential in order to remain in practice.

Rating: Established

Evidence: E, L

Open/Community Adjusting Areas

Sub-Recommendation

It is acceptable for chiropractic care to be provided in a setting where more than one patient receives care in the same room. In such a case, the patients involved must consent to this arrangement. The chiropractor should have procedures where a patient who wishes to be examined or adjusted privately may do so.

Evidence: E

Patient Testimonials

Sub-Recommendation

A chiropractor must obtain written consent before disseminating any testimonial or case report where a specific patient may be identified. In all cases, use of testimonials must be in compliance with applicable state and federal laws, rules, and regulations.

Evidence: E

Definitions:

Recommendation Ratings:

Established. Accepted as appropriate for use in chiropractic practice for the indications and applications stated.

Investigational. Further study is warranted. Evidence is equivocal or insufficient to justify a rating of "established."

Inappropriate. Insufficient favorable evidence exists to support the use of this procedure in chiropractic practice.

Categories of Evidence:

E: Expert opinion based on clinical experience, basic science rationale, and/or individual case studies. Where appropriate, this category includes legal opinions.

L: Literature support in the form of reliability and validity studies, observational studies, "pre-post" studies, and/or multiple case studies. Where appropriate, this category includes case law.

C: Controlled studies, including randomized and non-randomized clinical trials of acceptable quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified with each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved chiropractic care reflected in accurate identification and correction of vertebral subluxation

POTENTIAL HARMS

- Rare case reports of adverse events following spinal "manipulation" exist in the literature. However, scientific evidence of a causal relationship between such adverse events and the "manipulation" is lacking. Furthermore, spinal adjustment and spinal manipulation are not synonymous terms.
- In the case of strokes purportedly associated with "manipulation," the panel noted significant shortcomings in the literature. The panel found no competent evidence that specific chiropractic adjustments cause strokes. Although vertebrobasilar screening procedures are taught in chiropractic colleges, no reliable screening tests were identified which enable a chiropractor to identify patients who are at risk for stroke.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The most compelling reason for creating, disseminating, and utilizing clinical practice guidelines is to improve the quality of health care. The recommendations made in this guideline are specific to the clinical entity of vertebral subluxation and are applicable to the stated goals of the guideline.

- The recommendations are meant to be flexible, based upon each patient encounter and the goals of both the practitioner and the patient being cared for.
- These guidelines are for informational purposes. Utilization of these guidelines is voluntary. They are not intended to replace the clinical judgment of the chiropractor. It is acknowledged that alternative practices are possible and may be preferable under certain clinical conditions. The appropriateness of a given procedure must be determined by the judgment of the practitioner and the needs and preferences of the individual patient.
 - It is not the purpose or intent of these guidelines to provide legal advice, or to supplant any statutes, rules, and regulations of a government body having jurisdiction over the practice of chiropractic.
 - These guidelines address vertebral subluxation in chiropractic practice and do not purport to include all procedures which are permitted by law in the practice of chiropractic. Lack of inclusion of a procedure in these guidelines does not necessarily mean that the procedure is inappropriate for use in the practice of chiropractic.
 - Participation in the guidelines development process does not necessarily imply agreement with the final product. This includes persons who participated in the technique conference, leadership conference, open forum, and peer review process. Listing of names acknowledges participation only, not necessarily approval or endorsement.
 - The guidelines reflect the consensus of the panel, which gave final approval to the recommendations.

Modes of Adjustive Care

- These guidelines consider the modes of adjustive care in common usage, which adhere to one or more of the descriptive terms presented in this chapter, as appropriate for correction of subluxation. However, studies regarding their theoretical basis and efficacy are often conducted by advocates of (those practicing or instructing) the respective techniques. While the information attained in the numerous investigations is not in question, since many of the studies have not passed the scrutiny of peer and editorial review, it is suggested that the advocates of particular modes of adjustive care encourage research by chiropractic colleges, independent universities and other facilities to extend the level of credibility already achieved.
- Continuing research and reliability studies are necessary to better understand and refine the underlying mechanisms of action common to the various modes of adjustive care. In addition, it is suggested that more observational and patient self-reporting studies be conducted which deal with quality of life assessments and overall "wellness," to demonstrate the pattern of health benefits which heretofore have been the purview of the patient and the practitioner. A conference sponsored by U.S. Department of Health and Human Services, Public Health Service Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research), proposed many different approaches for studying the effects of treatments for which there is no direct evidence of health outcomes.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following peer review, announcement of the availability of the revised guideline was made to the profession through newspapers, professional journals, and news releases. The Council on Chiropractic Practice will provide counseling and recommendations for implementation strategies to interested parties. Implementation of the guideline will be discussed at continuing education seminars and symposia.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Council on Chiropractic Practice. Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 2003. 201 p. (Clinical practice guideline; no. 1). [1100 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2003)

GUIDELINE DEVELOPER(S)

Council on Chiropractic Practice - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Council on Chiropractic Practice

GUIDELINE COMMITTEE

Council on Chiropractic Practice Guideline Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Council on Chiropractic Practice (CCP) Board of Directors: Christopher Kent, DC, FCCI, President, CCP, Post-graduate Faculty, Life University, Marietta, Georgia, Ramsey, New Jersey; Matthew McCoy, DC, DACS (Cand.), Vice President, CCP, Director of Research, Life University, Marietta, Georgia; Terry A. Rondberg, DC, Treasurer, CCP, President, World Chiropractic Alliance, President, Chiropractic Benefits Services, Chandler, Arizona; Barbara J. Bigham, BA, Secretary, CCP, Director of Communications, World Chiropractic Alliance; Robert Blanks, PhD, Professor, Department of Biomedical Sciences, Florida Atlantic University, Boca Raton, Florida; Madeline Behrendt, DC, Associate Editor, Journal of Vertebral Subluxation Research, Chair, World Chiropractic Alliance, Council on Women's Health; William Ralph Boone, PhD, DC, Editor Emeritus, Journal of Vertebral Subluxation Research, New Zealand; Patrick Gentempo, Jr., DC, CEO, Chiropractic Leadership Alliance, Paterson, New Jersey; Veronica Gutierrez, DC, White House Commission on Complementary and Alternative Medicine, Private Practitioner, Arlington, Washington; Jerry Hardee, PhD, President, Sherman College of Straight Chiropractic, Spartanburg, South Carolina; Jay Holder, DC, CAD, DACAD; President, American College of Addictionology and Compulsive Disorders, Private Practice, Miami Beach, Florida; David Koch, DC, Vice President for International Affairs, Palmer College of Chiropractic, Davenport, Iowa; Michael McGee, MEd, CCP Consumer Member, Lock Haven University; Edwards F. Owens, Jr., MS, DC, Director of Research, Sherman College of Straight Chiropractic, Editorial Board, Journal of Vertebral Subluxation Research; Stephen F. Renner, DC, DACS, Member, American Board of Forensic Examiners, Private Practice, Spokane, Washington; William Sloane, JD, LLM, PhD, Academic Dean, Capital University of Integrative Medicine, Fellow, American College of Wellness

Guidelines Committee: Matthew McCoy, DC, DACS (Cand.), Vice President, CCP, CCP Project Manager for Guidelines Research, Director of Research, Life University, Marietta, Georgia; Christopher Kent, DC, FCCI, President, CCP, Post-graduate Faculty, Life University, Marietta, Georgia, Ramsey, New Jersey; Patrick Gentempo, Jr., DC, Board Member, CCP, CEO, Chiropractic Leadership Alliance, Paterson, New Jersey; Jerry Hardee, PhD, President, Sherman College of Straight Chiropractic, Spartanburg, South Carolina; David Koch, DC, Vice President for International Affairs, Palmer College of Chiropractic, Davenport, Iowa; Michael McGee, MEd, CCP Consumer Member, Lock Haven University; Jeannie Ohm, DC, FICPA, Secretary, International Chiropractic Pediatric Association, Private Practitioner; Keith G. Rau, DC, CCEP, Associate Professor, Life University, Marietta, Georgia, Team Chiropractor, Kennesaw State University, Kennesaw, Georgia, Team Chiropractor, Georgia Force of the Arena Football League; Stephen F. Renner, DC, DACS, Member, American Board of Forensic Examiners, Private Practice, Spokane, Washington; William Martin Sloane, JD, LLM (Labor), Attorney, Counselor, Priest, and Professor, Carlisle, Pennsylvania; Adrian Wenvan, BSc, BAppSc, MMedSc, Private Practitioner, Barcelona, Spain; Jay Holder, DC, CAD, DACAD; President, American College of Addictionology and Compulsive Disorders, Private Practice, Miami Beach, Florida; Dean L. Smith, DC, MSc, Miami University, Ohio, Private Practitioner; Steven C. Eisen, DC, Private Practitioner, Philadelphia, Pennsylvania; Michael J. Dunigan, DC, Private Practitioner, Shamokin Dam, Pennsylvania; Gregory Plaughter, DC, Director of Research, Life Chiropractic College West; Peter Scire, DC (Cand.), DACNB (Cand.), BS, CCP Student Representative, Founder and CEO, The Horizon Institute, Atlanta, Georgia; Ismay Campbell, BS, DC, Assistant to the Project Manager for Guidelines Research; John Downes, DC, Dean, Life University College of Chiropractic, Private Practice, Marietta, Georgia; Joel Miller, DC, FICPA, Chiropractic Pediatrics, Private

Practitioner; Robin G. Taylor, DC, Private Practice, Auckland, New Zealand, Past President, New Zealand Chiropractors Association, Past President, New Zealand College of Chiropractic; Mr. Jesse Green, General Counsel, Parker College of Chiropractic

Research Committee: Dr. Robert Blanks, Chair; Dr. Matthew McCoy, Vice Chair; Dr. Madeline Behrendt, Chair, WCA Council on Women's Health/Private Practitioner; Dr. Christina Cunliffe, Principle, McTimoney College of Chiropractic; Dr. Donald Epstein, Network Spinal Analysis; Dr. Mark Filippi, Director, WCA Collaborative Education, Private Practitioner; Dr. Jay M. Holder, Torque Release Technique, Private Practitioner; Dr. Rob Jackson, Private Practitioner; Dr. Christopher Kent, CCP President; Dr. Ted Morter, BEST Technique; Dr. Yannick Pauli, International Representative, Private Practitioner; Dr. Robin Taylor, Past President, New Zealand College of Chiropractic; Peter Scire, Student Representative

Certification Committee: Dr. Veronica Gutierrez, White House Commission on Complementary and Alternative Medicine/Private Practitioner; Dr. Jay M. Holder, Private Practitioner/Torque Release Technique; Dr. William Sloane, Attorney

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

International Chiropractors Association - Medical Specialty Society
World Chiropractic Alliance - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: Vertebral subluxation in chiropractic practice. Chandler (AZ): Council on Chiropractic Practice; 1998. 120 p.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Council on Chiropractic Practice Web site](#).

Print copies: Available from the Council on Chiropractic Practice, 2950 N. Dobson Road, Suite 1, Chandler, AZ 85224; (800) 347-1011.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on November 1, 1998. The information was verified by the guideline developer on January 5, 1999. This summary was updated by ECRI on June 11, 2004. The information was verified by the guideline developer on July 8, 2004.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 9/15/2008

