

Statement of
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Mr. Chairman and Members of the Subcommittee,

I am here today to discuss the Veterans Health Administration's (VHA) policy on provision of chiropractic services for veterans.

Background

On November 30, 1999, Public Law 106-117, the Veterans' Millennium Health Care and Benefits Act (Millennium Act) was signed into law. Section 303 of the Millennium Act required the Under Secretary for Health, within 120 days from the date of enactment, and after consultation with chiropractors, to establish a VA-wide policy regarding the use of chiropractic treatment in the care of veterans. The Millennium Act limits the definition of the term "chiropractic treatment" to the manual manipulation of the spine for the treatment of "such musculoskeletal conditions as the Secretary considers appropriate."

On February 24, 2000, a meeting was held between representatives of VHA and eight chiropractic organizations. Six of the chiropractic organizations represented at the meeting submitted written positions and/or recommendations for VA review. These included: 1) The Foundation for Chiropractic Education and Research (FCER), 2) The International Chiropractors Association (ICA),

3&4) The American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) provided a joint document, 5) The World Chiropractic Alliance (WCA), and 6) The National Association for Chiropractic Medicine (NACM). Other Chiropractic Organizations present included: 7) The Federation of Chiropractic Licensing Boards and 8) The American College of Chiropractic Orthopedists.

In sum, the generally common elements of the various chiropractic organizations' recommendations for VHA policy for use of chiropractic included:

- 1) full-time and contract employment of chiropractors, in both VA medical centers and satellite clinics;
- 2) "direct access" of patients to chiropractors, without referral requirements;
- 3) a very broad scope of practice, including diagnosis and treatment of a wide spectrum of non-musculoskeletal conditions, diseases, or disorders; and
- 4) clinical privileges to include primary evaluations, including history and physical examinations, ordering and interpretation of a wide range of diagnostic tests, "routine checkups", and functioning as "primary care providers".

However, there were discrepant opinions concerning the definitions of direct access, "primary care services," and "first contact provider," as well as many other issues. Disagreements included, but were not limited to, topics such as the precise scope of practice, and the utility of chiropractic to treat non-musculoskeletal conditions. For example, one organization asserted that chiropractic subluxation is without basis and fact and has never been proven to exist and further that the only conditions which should be considered amenable to chiropractic treatment would be mechanical back/neck pain.

Clarification of the role proposed for chiropractors as providers of primary care was not completely successful, in part because most representatives of chiropractic organizations did not seem to use the term "primary care" in the same sense as it has been employed by the Institute of Medicine (IOM) and the

general healthcare community. Consequently, the consultation with chiropractic organizations raised several issues that affected the development of the VHA policy directive.

VHA Policy Development

The current VHA policy allows medical centers and clinics to offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine, following a referral from a VA clinician. This policy was adopted following prolonged and detailed discussion thoroughly considering a number of factors, including the requests and submitted written materials of the chiropractic organizations and a review of the available scientific evidence.

When considering the scientific evidence concerning chiropractic care, it is important to keep in mind two related, but distinct, concepts. First, spinal manipulation is a form of manual therapy that is used by chiropractors, physical therapists, osteopaths, and some medical doctors. The second concept is that chiropractic treatment frequently involves spinal manipulation, but may also include other non-thrust manual therapies, such as mobilization and massage, as well as advice about exercises, nutrition, and proper diet. Published studies estimate that 70 to 90 percent of patients presenting to chiropractors will be treated with spinal manipulation.

There are insufficient scientific data to conclude that either spinal manipulation or chiropractic care is efficacious for any non-musculoskeletal medical condition (e.g., asthma). The effectiveness of either spinal manipulation or chiropractic care as compared to other forms of care for patients with low back pain is also not established. For example, a recent high-quality randomized clinical trial funded by the Agency for Health Research and Quality, and published in the *New England Journal of Medicine*, compared chiropractic care to physical therapy care or self-care. (Cherkin DC et al. *NEJM* 1998;339:1021-9.) Both the chiropractic group and the physical therapy group had small benefits compared to the patients receiving self-care, but there were no differences

between the chiropractic group and the physical therapy group. Both chiropractic care and physical therapy care cost more per patient than self-care.

There are limited data to support the efficacy of spinal manipulation as therapy for some patients with neck pain. This currently falls short of conclusive proof, but in one consensus process that included medical experts, spinal manipulation was judged as effective for certain neck pain syndromes. (Shekelle PG et al. J Spinal Disorders 1997;10(3):223-228.)

There is sufficient evidence in the form of randomized clinical trials to conclude that spinal manipulation is a modestly efficacious form of therapy for some patients with uncomplicated low-back pain. These data include clinical trials where the manipulations were provided by physical therapists, osteopaths, and chiropractors. However, there are no clinical trial data to support a position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner.

VA is opposed to allowing chiropractors to act as “referring primary care physicians”, as it is not possible to develop a precise definition of chiropractors as primary care providers. Available evidence in conjunction with commentary and written materials provided by chiropractors at the joint meeting do not afford confidence that chiropractors have demonstrated that they function as primary providers in the sense that term is defined by the IOM of the National Academy of Sciences, and is commonly used in the healthcare community.

The Institute of Medicine defines primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Primary care providers in VA typically treat patients with hypertension, heart disease, diabetes, pulmonary diseases, depression, and a host of other conditions. They are expected to diagnose and to treat conditions from upper respiratory infections to myocardial infarctions. The diagnosis, treatment and ongoing management of these problems are not part of chiropractic practice. We believe that VA has an obligation to assure that any

primary medical care provided to our veteran patients meets or exceeds the standards in the best of the private sector within the parameters defined by the IOM.

The policy requirement for a referral to chiropractic care was adopted because virtually all non- primary care provided in VA is accomplished through referrals, and VA does not typically allow direct access to other types of consultants or contract providers. In addition, referrals are required for those VA providers that offer specialized types of services, e.g., cardiologists. Formal referral and consultation ensures that the patient, the primary care clinician, and the consultant are working together, and are aware of the reasons for, and expected results from, the consultation.

We determined that it would not be appropriate to hire chiropractors at this time for several reasons. VA has not developed a body of experience in the type and amount of chiropractic services that VA facilities may need for enrolled veterans. Neither do we have information addressing the regional variation in need for and availability of chiropractic services in VA.

Our national policy on chiropractic care in VA was published in May 2000. Veterans Integrated Service Networks (VISNs) and/or medical centers were required to develop local plans for chiropractic care and services within 120 days of the publication of the national policy. Such plans, at least in draft form, have been received from all VISNs and are currently being reviewed. It is expected that publication of local procedures will eliminate confusion about eligibility for, and availability of, chiropractic as a treatment modality. We are preparing provider and patient information and education related to chiropractic services. Educational materials for patients are in draft and are currently being tested for readability and understanding with groups of patients and it is expected that a patient education brochure template will be released within the next 60 days. Much of the treatment information contained in the draft brochure was adapted from material provided by a chiropractic group. VISNs are developing their own provider education materials.

Our policy establishes mechanisms to monitor the cost, quality and utilization rates of chiropractic care. We will identify and collect data related to the provision of chiropractic services that can be analyzed from a national perspective. Currently, VA's databases do not include chiropractic services, thus it is not possible to accurately determine how many patients have seen chiropractors or to determine the number of visits or the dollars spent on chiropractic. This lack of information about utilization of chiropractic services is addressed in the policy by its requirements to collect certain data elements related to chiropractic care, which will be collated nationally. These changes are expected to be completed by November 30, 2000.

Summary

We believe that VA has taken a responsible and reasonable approach to the introduction of chiropractic care. Our policy is based upon consideration of the views of various chiropractic organizations and a careful review of the highest quality available published evidence. VA does not currently have data that address the magnitude and geographical distribution of appropriate chiropractic care within our system. Our current policy provides for collecting that information.

VISNs are just now beginning to implement the new National Chiropractic Policy and the work on databases that is required to collect necessary information about chiropractic utilization and the cost will be completed later this year. We need time to implement the policy and to gain experience in the provision of chiropractic care before making assessments about our policy or the level of chiropractic services that veterans need.

This concludes my statement, I will be glad to respond to any questions you may have.