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BECAUSE EVERY CHIROPRACTOR NEEDS A HAND.

A Glitch in the Matrix

by Claudia Anrig, DC

Several weeks ago, Joan Fallon, DC, of the International Chiropractors Association's Council on Chiropractic Pediatrics, released a disturbing paper in the council's *Journal of Clinical Chiropractic Pediatrics*, titled, "The Child Patient: A Matrix for Chiropractic Care."

The author of the paper is an individual in our profession who has been admired by many for her previous contributions with regard to chiropractic care for the child and pregnant woman. Her supplement paper, however, has raised deep concerns from a majority of chiropractic family wellness academies, leaders and practitioners in the profession at large. As written, this paper attempts to introduce practice guidelines for the pediatric population that seem to serve the insurance industry, rather than the practicing chiropractor.

Upon reading this paper, members of the International Chiropractic Pediatric Association (the oldest and largest chiropractic pediatric organization, separate and distinct from the ICA and its pediatric council) voiced their concerns and requested a written review of the paper from the profession's pediatric authorities. Several leaders in the chiropractic pediatric community also provided written responses, including Anthony Carrino, DC, president of the ICPA; Liz Anderson-Peacock, DC, diplomate of the ICA Council on Chiropractic Pediatrics; Michael Perusich, DC, FICPA, vice president of the ACA Council on Chiropractic Pediatrics; and Joel Alcantara, DC, research director of the ICPA.

*Response from Anthony J. Carrino, DC
President, International Chiropractic Pediatric Association*

Although it is commendable that this author has taken the time and effort to publish her perspective on guidelines for chiropractic treatment in children, this paper is simply that: an individual's personal perspective. It has no place in any "Best Practice" guideline considerations and should not be interpreted as such. Research of this magnitude calls for significant collaboration amongst the most experienced in our profession. An excellent place to start would be a concerted effort of both college researchers and field practitioners. Applying poorly documented time frames or number-of-visit algorithms for treatment without taking into account the individual needs and circumstances of every patient encountered would be an injustice to all children.

*Response from Elizabeth Anderson-Peacock, BSc, DC
Diplomate, ICA Council on Chiropractic Pediatrics*

I certainly appreciate the effort and rationale behind the necessity for developing guidelines in frequency of care for the pediatric population. However, there are some concerns, which I would like to [address].

First, I realize that this is a start in the development toward formation of pediatric guidelines, but I wonder if this matrix was created in consultation with experts in the field (such as chiropractors with certification and diplomate status). As

the paper does not state so, I assume this is not so and I believe this is a great weakness, as greater weight would be given had the paper been in consultation with other stakeholders of experience within the pediatric arena.

I do agree that there is a great difference which needs to be identified between a "non-symptomatic" child, those with presenting active complaints, those with underlying permanent disability, those with comorbidity and combinations thereof. However, we do need to be very careful in addressing how we emphasize that some may "treat" in a condition-based care model. I would prefer to clarify our position as having an impact on functional states as a result of unattended to, overwhelmed or acute aberrant physiology or end-stage dysfunction as a byproduct as it relates to the presence of subluxation or vertebral subluxation complex. We tread into a very, very disturbing arena when we get into "treating" otitis media or asthma, per se, as we care for the underlying aberrant functional or physiological state, not the disease itself.

Chiropractic care is directed to restore normal biomechanical and neurological balance to the individual and to assist in the prevention and minimization of subluxations through regular checkups and education.

I am wary of placing frequency of care into boxes, even though Dr. Fallon's paper states that the "matrix should serve only as a guide. It is not intended to be prescriptive and variations will occur on a case-by-case basis." The sheer process of having frequency of visits noted within the text will cause, by its very nature, utilization as such. I am even more concerned that this paper, as created by one individual, may or may not represent the views of many other chiropractors with experience in the pediatric arena.

For example, it is my experience that a child who presents with vertebral subluxation in the upper cervical spine and a history of 10 or so episodes of otitis media, does not respond to chiropractic care in 3-5 visits, which the matrix implies it should. A child with ongoing asthma of 10 years does not respond to chiropractic care within 3-5 visits. These are chronic complaints with ongoing habituation, aberrant tissue changes, and learned neuroimmunological responses by the body in its response, and environmental factors which usually complicate the issue.

I agree with Dr. Fallon, who states that chiropractic care must take into consideration many issues when determining frequency of care, such as emotional, chemical and physical needs. Perhaps what is more appropriate is really looking at chiropractic care which is examination and outcome- based. For example, care should not be indefinite, as regular reassessments should be performed to determine the response to care and outcome, changes in care and frequency, which need to be considered and/or modified, and frequencies which reflect the individual needs.

Unfortunately, I predict that this matrix will be used by third-party payers to justify rigid "sets" of care, as experience dictates they use numbers in adjudicating care, not individual needs and responses. There is no case for understanding that each child is unique, each presentation is unique and each response is unique. Unlike pharmacology, chiropractic care does not work as a "dose" response, whereas this paper represents an adjustment as a fixed "dose" per condition.

*Response from Michael Perusich, DC, FICPA
Vice President, ACA Council on Chiropractic Pediatrics*

While all health care professions are more and more required to function within the scope of "best practices" and "medical necessity," we must realize that we are still bound by professional oath and ethics to take care of the patient's needs. While I can appreciate the attempt to garner a position of communication within the profession about the need to establish evidence-based best practices for chiropractic pediatric care, it seems precarious to develop a matrix of care to satisfy the needs of managed care, rather than those of the individual patient. An open-forum round-table discussion might be the best place to discuss this need, rather than through a published model. I look forward to continued discussion on this topic, with peer-reviewed research and clinical protocols developed that can be accepted by the profession on a broad-scale basis.

*Response from Joel Alcantara, DC
Research Director, International Chiropractic Pediatric Association*

The abovementioned article, written by Dr. Fallon, purports to provide a matrix for chiropractic care for the pediatric

patient. In so doing, she has indeed initiated a dialogue on the importance and controversial nature surrounding children and chiropractic care. It should be understood that this may, in the humble opinion of this author, open a Pandora's box that third-party payers may use to adversely affect a chiropractor's clinical decision-making ability to provide quality patient care. How much care should children receive? What is too much? What is not enough? What are the limits and what are the needs? What frequency of care should I recommend to parents? Why does the child need care?

Dr. Fallon states that these are questions that all chiropractors are challenged with in the daily care of their patients. Furthermore, Dr. Fallon writes that the care of the pediatric patient is simply not a small, scaled-down version of an adult and that there are "special considerations and circumstances" unique to this patient population, necessitating the need for thorough clinical history and physical examination. She then proceeds to provide a matrix of care for the pediatric patient that is counterintuitive to the above considerations, [and] also to the uniqueness of every patient in their clinical presentation and their response to chiropractic care. Fallon's matrix of care is provided in Table 1.* She states that her "paper is not simply an attempt to justify the need for care of the child, but rather an attempt to justify the frequency of care based on developmental and environmental effects on the child." Sadly, even with such considerations (or lack thereof), we will demonstrate from a brief critical appraisal of her article that she fails miserably in this attempt.

In the interest of brevity, consider the first two types of care in her matrix: a child with normal development and absent comorbidities or other conditions and a child with normal development without comorbidity but [who] has a condition present. She lists the types of conditions under this type of care as: upper respiratory infection, viral infection, acute otitis media, constipation, a fall, sprain/strain, other small injury, and headache. She describes comorbidities as congenital torticollis, talipes, congenital hip dysplasia, clavicle fracture, other fractures, mild scoliosis, allergy, in-utero constraint (mild-moderate), abnormal birth presentation and colic. She makes no mention of how she distinguishes a condition from comorbidity, except her opinion that a condition is a transient event and comorbidity is not a permanent disability.

First, from a global perspective, although Fallon briefly mentions that the patient encounter should include the detection of subluxation and associated factors, her matrix of care is condition-based rather than the detection and removal of spinal (and extraspinal) subluxations. She focuses and makes treatment recommendations for the existence of a condition or comorbidity but does not specify on the care of the patient with subluxation. Consider her first type of care (i.e., for the normal child). From a chiropractic perspective, the unique biomechanical features of the pediatric spine (see Table 2*)² place into question her recommended treatment frequencies of 6-12 visits per year. Furthermore, a lack of appreciation of these unique features by those within and outside the chiropractic profession have caused them to question the need for pediatric chiropractic care of the patient who does not present with a complaint of musculoskeletal pain.³

Although denied by Fallon, her recommended frequency of care is indeed arbitrary. Consider the changing applied forces the pediatric spine is subjected to. In-utero, the fetus is subjected to intra-uterine constraint, possibly predisposing the child to congenital deformities that may not be overtly obvious at birth and only detectable by a thorough examination of the spine. Even during natural childbirth, the neonate spine is subjected to distractional and rotational forces (or combinations thereof) resulting in birth trauma. As the child grows, simple developmental functional milestones such as crawling, walking and eventual running subject the child to changing external/applied forces while undergoing a changing spinal contour. It is not hard to conceive the pervasiveness of the development of spinal subluxation in such and every child.⁴ Such an event is not predictable on a monthly basis, but rather, should be predicated upon: (1) the concerns of the parent for overt clinical manifestations such as excessive crying, disturbed sleep pattern, change in appetite, change in mood, etc., in addition to accompanying co-morbidities (to the subluxation) such as common childhood conditions (i.e., otitis media, torticollis, atlanto-axial rotatory fixation, SCIWORA, etc.) and (2) a thorough history and physical examination findings. The treatment frequency for such a child would then depend on the uniqueness of that child's clinical presentation and his or her ability to respond to care.

Regarding the second category of care - the normal child with a condition present but without a comorbidity- this seems nonsensical from a chiropractic perspective. A chiropractor's responsibility is the detection and removal of spinal subluxations,⁵ making a proper diagnosis of any existing comorbidity, and making the proper referral as needed. From a chiropractic perspective, the presence of any condition (i.e., headache, constipation, etc.) is a comorbidity to spinal dysfunction and, if needed, should be co-managed with an appropriate health care professional. Additionally, a "fall" is not a condition, but rather, a mechanism of injury, with the result being a sprain/strain, fracture or dislocation, dependent on the forces involved.

Furthermore, I would disagree with Dr. Fallon's criteria for what constitutes a comorbidity - a case that does not result in

permanent disability. Consider the growing pediatric spine that results in deformation as a result of in-utero constraint. The resultant altered structure (and function) may result in a lifetime of disability. Consider intrauterine growth retardation resulting in short stature in children that carries over into adulthood.⁶ Lack of attention to such simple clinical consideration places into question her clinical ability to make such a recommendation, questions the strength and legitimacy of the peer-review process in the publication of such a paper, and ultimately, it questions the validity of her matrix of care.

In closing, I would like to address Fallon's use of the references cited in support of her matrix of care. A majority of her references were taken from Conference Proceedings of the Annual Conference on Chiropractic and Pediatrics (sponsored by the ICA), articles from the International Review of Chiropractic, and articles from the *Journal of Clinical Chiropractic Pediatrics*, sprinkled with some Index Medicus articles. A great majority of the references cited do not address the care of the "normal child," make no recommendation of treatment frequencies of 6-12 visits per year, and in fact address the care of a child with a presenting clinical condition. Dr. Fallon cites these same references in support of her treatment frequency in the care of a normal child with a condition as well as additional references. Most of these references are either a commentary on pediatric care and/or illustrative case reports on the care of a patient with a comorbidity. Unfortunately, the use of commentaries falls short of supporting any recommended treatment frequency of care in any system of health care. In using case reports to support her matrix of care, Dr. Fallon demonstrates her lack of appreciation for the use of the literature to support her stance. That is, case reports, as any chiropractic student with an introductory course in research will tell you, lack generalizations to the rest of the patient population. In essence, Dr. Fallon's matrix of pediatric care lacks any validity or legitimacy.

Author's note: References and the two tables detailed in Dr. Alcantara's response are available online at www.icpa4kids.com/chiropractic_pediatrics_research_response_fallon.htm.

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