Defending the Manga report on the chiropractic management of low-back pain

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Resume : Dans l'éditorial précédent (voir pages 1247 à 1249), le Dr Gaétan S. Tardif critique le rapport Manga sur le traitement chiropratique de la lombalgie mais n'étaye pas ses critiques et interprète de façon erronée certaines des conclusions du rapport. Le présent éditorial confirme que les médecins peuvent encore prescrire un long repos au lit pour la lombalgie, que le traitement médical de la maladie a des conséquences ayant trait à la sécurité et qu'il existe un obstacle au traitement chiropratique de la maladie puisqu'un médecin praticien doit signer une formule de congé de maladie. Il faut plus de données cliniques sur la validité du traitement médical de la lombalgie.

Dr. Gaétan S. Tardif, in the preceding editorial (see pages 1247 to 1249 of this issue), asserts that our report about the chiropractic management of low-back pain[1] has "shortcomings," "obvious problems" and is "permeated with confusion" and that our research contained "design flaws and biases," but he does not offer substantiating evidence for his claims. Such dismissive statements are all the more puzzling in view of his statement that "it is not [his] intention to perform a full critical appraisal of the report." It is apparent from his article that he has yet to make a careful, full appraisal of the report, but surely as a critic he is obligated to substantiate his criticisms.

The Manga report comes down "strongly on the side of the chiropractor," as Tardif states, but this is not the primary issue. Our principal concern in carrying out the study was to discover which services used to treat low-back pain were most effective and cost-effective for patients, taxpayers and employers.

Our report does not mention the quality of health care in Canada relative to — let alone being superior to — that in the United States. The Canadian and US systems are compared only in terms of accessibility, mortality rates, life expectancy and cost. We do not make assumptions about differences in quality between the systems, nor do we know health care professionals' views about this. How our opinion of the quality of care in Canada differed from that of the health care professions was therefore not known nor of any importance to our study. Thus, Tardif cannot assume a "divergence of opinion" on this matter, and to relate this divergence to our unwillingness to invite a physician, clinician or chiropractor to participate in the study is a *non sequitur*. The reason why we avoided including such professionals was to ensure objectivity and independence in carrying out the tasks assigned to us by the Ontario Ministry of Health.

The astute and careful reader of our report will find more pearls of insight and elucidation of problems in the treatment of low-back pain than Tardif appears to credit us. Our report does frown on medical practitioners' too-frequent use of long-term bed rest as treatment, and it is reassuring that most physicians in physical medicine and rehabilitation do not recommend strict bed rest. But where is the evidence that "other physicians" do not use the treatment? Tardif's citation of Lowry[2] hardly constitutes evidence of this. Although experts and opinion leaders may have discovered and acted upon the abundant evidence against the use of long bed rest, the general practitioner or family physician may not have caught up to the evidence. Why were so many studies over such a long period necessary to persuade the medical profession of the inadvisability of this treatment? And why did the profession use the treatment for so long without proper clinical evaluation?

Tardif's reference to a "[pearl] sure to bring a smile to the astute reader" in our Table 7 leaves me in despair. This table lists the chiropractic procedures used to treat all neuromusculoskeletal disorders, not just low-back pain. That 82% of chiropractors recommend bed rest simply means that 82% of chiropractors may or will consider bed rest as an option to treat one or more of their patients with neuromusculoskeletal conditions. If a chiropractor were to use bed rest for just 0.001% of patients with neuromusculoskeletal conditions he or she would be included in this figure. Thus, it does not mean that 82% of patients with low-back pain are counselled to rest in bed.

The 82% figure in Table 7 does not say anything about the duration of bed rest when recommended. The

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table does not contradict our findings about the use of bed rest by medical practitioners. Our report notes that chiropractors rarely prescribe bed rest for low-back pain, and when they do they suggest a few days only. The low frequency of the use of bed rest and the recommendation of a short duration contrasts sharply with medical practitioners' too-frequent use of bed rest for long durations, sometimes sufficiently long to be harmful. The astute reader would have surely gathered this from chapter 4.

There is more in our report on the safety of the chiropractic and the medical management of low-back pain than Tardif intimates. We cite many studies that showed significant iatrogenic complications from the medical management of low-back pain and the unnecessary use of invasive and surgical procedures. In quoting from our executive summary Tardif should have included the complete statement — that "there is also some evidence in the literature to suggest that spinal manipulations are less safe and less effective when performed by nonchiropractic professionals." In chapter 4 we present many studies to support this conclusion. We left out studies that were unpublished and ones reported in the media that we did not read for ourselves, including ones whose conclusions were against the medical profession. For example, according to a newspaper report of a recent Australian study of the safety of spinal manipulation over 31 years, 90% of the patients who had a stroke following spinal manipulation were treated by physicians, not chiropractors.[3] Instead of merely asserting "antiphysician bias" on our part Tardif may want to demonstrate how we either misread the literature or left out, deliberately or otherwise, studies that contradict our findings and conclusions.

I do not know where we offer a "statistical demonstration . . . that patients who consult physicians for back pain are absent from work three or four times longer than patients who consult chiropractors." We did not undertake this kind of analysis. However, most of the studies we describe strongly support the view that patients treated by medical practitioners are absent from work for significantly longer periods than patients treated by chiropractors. Tardif cites "patient selection bias" as one of the reasons for this finding. A number of studies suggest that patients who consult chiropractors are more likely to have chronic conditions than those who visit medical practitioners. As well, many worker's compensation programs require *medical* certificates for sick leave. Thus, an institutional barrier compels patients to contact medical practitioners and not others to have sick-leave forms signed. But patient selection bias is surely a wrong conceptualization and identification of the problem. Worker's compensation programs must re-examine their policies on sick leave. Ironically, medical doctors who treat low-back pain less effectively and less cost-effectively than chiropractors are given the privilege of completing sick-leave forms.

I am gratified by Tardif's acknowledgement that back pain is a significant problem, and I agree with his call for more research. I remind him of our statement that "what the literature revealed to us is the much greater need for clinical evidence of the validity of medical management of low-back pain."

Tardif's comments about the shortcomings of medical education and medical practice are interesting, as are his observations about differences in attitudes between physicians and chiropractors. I agree that patients deserve better care and add that patients, taxpayers and employers deserve a cost-effective health care system.

References

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2. Lowry F: Orthopedists have bone to pick with economist over report on chiropractic. *Can Med Assoc J* 1994; 150: 1878–1881
3. Wilk C: Strokes, 20/20 and strategy for 1994. *Florida Chiropractic News* 1994; 3 (3): 7–10