

## *Guidelines for Chiropractic Quality Assurance and Practice Parameters*

### “Mercy”

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The following information is provided to assist in the understanding of “Mercy”. It is highly recommended that anyone relying on Mercy for any reason read the entire document. Essentially, guidelines of all types serve as background information and assist in clinical decision-making, but alone are not cookbooks or pre-determined prescriptions for care. Each case is unique, and although evidence-based decision-making is critical, clinical observation, experience, and common sense are also important when determining appropriate patient care.

#### **Mercy acknowledges the importance clinical experience/observation:**

*“Guidelines concerning the treatment plan should be tempered with a balance of scientific information and systematic observation derived from clinical experience.”*  
[Page 117]

*“More concrete treatment/care protocols, then, may be based on the clinical impressions rather than on knowledge of the lesion mechanics or treatment efficacy.”* [page 117]

#### **Mercy pertains to uncomplicated cases.**

*“Their purpose is to assist the clinician in decision making based on the expectation of outcome for the **uncomplicated case**.”* [page 117]

*“Clinical expectation regarding treatment outcome must be based upon more than personal opinion. This approach to the development of guidelines for chiropractic quality assurance and standards of practice pertaining to the frequency and duration of treatment focuses on the **uncomplicated case** and logically includes the following considerations:*

- 1. The natural history of common spinal disorders,*
- 2. The characteristics and stages of tissue repair processes,*
- 3. Reasonable treatment/care outcome classified into short and long range goals.”* [page 117]

#### **Each case is unique.**

*However, guidelines framing expectations of treatment outcome can be drawn from the literature and adapted by practical experience on a case-by-case basis.* [page 117]

**Mercy supports ongoing care, when necessary.**

*The primary missions of health care delivery are to provide sufficient care to restore health, maintain it, and prevent the recurrence of injury and illness. [page 117]*

**5 principles of case management:**

1. *...is that early return to activity is associated with reduced disability and symptoms.*
2. *..based upon the experience gained from monitoring the response of patients having no treatment, and those with treatment. The lesson learned is that there is a natural history of recovery for **uncomplicated** cases, that can serve as a time frame from which to evaluate and shape a successful treatment plan.*
3. *..chronicity should be prevented wherever possible.*
4. *...repeated use of acute care measures **alone** generally fosters chronicity, physician dependence and over-utilization.*
5. *Therapeutic motivation, goals, and fiscal responsibility are different for elective care than for therapeutically necessary care. [page 117-118]*

\*\* Please note: The principles of case management which pertain to natural history are related to “uncomplicated cases”. Additionally, please note that #4 only suggests that acute care measures “**alone**” foster chronicity, etc. This often-misquoted section of Mercy does not prevent ongoing utilization of passive care (ex. spinal manipulation), especially if active care recommendations have also been recommended. One cannot rationally equate and interchangeably use the terms “acute care measures” with “passive care” or manipulation.

This section in no way suggests that “ongoing use of passive therapy such as spinal manipulation rendered at a frequency of 1-2 visits per month fosters chronicity and physician dependence.”

**Natural History vs. Complicated Case and Supportive Care:**

Definitions:

*“**Complicated Case:** A case where the patient, because of one or more identifiable factors, exhibits regression or retarded recovery in comparison with expectations from the natural history.” [page 118]*

*“**Uncomplicated Case:** A case where the patient exhibits progressive recovery from an illness or injury at a rate greater than, or equal to, the expectation from the natural history.” [page 119]*

*“Natural History: The anticipated clinical course of recovery for **uncomplicated** disorders either without treatment/care, or with conservative treatment/care.”* [page 118]

*“Supportive Care: Treatment/care for patients having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. Supportive care follows appropriate applications of active and passive care including lifestyle modification. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modifications, have been considered and attempted.*

*Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behavior, or secondary gain.”* [page 118]

\*\* The last paragraph is by far the most mis-quoted and misinterpreted paragraph in Mercy. When taken out of context, one may inadvertently opine that supportive care is not recommended per Mercy. However, Mercy suggests no such thing, especially if active care recommendations were also provided to the patient. Obviously, when the **benefits** of supportive care **outweigh the risks** (ex., increased use of drugs or work loss), ongoing passive and active care is certainly justified.

### **Passive Care:**

*“It is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care.”* [page 120]

*Reaching the rehabilitation phase as rapidly as possible and minimizing dependence upon passive forms of treatment/care usually lead to the optimal result.* [page 122]

\* Note: The term used is “minimize”. Mercy does not suggest complete dis-continuation of passive care in every case, only that passive care be “minimized”.

*“The scientific literature is not helpful in deciding when manual treatment/care should be stopped, either with respect to improvement or worsening of symptoms.”* [page 120]

\* Note: Care denied based on “no scientific literature proving effectiveness” is simply inappropriate. The medical necessity of care is found in the patient’s chart, not the literature.

**Active Care:**

1. Remobilization
2. Rehabilitation
3. Life Style Adaptions [page 120]

**Physician dependence and Supportive Care:**

Complicated Cases: Subacute Episode:

*Symptoms have been prolonged beyond six weeks, and passive care in this phase is as necessary, **not generally to exceed two treatments per week**, to avoid promoting chronicity or physician dependence. [page 125]*

Complicated Cases: Chronic Episode:

*Supportive Care: Supportive care using **passive therapy may be necessary** if repeated efforts to withdraw treatment/care result in significant deterioration of clinical status. [page 125]*

*About Dr. Farabaugh: Dr. Farabaugh has been in practice since 1982. He is certified in LOW SPEED REAR IMPACT CRASH RECONSTRUCTION through the Spine Research Institute of San Diego (SRISD), and holds a subspecialty as a Certified Chiropractic Sports Physician. He is also Past President of the Ohio State Chiropractic Association where he now serves as Treatment Guideline Chairman (2001-2003).*