



## How to Build an Evidence-Based Practice, Part 3

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Evidence-based practice has many facets of utilization. The evidence is available as a tool in patient management, substantiation of care, and serves to professionally defend your care against unwarranted and inappropriate care.

Today, I would like to discuss one of the methods of how to utilize it to substantiate the care process and defend your care.

Although competitive and belligerent practitioners were more common 20 years ago, they are still prevalent in health care. Competition in health care heats up. All of us have experienced the occasional run-in with the local medical professional who provides misleading and biased information to your patient in order to scare them out of your office. In the early 1990s, some medical professionals would stick to downgrade and berate the chiropractic profession. Well, evidence-based practice can not only help you defend your care, but it can also help you share one instance in which it was beneficial in my health care community.

A patient presented to my office for complaints of severe intermittent low back pain of sudden and insidious onset. With a limited knowledge of the patient's history and after examination, it was found that she was suffering from acute facet-locked syndrome, along with chronic cervicodorsal joint dysfunction. However, she was 64 years old. As a result of an earlier bone-density study performed by Dr. MD. As a result of the age and history of possible decreased bone density, I ordered standard screening X-rays of the lumbar spine (AP and lateral) to assess the type of manipulative therapy that would be most appropriate to rule out progression of osteopenia. Due to her insurance policy requirements, she needed her primary care physician's approval. Therefore, I forwarded my office notes and X-ray requisition form to Dr. MD.

Unfortunately for the patient, Dr. MD decided not to approve the referral. However, he gave no clinical rationale. When I asked why the referral was denied, she was given a handwritten note telling her to find a physical therapist or a chiropractor. This made it quite clear that Dr. MD was making uninformed diagnostic and treatment decisions based on economic reasons as opposed to clinical rationale. Such biased decisions unnecessarily put his patients at risk. The doctor failed to respond directly to my concerns and neglected to forward to me any previous bone-density study.

I called and subsequently followed up in writing with the managed-care network regarding the fact that the patient's care was unnecessarily needing to be adapted to a less-optimal alternative, due to the unknown and unverifiable reasons. This precluded the optimum outcome in the most cost-effective and expedient fashion. Insurer policies for our managed-care network provider (PCP) can only be effective if the PCP reviews the case and makes a rational clinical decision based on the best available evidence and the patient's values and needs, and then coordinates this with the clinical judgment of the referring physician. If the MD ignore the clinical evidence from the chiropractor, the literature-based evidence for risk factors for osteopenia, manipulation,<sup>1</sup> and the needs of the patient by making a biased decision – they undermine the insurance company's commitment to quality care to the managed-care networks' insured.

The payer was indeed interested in improper clinical decisions that compromised the quality and cost-effectiveness of care. The decision taken up by the medical director and Dr. MD was subsequently disciplined, with a copy of the letter sent to the patient. The evidence in my documentation and the literature which substantiated my clinical rationale certainly over-

actions. Doesn't this look like role reversal?

As you become more familiar with the evidence, you begin to learn how often medical clinicians make a year since this situation occurred. Dr. MD continues to provide PCP services to a number of my patients improper road block to my patients' care. In fact, he is less likely to challenge or second-guess my clinic request since this incident. His actions reflected poorly on him, lost the confidence of his patient and the other patients in this network. The patient completed care at our office with a good outcome. Once the patient immediately switched her PCP.

The moral here is that evidence-based practice can work in our favor with patients, payers and other professions of practitioners for their bias against chiropractic. Wow, this evidence-based practice is getting common.

#### *Reference*

1. Haldeman S, Chapman-Smith D, Petersen DM Jr. *Guidelines for Chiropractic Quality Assurance: The Mercy Center Consensus Conference*. Gaithersburg, Md: Aspen Publishers, Inc., 1993.

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