submission CBA draft

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Dear CBA

Thank-you for this opportunity to make a submission to the recent national draft.

My wider concern regarding this draft is best put in the words of the father of evidence based medicine, DL Sacket when he wrote "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients."(1)

There are numerous current studies that further acknowledge the limits to demanding external evidence-based research. (21 22 23 24 25 26 27 below) for all clinical decisions in a chiropractic office.

In Lintons book (11) "The guidelines for medical practice" he states, "Being "evidence based" was never intended to be "evidence enchained. Although sharing some common interests, evidence-based practice and guideline development are inherently incompatible when directly overlaid to create a template for patient care. The underlying motivation and value of evidence is in the guidance of clinical decision making for individual patients considering the individual context. The elements of that context include (1) case complexity, (2) the best available evidence, (3) the provider's expertise and experience, and (4) the patient's preferences and beliefs"

I would urge the CBA not to limit chiropractic to a narrow reliance on randomized control trials alone and respect individual clinician decision making.

How much of orthodox medicine itself is evidence-based? (2)
An article in the British Medical Journal regarding 2500 medical treatments, supported by good research evidence, "only 15% of treatments were rated as beneficial, 22% as likely to be beneficial, 7% part beneficial and part harmful, 5% unlikely to be beneficial, 4% likely to ineffective or harmful and of the remaining 49% the effect was unknown".

All recognized international guidelines clearly acknowledge the "norm" for an individual patient's evaluation, radiographic or otherwise may vary and may be unique to the individual history and the individual's orthopedic findings. In this same context, an orthopedic surgeon must make his own clinical judgments on the number of and frequency of radiographs he requires for the initial pre-operative radiographs, immediate post operative, one month and then six month films typically considered in each case. This professional individual judgment is typical for cervical and lumbar disc orthopedic surgery with up to 4 sets of images over a two year period is common. (3a 3b)

Wyatt's respected "Handbook of clinical chiropractic" provides the clinical question, "Will the treatment or the prognosis for the patient change if this study (radiographic) is performed?" There is a large amount of clinical data to findings typical to a chiropractic office, whereby the answer to this question is "yes" in regards to indicated radiographs or

follow-up radiographs. (4)

The growing recognition and radiological classification of today's uncorrected aberrant biomechanics is central to chiropractic. This paradigm takes the relevance of chiropractic radiography beyond limited red-flag findings. Chiropractic radiography has a broader role within a health profession specializing in the wider aspects of biomechanics and avoiding chronic spine related health problems is the focus of the front line chiropractic clinicians.
Troyanovich et al notes that radiography is "the only reliable method in the chiropractic office setting to accurately assess overall lordosis, individual intersegmental contributions to lordosis, certain aspects of pelvic mechanical integrity, and global anterior or posterior translational displacements of thoracolumbopelvic posture…"

There is growing evidence that spinal biomechanical conditions, more broadly termed by chiropractors as "subluxations", have wider health and pain implications. Any discussion on the dangers and costs associated with radiography are thereby acknowledged within the context of the dangers and costs of these spinal health issues being misunderstood.

Hanson says that "those who do not realize the suffering caused by subluxations are certainly not long-time clinicians. We would note that today's uncorrected subluxation may very well be tomorrow's chronic problem,

Tonn writes (12) that " Dental X-rays help your dentist visualize diseases of the teeth and surrounding tissue that cannot be seen with a simple oral exam. In addition, X-rays help your dentist find and treat dental problems early in their development, which can potentially save you money, unnecessary discomfort, and maybe even your life "

Chiropractic is a growing spinal hygiene science.

If chiropractic is to further evolve as both a spinal health discipline and spinal pain discipline, then radiography has applications to both. Chiropractic recognizes the public health imperative that early detection and intervention of progressive spinal health conditions may reduce the larger multi-million dollar long-term costs of preventable musculoskeletal conditions of the spine related to headache, mechanical neck and back pain, radicular pain, disc and degenerative pain, poor mobility and spinal stenosis to name a few.

May I request your inclusion of presenting pain and biomechanical health be enshrined further in radiography/radoology section 2.6 and the very heart of chiropractic and individual clinician decision making be respected more clearly in all sections of this document.

Regards

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