Commentary

The Interface of Jurisprudence, Ethical Practice Management and Chiropractic Care for Older Adults

Brian J. Gleberzon DC, MHSc

Address: 1Professor, Chair of Department of Applied Chiropractic, Canadian Memorial Chiropractic College, Toronto, Ontario, Canada; Council Member, College of Chiropractors of Ontario

Email: Brian J. Gleberzon DC, MHSc* - bgleberzon@cmcc.ca

* Corresponding Author

Abstract

Chiropractic care involves special considerations with respect to history taking, physical examination and management protocols, including the provision of manual therapies, prescription of exercises and promotion of health lifestyle choices; these issues are often explored in the peer-reviewed literature. However, there is a paucity of literature addressing other important management issues germane to providing care to this segment of the population. Such topics include issues of jurisprudence and ethical practice management, issues that are often stringently regulated in many jurisdictions. This article explores these equally important—albeit seldom considered—management issues of chiropractic geriatric care.

Introduction

A flurry of recently published articles has provided an extensive analysis of issues that are typically the focus of scholarly works by chiropractic content experts in peer-reviewed journals, textbooks and position papers when they turn their collective attention towards chiropractic geriatric care. Such topics
include: a ‘Best Practices’ approach for managing older patients;¹ articles or position statements on education, training and cost-effectiveness of care;²⁻⁵ safety of delivering manual therapies, especially spinal manipulative therapy;⁶⁻⁸ narrative reviews of the chiropractic literature;⁹ clinical trials investigating the effect of different methods to manage pain;¹⁰ and assessing the effectiveness of manual therapies for a plethora of clinical conditions on patients of all ages, from which extrapolations are made to older patients.¹¹ That said, few articles have specifically focused on other important issues germane to this area of clinical practice, specifically issues of jurisprudence and ethical practice development. This article will provide a preliminary platform from which a more comprehensive discussion of those seldom considered yet equally relevant management considerations will hopefully develop.

**Issues of Jurisprudence**

“Every human being of adult years and sound mind has a right to determine what shall be done to his body”¹²p109

Along with accepted standards of practice (i.e. practicing within a jurisdiction’s scope of chiropractic practice; maintaining proper clinical records; continuing education requirements) there are a number of issues of jurisprudence that specifically relate to older patients, chief among these being informed consent, advertising and billing practices.

It is difficult to believe that there still exist practitioners who can argue against the concept of informed consent, and yet recent articles indicate there are still some who resist providing it to patients.¹³,¹⁴ Informed consent is built on five ethical principles, all vitally important to patient care.¹³ These are:

(i) respect for patient autonomy (self-determination)
(ii) veracity (truthfulness)
(iii) justice (equal treatment of all patients and equal status of patient and doctor)
(iv) nonmaleficence (not deliberately causing harm to the patient)
(v) beneficence (acting in the patient’s best interest)

Informed consent is more than simply giving a patient a form to sign with a laundry list of possible
adverse effects prior to the commencement of treatment. Informed consent is a process and dialogue between the doctor and patient during which the patient has the right to know what his or her problem is (diagnosis); what therapy the doctor plans on providing; and the risks, benefits and alternatives to the proposed treatment plan. Consent cannot be obtained through fraud or misrepresentation, and it is imperative that a practitioner use plain language in describing the risk, benefits and alternatives to the proposed care plan. Conversely, if a practitioner used technical jargon not easily understood by the laity, it can be argued that he or she did not appropriately obtain informed consent. This doctrine of ensuring the patient is an active participant in his or her health care further avoids the patriarchal tendency of traditional health care models, an approach that resonates with the World Health Organization (WHO) definition of health promotion.

Patients are entitled to know what, if any, material risks the proposed plan of management carries with it. Although the definition has evolved over the past 30 years, a risk is said to be ‘material’ if it is common and non-life-threatening, but still can negatively impact a person’s life (i.e. rib fracture) or if it is significant and more serious, even if it is rare (i.e. disc herniation, stroke, death). Although approximate treatment timelines and costs should be provided to patients, guarantees of cure should not. A good rule of thumb is: would a reasonable person in the same or similar circumstances change his or her mind with respect to permitting the doctor to provide the proposed therapy if provided with all the potential side effects? Lastly, it should be stressed that informed consent is seldom a ‘blanket’ consent for the entire body. For example, if a patient consents only to a chiropractic adjustment to his or her talus or elbow, that consent is not transferable to other anatomic regions (i.e. lumbar, thoracic or cervical spine), each of which may have other potential associated risks.

Since many older patients have accrued a number of injuries over time, due to a lifetime of traumas including falls or motor vehicle accidents, and may have complex medical histories that include co-morbidities and poly-pharmacy, they are more susceptible to adverse effects than are younger patients. Bearing that in mind, older patients should be informed that a manual procedure may cause them bruising, swelling, stiffness or pain that is more severe than may be experienced in a younger patient and that their time to recovery may be prolonged.

Inherent in the informed consent process is the issue of capacity. A person must have the necessary
mental capacity to provide his or her consent.\textsuperscript{15} If a practitioner suspects a patient is experiencing a decline in cognitive function such that he or she can no longer provide informed consent—that is, that he or she lacks the capacity to consent—it is imperative a substitute decision-maker be consulted.\textsuperscript{14,15} Exceptions are emergency situations wherein a practitioner is exempt from liability if he or she has rendered care to an unconscious person in good faith.\textsuperscript{15,16} This can be a complex area of health care, and it behooves the reader to become familiar with the specific regulations and standards of practice in the jurisdiction in which he or she practices. As a point of reference, a recent article by Langworthy and Cambon reported that almost half of a sample of American chiropractors were unfamiliar with the legal requirements related to informed consent; this is in stark contrast to similar data collected from the United Kingdom that reported over 90% of chiropractors were aware of their legal requirements.\textsuperscript{13}

Lehman et al\textsuperscript{14} reported a number of reasons for chiropractors not attempting to obtain informed consent from their patients, or doing so inadequately. These include: 1) the chiropractor believes that he or she can predict who will or will not sustain an adverse reaction to spinal adjusting; 2) the information is provided in the literature in the waiting room; 3) if the doctor does not use rotation of the cervical spine during pre-manipulative or manipulative procedures, he or she believes there is a lessened risk of harm; 4) it is not necessary because of the rarity of serious side-effects; 5) discussing side effects may spread fear and anxiety to other patients; 6) if side effects are discussed, the patient may decide against care. Additionally, paternalistic attitudes also contribute to avoiding adequate adverse event discussion; e.g., “the patient is the one seeking the chiropractor’s expertise and must therefore trust his/her judgment;” “for the most part, patients need to be told what to do, much as a child would”; “I am the doctor, the patient knows little about what is going on.”\textsuperscript{14p427}

Another issue of jurisprudence often not discussed in connection with the management of older patients is advertising. Advertising is often protected as a basic freedom of expression, at least in Canada, under the Charter of Rights and Freedoms. This was affirmed in Rocket v Royal College of Dental Surgeons of Ontario, where it was decided that it was in the public interest for a dentist to advertise his or her hours of operation, language spoken, services provided, fee schedule and so on.\textsuperscript{18} However, advertising must be truthful, verifiable and factual; it must not denigrate another practitioner or profession, not claim superiority to another practitioner, not offer a guarantee of success and, in some jurisdictions, not tarnish the profession as a whole. These requirements guard against practices such as planting the seeds of false hope in the minds of patients who may be at their wits’ end due to chronic
debilitating pain or disability. It also guards against making unreasonable claims of cure, or luring patients with promises of free or discounted services only to subsequently do a ‘bait and switch’ and eventually entice patients to enlist in care plans with no foreseeable end in sight. Some jurisdictions have developed codes of ethics and conduct to prevent practitioners from these unethical practice activities; however, enforcement is often difficult.

Older patients are often specifically targeted by these such practice activities and are more susceptible to them due to a phenomenon known as the “illusion of truth,” a cognitive challenge more prevalent among older persons. The illusion of truth is a cognitive model that posits older people are more likely to experience a distortion of memory born from a repetition of a statement, even if it’s false. This distortion is magnified if the information presented is phrased negatively. A result of this illusion of truth is that older persons are more gullible and less socially vigilant or skeptical and thus subsequently more susceptible to fraud, scams and quackery. This is more pronounced if the person is socially isolated or alone.

Scope of practice must be considered, and any plan of management must be defensible in terms of what a particular jurisdiction permits a chiropractor to do or not do. Patients cannot be “experimented-on” by practitioners who may have just learned a new treatment procedure at a seminar. In order to meet their mandate of protecting the public interest, many jurisdictions require several criteria be met before a practitioner can use a manual therapy technique system on a patient.

These include:

- The technique must be taught at an accredited college in the core curriculum, as an elective or during a continuing education program. This is because many regulatory bodies are content to defer the vetting of “accepted” or “reasonable” clinical approaches that rely on scientific plausibility and have some evidence of clinical effectiveness to the academicians in accredited chiropractic colleges
- The practitioner must have some specific training in the technique s/he plans on using. Preferably this includes a test for clinical competence, since it is in the public interest for a practitioner to have specific training and have achieved a level of competence in a manual approach they plan on providing to a patient.
· The technique is not specifically prohibited for use in a jurisdiction. For example, some Canadian jurisdictions do not allow the use of a Toftness Radiation detector (British Columbia), or the use of manual muscle testing by Applied Kinesiology to detect food allergies (British Columbia) or surrogate testing (Alberta).
· The malpractice insurance carrier is notified.
· The patient provides informed consent, and the more the technique differs from usual and customary care, the more important obtaining specific informed consent is.

Ethical Practice Building

The Canadian Federation of chiropractic regulatory and educational accrediting boards has developed extensive standards for doctor of chiropractic programs. Along with requirements to conduct a proper history, physical examination and to develop and render appropriate and competent therapy, the Federation document has the following requirements:

13. Professional Issues, section A (Attitudes):

“The student must demonstrate ability to:

a) exhibit ethical attitudes regarding the provision of patient care services, fees, financial arrangements, billing practices and collection procedures;

b) identify and acknowledge an obligation to refrain from illegal and unethical patient care and practice management procedures

These educational requirements are in place to deter any chiropractic practitioners from operating in an unethical manner, particularly towards vulnerable populations, including the elderly.

In addition to prohibiting improper marketing and advertising tactics, the Health Professional Procedural Codes of Ontario, which is Schedule 2 of the Regulated Health Professions Act in Ontario, specifically prohibits attempting to convince an older person to change their last will and testimony, making the chiropractor the principal beneficiary of a person’s estate. Another example of unethical behavior addressed by this act is that it is an offence under the Act to provide an invoice that is false or misleading. It is also considered an act of professional misconduct to not disclose to a patient the fee for a service before the service is provided, including a fee not payable by the patient. Other jurisdictions may have
similar misconduct regulations and it behooves a practitioner to be well-acquainted with all regulations, standards of practice, guidelines and policies of the jurisdiction in which they practice, lest they find themselves in a position of non-compliance and face disciplinary action.

Some unscrupulous chiropractors have been known to attempt to convince patients to pay in advance for a large number of treatments (so-called block fees) that may not be clinically necessary. Paul Carey, Executive Director of the Canadian Chiropractic Protection Association (CCPA), the largest malpractice carrier in Canada, recently commented “[There are] two main concerns that people seem to have regarding chiropractic care. One is that chiropractic care often appears to be on-going without rationale. The other is that chiropractors seem to be more interested in money than they are in providing evidence or logic-based health care.” Some provinces in Canada have tried to deal with this problem by limiting either the amount (in British Columbia) or number of treatments (in Alberta) a practitioner can require a patient to pre-pay. Some chiropractors may also try to convince patients to purchase ancillary items at great profit to the chiropractors (orthotics, back supports, nutritional supplements) that the patient does not need. Alternatively, a chiropractor may pressure a patient to purchase a product from a company in which the chiropractor has a financial interest, a practice that is often a violation under state law (see discussion below).

A recently published “roadmap” published by the U.S. Department of Health & Human Services (Office of the Inspector General or OIG) provides guidance to health care providers with respect to avoiding Medicare and Medicaid Fraud and Abuse. The Roadmap sites the five most important Federal fraud and abuse laws. These are: 1) the False Claims Act (FCA); 2) the Anti-Kickback Statute (AKS); 3) the Physicians’ Self-Referral Law (Stark Law); 4) the Exclusion Authorities; and 5) the Civil Monetary Penalties Law.

The Road map reminds health care providers submitting claims to Medicare that they are essentially billing the Federal government for a service. Bearing that in mind, it is illegal to submit a claim for payment to Medicare or Medicaid that a provider knows or should know is false or fraudulent. Filing false claims carries a fine of up to three times the program’s loss plus $11,000 per claim filed.

In some industries, it is acceptable to reward a person who refers business to you. However, in health care it is not considered acceptable, and under the Federal health care programs, paying for a referral is
a crime under the Anti-Kick back laws. Despite that, it is not uncommon for health care providers to be offered kickbacks for referring patients to certain labs for services, or to pay lawyers or even tow truck drivers who bring patients who were in motor vehicle accidents to specific rehabilitation clinics. Along the same lines, the Physician’s Self-Referral Law or Stark Law prohibits physicians from referring patients to receive “designated health services” (DHS) payable to Medicare or Medicaid from companies or corporations with which the doctor or an immediate family member has a financial relationship (certain specific exceptions apply). In the case of chiropractic, this may apply to orthotic labs or other assistive devices.\(^{24}\)

Accurately coding and billing services to Federal payors is imperative, and a health care provider must be wary of “upcoding” a billed service. This refers to the practice of using a billing code that reflects more severe illness than actually existed or a more expensive treatment than was provided. Other examples of fraudulent billing procedures include:\(^{24}\)

- Billing for a service that the practitioner knows was not rendered
- Billing for a service that was not medically necessary
- Billing for a service that was performed by an improperly supervised or unqualified employee
- Billing for services that are such low quality that they are essentially worthless
- Billing separately for services that are already included in a global fee, such as billing for an evaluation and management service the day after surgery.

The Roadmap provided some real-life examples of penalties imposed by the OIG with respect to fraudulent billing practices.\(^{24}\)

- A physician was ordered to pay $50,000 in restitutions for falsely indicating on his provider number application that he was operating his own practice when, in fact, a neurophysiologist was operating the practice and was paying the physician a salary for use of his number.
- A physician paid $100,000 and resolved liability related to referring patients to a lab owned by his brother.
- A psychiatrist was fined $400,000 and permanently excluded from participating in Federal health care programs for misrepresenting that he provided therapy sessions requiring 30 to 60 minutes of face-to-face time when he in fact only provided medication checks for 15 minutes or
less. In this case, the therapy sessions were actually provided by a non-licensed individual but billed as if the psychiatrist rendered the care.

· An osteopathic physician was sentenced to 10 years in prison and ordered to pay $7.9 million in restitution after she accepted cash payments for signing preprinted prescriptions and Certificates of Medical Necessity for motorized wheelchairs for beneficiaries she never examined.

Summary

This article briefly explored several areas of jurisprudence and ethical business management that are not typically discussed in articles that explore issues germane to chiropractic geriatric care. It is essential that regulatory bodies fulfill their mandate of protecting the public interest by developing and enforcing standards of ethical practice activities and appropriate care planning; continued participation in Federal third-party programs depends on it. Unfortunately, a recent comparative audit by this author suggests that many areas of jurisprudence discussed in this article may not be adequately covered at all accredited chiropractic colleges; if this is proven to be the case, this educational gap must be filled.

References


16. Health Care Consent Act, 1996 (Canada)


