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**Physiotherapy, a responsible profession to use cervical manipulation. Response to Refshauge et al**

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It is an exciting but challenging era when physiotherapy has matured to the point where we are able to debate issues of great significance to the profession (see also Malone 2002). Unfortunately, the “debate” about cervical manipulation now risks being argued around interpretation of fine detail of fact rather than around the real issues concerning cervical manipulation. This lends emotion rather than measured argument to the debate. Jull et al have not reflected on the major issues as we would have hoped; rather, they have chosen to cloud our discussion with the very strategies they contend we have employed, ie selective use of literature and misrepresentation of results. More importantly, they appear to have misunderstood the entire point of our paper.

Our question is not whether the physiotherapy profession is
In our original paper. An even higher rate of complications was reported more recently by Hanson and Coyle (2002). These are primary data that are not reliant on incidence of complications reported in the literature and they show, for the first time, a much higher incidence of serious complications than previously reported. We should take time to reflect on these data before jumping to defend our current practice.

When Jull et al downplay the risk associated with manipulation, they do so by comparing manipulation to “realistic” alternative interventions such as NSAIDs and neck surgery with higher frequency of other risks. They cite chiropractic estimates that manipulation is safer than use of NSAIDs. However, a recent well-conducted risk analysis shows that use of NSAIDs does not increase the risk of death (relative risk 1.1; Feenstra et al 2002). Similarly, surgery is an alarmist alternative suggestion for mechanical neck pain, and is not a valid comparison as surgery is rarely an option for mechanical neck pain or cervicogenic headache.

Of the appropriate comparisons made by Jull et al, it is true that Vernon et al (1990) found manipulation to be superior to mobilisation for chronic neck pain. However, Cassidy et al (1992) actually found no difference that was statistically significant, and Hoyt et al (1979) found that the improvement with manipulation was equivalent to that of mobilisation for headache. Other studies also found no difference in efficacy between manipulation and mobilisation, either clinically or statistically (eg Jordan et al 1998). Nevertheless, we agree with Jull et al’s conclusion that there is currently “a lack of high quality trials ...... to provide evidence of efficacy of ........ cervical manipulation”. In other words, there is little evidence in favour of manipulation.

Several of us have provided expert witness reports for many cases from all around Australia where there have been serious complications from neck manipulation. These complications, which can be devastating, may have often been prevented by adequate screening as recommended in our original paper (see Appendix). In many of those instances, screening was absent or incomplete. Where the complications are so serious, comprehensive screening is essential. While the Clinical Guidelines for Pre-Manipulative Procedures for the Cervical Spine (Magarey et al 2000) are freely available, a comprehensive checklist such as presented in the Appendix, or even a comprehensive list of the contraindications and precautions for manipulation, is not, in fact, freely available. No clinically portable checklist is published in any of the texts cited by Jull et al. Such screening procedures may well be taught in all undergraduate curricula, but a comprehensive checklist is not currently available for clinicians, even in the Clinical Guidelines.

The issue we raise therefore is simple, and based on these two factors: What are the known risks of manipulation? What are the known benefits? The known risks of manipulation we agree may be “slight”, but they are associated with “devastating side effects”. The known benefits are not clearly superior to safer, alternative interventions. We therefore argue that a patient must be informed. This argument is as relevant now as it was in whatever past era Jull et al feel we are practising in. That is because in offering patients the choice of manipulation, we promote the technique, no matter how judiciously. Jull et al are right that our strength is that we can offer alternative techniques besides manipulation. We argue that the profession should promote these strongly and should consider what is the appropriate educational standard for someone within the profession to manipulate.

It appears that Jull et al are in favour of the status quo. This may be a valid position, but it has not been convincingly argued. Their arguments support the current situation rather than argue what is best for the profession and for the community. The community has moved beyond accepting practices because they have always been done that way. The community is now informed. The findings of Rogers vs Whitaker, 10 years ago as the authors correctly state, reinforce this community attitude, and the judgment brought down argues convincingly against accepting the current position posed by Jull et al. We need to reflect the needs of the community, and impose safeguards for our profession, and in doing so we will help to maintain the right to manipulate by demonstrating that we are responsible, not just by stating that we are.

Perhaps the physiotherapy profession is demonstrating how responsible it is by infrequently using cervical manipulation. Perhaps the profession is already leading us. The data that we quoted on frequency of manipulation by physiotherapists was partly derived from New South Wales (NSW) of 10 years ago, because data had not been collected elsewhere. We need hard evidence from Jull et al, not derision, to refute these data. We would argue that other data from Grimmer (1998) reflect practice by physiotherapists throughout Australia and, as we stated, they are certainly consistent with the earlier data from the NSW Physiotherapists Registration Board. Dare we suggest that perhaps Australian physiotherapists already believe that the best people to manipulate the cervical spine.
are those who have an appropriate standard of education in the area.

Finally, consider the example of a patient who asked his general practitioner for a referral to a physiotherapist for cervical manipulation for persistent mechanical neck pain. Who would the profession prefer the patient be referred to? Is it the profession’s position that the physiotherapist should have postgraduate education in cervical manipulation, or do they believe that undergraduate education is adequate and appropriate?

References

Cassidy JD, Lores AA and Yong-Hong K (1992): The immediate effect of manipulation versus mobilization on pain and range of motion in the cervical spine: a randomized controlled trial. *Journal of Manipulative and Physiological Therapeutics* 15: 570-575.


