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Should the chiropractic profession embrace the doctrine of informed consent?

In reply:

We appreciate the opinions of the authors, for they imply that the chiropractic profession recognizes the importance of the doctrine of informed consent and patient safety. For clarification, we elect to elucidate our position of the utilization of the terms *promulgate* and *standard of care* in our article. It is our collective opinion that the chiropractic profession make it be known by open declaration (promulgate) that the "Doctrine of Informed Consent" be clearly and forcefully supported as the standard of care that chiropractors must implement into their clinical practice on every patient. We believe the national organizations and, to some extent, the state licensing boards fail to meet this threshold obligation. As a result of this leadership failure, chiropractors are not provided

with an unambiguous platform with which to integrate this mandatory practice procedure.

It is not enough to state that chiropractors should enable patients to make an informed choice; but rather, chiropractors must inform patients of the appropriate and necessary information required for the patients to make informed decisions in which to consent to treatment. We agree with the premise that chiropractors do not appropriately implement the informed consent process. Yet, our question "Should the chiropractic profession embrace the doctrine of informed consent?" remains to be answered with clarity and firm commitment by the chiropractic associations under the standard of care umbrella.

The recent American Chiropractic Association House of Delegates expanded Code of Ethics language does not go far enough to ensure the necessary clarity to promulgate that the doctrine of informed consent is a requirement rather than simply recommended. It is evident that individual state legislatures are leading the way on this issue with clearly worded statutes defining informed consent language that is required for every licensed health care provider. It appears that the chiropractic organizations and leadership bodies, to date, have been unwilling or reluctant to follow the lead of state legislatures. This egregious error requires immediate attention.

We propose that to promulgate the Doctrine of Informed Consent under the chiropractic profession standard of care umbrella requires revising current national organizational language. Furthermore, the utilization and methodology of incorporating appropriate and standardized informed consent procedures will require an educational process for all licensed chiropractors. In the United States, informing and educating the chiropractic profession should be provided by the Association of Chiropractic Colleges and the American Chiropractic Association. We believe that these groups must be in the forefront because of the importance of ensuring that all chiropractors are fully informed as to the standard of care requirements for informed consent. We strongly encourage regulatory actions by the State Boards of Chiropractic Examiners to clearly define the informed consent process and require it to be performed as a standard of care. This statutory mandate by state licensing boards would demonstrate professional maturity and further promote patient safety. Chiropractic State Associations could complement the effort to promulgate the Doctrine of Informed Consent by teaching the informed consent process at continuing educational seminars.

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Surface area congruence of atlas superior articulating facets and occipital condyles

To the Editor:

It is encouraging to see new, clinically relevant upper cervical anatomical research; and no Blair practitioner will be surprised by the findings of Briggs et al¹ of bilateral asymmetry of the atlantooccipital (AO) articulations. However, several of the references of Briggs et al to Blair's hypothesis on the matching of ipsilateral AO surfaces, his research database, and his radiographic analysis require clarification.

Blair² does state broadly that "the articulations of the body perfectly match at the articular surfaces"; but he subsequently restricts his consideration to the³ "comparison of articular surfaces at their margins," advancing no specific hypothesis as to surface areas. Finding that the medial margins of the AO articulations are "seldom well-defined" and "do not offer us articular surface comparison," he developed the Blair Oblique Protractoviews specifically to image the most anterolateral or "distal condyle lateral mass margins" parallel to the longitudinal axis of each articulation.⁴ Viewing even these distal margins at too posterior⁴ or too anterior⁵ a point can be misleading as to articular alignment.

Blair's research was based not on "matched and unmatched" cadaver specimens with cartilage attached, but primarily on hard tissue "stereoscopic [i.e., three-dimensional] study of hundreds of Cranial-Atlanto-Axial-Cervical spinographs" (precision postural radiograph meeting chiropractic standards)² and on malformation data from "anatomical measurement" of dry specimens in the BJ Palmer Osteological

Collection supplied by Dr LG Fraser.⁴ Thus, the findings of Briggs et al are essentially peripheral to Blair's assertions, which invariably refer to osseous, not soft tissue, margins. Nevertheless, several potential sources of investigational error should be noted.

The cleaning itself, however meticulous, of the acute distal edges of lateral mass vs the obtuse (and often very short and indistinct) distal edges of the condyle presents 2 distinct psychomotor challenges to the hand. Any potential systematic error thus introduced would be compounded for methods 2 and 3 of Briggs et al by the "cut[ting] out," by unspecified but presumably equally vulnerable means, of the aluminum foil molds.

For all 3 methods of Briggs et al, the outlines obtained will indeed depend, as the authors suggest, on the exact angle at which the mold or anatomical material is mounted with respect to the projectional surface. However, this is not a "minor measurement flaw" but a major source of potential error that must be carefully controlled in clinical practice.^{4,5} Consistent measurement is not necessarily correct measurement.

Briggs et al state that their method 3 is the most relevant because it mimics what is seen on the Blair Protractoviews.¹ Their method looks at the image mimicking a base posterior or vertex radiograph (a coronal view). Blair insisted that the relationships of the condylar and lateral mass distal margins should not be assessed from the coronal view at all, but from a diagonally vertical perspective and "on a plane 90° to the [slope of the] articulation."⁴ Therefore, the conclusion of Briggs et al comments on radiographic images that they did not study in their article.

A more technical exposition of Blair's hypotheses, observations, and methods as related to the procedures of Briggs et al is available at www.blairchiropractic.com. Hopefully, such studies as that of Briggs et al will stimulate further investigation into this pivotal area of the spine.

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