OUTCOME MEASURES - A new way -
COMMENTARY

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Key Indexing Terms: Outcome measures, practice guidelines, chiropractic.

Compliance with established standards has been the benchmark of evaluating all kinds of academic, professional, commercial and administrative endeavours over the last one hundred years or so. Academic awards, for example, have been gained by passing examinations specific to that discipline of study. The awards themselves have been subject to accreditation procedures, often established by both internal and external agencies, which attempted to establish whether the course had the relevant subjects in just the correct amounts and, of course, with proper sequencing. Examinations had to be rigorous but fair and the accreditation team, assessing the educational program, was required to be given open access to all records of syllabus and curricula - staff, student and examination details - and more, much more, as everything had to measure up against an established standard.

Since the 1980’s, there has been a shift away from the traditionally accepted and respected ‘compliance with standards’ as the primary yardstick in the measurement of various human endeavours. ‘Outcomes’, ‘Outcomes Assessment’ and ‘outcomes Measures’ have found themselves to be common usage words in the 1990’s. In essence, the judge’s attention has been drawn away from ‘whether the program complies with predetermined standards’ to a serious concentration on whether the end product, the ‘outcome’, matches up well with the intended outcome of the endeavour when it was first commenced.

In chiropractic education this has not resulted in the accreditation agencies [CCE(US), CCE(Canada) and ACCE] completely abandoning their previous interest in prescriptive aspects of the curriculum of their members colleges. It has, however, led to an appreciation that the importance of these measures can be over-rated and of greater importance that compliance with standards is some enquiry as to whether the end product - the graduate chiropractic practitioner - is capable of doing the various tasks he/she would normally be required to do in day to day practise.

It is good and proper that various human pursuits be judged not only by the conduct of the pursuit but also by the result of it.

Of increasing interest to the health sciences is not just ‘outcomes’ as they relate to educational processes but clinical interventions as well. The most prestigious spine related journal in the world -SPINE - has recently devoted an entire supplementary edition to a discussion of ‘Clinical Outcomes’ (1).

Another document (2) provides the following definitions:
“Outcome Measure: Procedure or method of measuring a change (my emphasis) according to a predetermined set of standards. In health care, it involves measuring a patients status following specific treatment, thus reflecting its effectiveness.

“Practice Guidelines: systematically developed statements to help health care practitioners and their public make decisions about appropriate health care in specific clinical circumstances.”

The reasons for these developments are multiple, however, several factors are identified as being of particular significance.

All professions through the seventies, eighties and nineties have been subject to an increasing public suspicion and a demand for accountability to the public they serve. The health care professions, in addition to facing this general push for accountability, have been and will continue to be subjected to increasing scrutiny as a result of their rather generous incomes being largely derived from public or quasi public funding agencies, like universal health coverage schemes, workers compensation agencies and similar third party payers. The need to demonstrate efficacy, both clinical and economic terms, is emphasised in a climate of global recession and budgetary constraints.

Why should any health care purchase, whether it be a privately funded individual or a government/quasi-government agency, pay for clinical interventions of any sort when some other form of treatment is proven more effective and may involve less cost in the long run?

The quandary has been, until now, that there has been little or no impetus for anyone to ‘systematically develop statements to help health care practitioners

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and their patients make decisions about appropriate health care in specific clinical circumstances’ (2).

If one were to be brutal, one might suggest ‘protection of the professional patch of territory’, or avarice or simply ‘sloppy practice’ as the reason(s) why this endeavour has not been energised before now. To give all the benefit of the doubt, however, it may reasonably be argued that prior to the 1980’s and 90’s, practice guidelines and outcomes measures quite simply have not been seen as relevant, appropriate or necessary. Today they are seen as being absolutely necessary. Once established and operational they will assist in challenging pre-existing demarcations of ‘professional territory’, they will certainly challenge past practices which are not efficacious in both clinical and dollar terms and they will encourage all health care practitioners to think a lot more about what they are doing, why they are doing it and what results might be reasonably expected.

Challenges to the status quo will be based exclusively on that which has been established scientifically as published in peer reviewed journals and on consensus views of the relevant profession. Assessment of the scientific data will be ongoing as will studies as to the strength and validity of that data. In the absence of conclusive scientific data, consensus views may be adopted about different tests or procedures, the magnitude of that consensus also subject to ongoing scrutiny (3). From this point in time on, practising chiropractors, patients, third party payers, legal advocates/lawyers/attorneys and courts/arbiters/judges will have a point of reference, authored and sanctioned by the profession itself, upon which to determine and judge what might be ‘appropriate chiropractic care’.

Improved patient care is the primary goal of practice guidelines. One would expect that this will eventually lead us all to ongoing improvement of clinical practices and, therefore, more cost efficient care - value for expenditure being one of the objections most often raised regarding health care interventions, including chiropractic.

1. SPINE. Sept. 1994. Vol.19: No. 18S.
2. Clinical Guidelines for Chiropractic Practice in Canada. Ed. Donald Henderson. April, 1993.
3. Paul Shekelle M.D. MPH. The evolution and mechanics of a consensus process. In ‘Guidelines for Chiropractic Quality Assurance and Practice Parameters’ Eds. Haldeman S., Chapman-Smith d., and Petersen D. Aspen Publications Inc. Gaithersburg MD, 1993: Pg.xxix.