

**CHIROPRACTORS REGISTRATION BOARD OF VICTORIA  
STANDARDS OF PRACTICE GUIDELINES**

**THE CHIROPRACTIC CARE OF CHILDREN  
JUNE 2008**

**1. PREAMBLE**

The purpose of these guidelines is to assist practitioners in providing acceptable standards of care for the treatment of children. The aim of these guidelines is to protect the public by assisting the practitioner to comply with the Act and avoid allegations of unprofessional conduct.

**2. DEFINITIONS**

- (1) Child:** - A person between the ages 0-13 years (approximately).
- (2) Parent:** Includes parent, guardian, carer or a person with whom legal custody of the child is entrusted. It applies equally to more than one parent.
- (3) Purpose:** “To protect the public by providing for the registration of chiropractors and investigations into the professional conduct and fitness to practice of registered chiropractors” [Section 1(a) of ‘The Act’]
- (4) The Chiropractors Registration Board of Victoria:** The ‘Board’
- (5) The Health Professions Registration Act 2005:** ‘The Act’
- (6) Unprofessional Conduct:** s3 of ‘the Act’.

The relevant sub-definitions include:

- (a) Professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered chiropractor.
- (b) Professional conduct which is of a lesser standard than that which might be reasonably expected of a chiropractor by his or her peers.
- (c) Providing a person with health services of a kind that is excessive, unnecessary or not reasonably required for that persons well being.
- (d) Influencing or attempting to influence the conduct of a chiropractic practice in such a way that patient care may be compromised.

### **3. INTRODUCTION**

- (1) The potential benefits of any health care should be honestly weighed up against all risks associated with the care and the costs in terms of time, and money.
- (2) There are significant anatomical, physiological, neurodevelopmental and psychological differences between children and adults.

### **4. GENERAL CLINICAL PRINCIPLES IN THE CARE OF CHILDREN**

- (1) The strong emotional bond between parents and children may affect the judgement and decision-making of the parent, thus putting the parent and child in a vulnerable position.
- (2) Compared with the adult, a child's:
  - (a) Neuro-musculo-skeletal structure is not as rigid.
  - (b) Structure and function are more flexible.
  - (c) Physical, psychological and emotional responses to dynamic intervention vary and may be at greater risk of injury or insult.
  - (d) Developing tissues may be more sensitive to injury or damage.

**5. THE CLINICAL ENCOUNTER** - Some of the important issues, include, but are not limited to:

#### **(1) Communication Skills**

- (A) The younger the child, the greater is the need to involve and rely on the parent. Depending on the child's age, the child should also be encouraged to be actively involved in the clinical encounter.

#### **(2) Informed Consent**

- (A) A minor cannot give informed consent on their own behalf.
- (B) For the paediatric patient, parental (preferably both parents) consent to history taking is implied. Prior, preferably written, informed consent (preferably from both

parents) is necessary for the examination and treatment of the child. Additionally, verbal consent of the older child is recommended.

(C) Refrain from treating the older and more cognisant child who vigorously objects to being treated and refer on if necessary. (Guidelines for Informed Consent [http://www.chiroreg.vic.gov.au/docs/gl\\_consent.pdf](http://www.chiroreg.vic.gov.au/docs/gl_consent.pdf))

### **(3) Record Keeping**

(A) Patients' records should be kept in safe custody by the chiropractor to whom they belong for a period of 7 years from the date of the last visit of the patient to the chiropractor, except for patients under the age of 21 years, where records should be retained until the period of 7 years expires, or, until the patient reaches 21 years of age, whichever event occurs last. (Guidelines for Record Keeping [http://www.chiroreg.vic.gov.au/docs/gl\\_patientrecords.pdf](http://www.chiroreg.vic.gov.au/docs/gl_patientrecords.pdf) )

### **(4) Clinical History**

(A) A directed case history must occur at the initial and each subsequent presentation noting objective and subjective information. A review of systems, family history and past medical history is useful in the identification of diagnostic 'red flags'. This obligation to the patient outweighs any other moral or philosophical point of view of the practitioner.

### **(5) Examination**

(A) Non-indicated, unreliable and invalid diagnostic tools, instruments or methods and unnecessary diagnostic imaging procedures are to be avoided. There must be an adequate diagnostic assessment. Techniques of assessment should be clinically relevant and accurate/valid allowing the practitioner to move from a basic working diagnosis and probability diagnosis, based on the history, to a short list of differentials.

(B) Certain paediatric examination procedures and techniques require extensive training and experience in order to be performed at an acceptable level. Unless the practitioner has had adequate training and experience in these areas of examination, appropriate referral is required.

## **(6) Radiographic Assessment of Children**

(A) Generally, X-rays of children would be obtained for the following:

- (i) Clinically suspected trauma-induced injury, such as fracture or joint dislocation
- (ii) Clinically suspected orthopaedic conditions including, but not limited to, hip disorders (such as dysplasia or Perthes disease), slipped femoral capital epiphysis, congenital conditions (such as Klippel Feil Syndrome) or scoliosis.
- (iii) Clinical suspicion of pathology such as bone malignancy or rheumatic conditions
- (iv) Cases of unresolved skeletal/spinal pain
- (v) Cases needing further investigation to determine their suitability for chiropractic care, given the real possibility of absolute or relative contraindications. For example:
  - (a) Down Syndrome (trisomy 21). Plain film radiographs of the cervical spine (including and not limited to flexion/extension views) are required before any manipulation, to verify that there is no atlanto-axial instability.
  - (b) Juvenile rheumatoid arthritis. Plain film radiographs of the cervical spine (including and not limited to flexion/extension views) are required before any manipulation, to verify there is no atlanto-axial instability or spinal fusion.
  - (c) Other conditions might include severe scoliosis, etc.

(B) Routine radiographic examination and re-examination of paediatric patients is not recommended without clear clinical justification. X-ray examinations should not be performed solely for the detection of biomechanical disorders of the spine, such as vertebral subluxations, postural analysis or for the monitoring of spinal curves or posture, unless for monitoring progressive scoliosis.

**(7) Communicating the Diagnosis**

(A) The diagnosis must be communicated to the parent (and the older child if appropriate) in an age-appropriate and comprehensible manner and without causing undue alarm.

**(8) Important 'Red Flags' With the Paediatric Patient**

(A) **Serious symptoms and 'red flags'** necessitate immediate and appropriate referral to, and management by, a general practitioner, paediatrician or hospital emergency department. Paediatric conditions that warrant immediate medical referral include, but are not limited to:

**(B) Acute illness:**

- (i) A decreased fluid intake of 50% or greater over a period of 24 hours in infants and very young children
- (ii) Acute weight loss exceeding 5% in an infant or very young child
- (iii) Inability to rouse the child
- (iv) Persistent inconsolable high pitched crying or a weak cry with drowsiness
- (v) Dyspnea, which may be accompanied by nasal flaring, supraclavicular retractions and grunting, especially with effort.
- (vi) Petechial or purpuric rash
- (vii) Pallor
- (viii) Faecal blood
- (ix) Sudden onset or persisting acute abdominal symptoms
- (x) Persistent vomiting
- (xi) Bile stained vomiting
- (xii) Convulsions, particularly if no prior history or associated with head trauma
- (xiii) Cold, pale white distal lower extremities and or oral cyanosis
- (xiv) Fever of 40 degrees centigrade or higher, particularly if spiking or associated with a petechial rash of more than 3 days duration whilst the child is taking antibiotics
- (xv) Bone fracture or dislocation
- (xvi) Other orthopaedic emergencies such as slipped femoral capital epiphysis or Perthes' Disease

- (xvii) Gastrointestinal conditions such as intussusception, bowel obstruction or acute appendicitis
- (xviii) Pneumonia or an acute severe asthma attack
- (xix) Head trauma with unresolving headache and/or convulsions, neurological deficits, nasal or otic discharge
- (xx) Meningitis
- (xxi) Moderate to severe dehydration
- (xxii) Acute urinary tract infection. Infections such as Kawasaki disease or acute croup with upper airway obstruction
- (xxiii) Other unknown acute infections
- (xxiv) Acute neurological disorders
- (xxv) Acute unresolving and/or worsening otitis media, sinusitis or tonsillitis

**(C) Subacute:** This group includes many symptoms, which may indicate a serious medical problem. These include, but are not limited to

- (i) Back or neck pain (indicates serious pathology in children until proven otherwise)
- (ii) Headache
- (iii) Visual disturbance
- (iv) New onset strabismus
- (v) Slurred speech
- (vi) Gait disturbance
- (vii) Personality change
- (viii) Unexplained weight loss
- (ix) Persistent vomiting
- (x) Persistent diarrhea
- (xi) Arthralgia/arthritis
- (xii) Recurrent fevers

**(9) Diagnostic Testing for Serious Conditions and for ‘Red Flags’**

**(A) These may include but are not limited to:**

- (i) Vital signs including temperature, heart rate, respiratory rate, weight, height/length, head circumference plus fontanelle size and condition in infants

- (ii) Inability to rouse the drowsy child
- (iii) Cardiovascular tests such as blood pressure, auscultation of the heart and blood vessels, tests for circulatory sufficiency and observation for signs suggestive of cardiovascular disease
- (iv) Pulmonary tests such as auscultation of the lungs and observation for signs suggestive of lung disease.
- (v) Otosopic examination
- (vi) Ophthalmoscopic examination
- (vii) Palpation and auscultation of the GI system
- (viii) Neurological tests including those to determine specific neurological deficits such as MSR, muscle strength, sensory findings and coordination along with tests for general neurological conditions and neuromaturation such as developmental screening tests and infantile automatisms.

**(B)** Chiropractors who do not possess the appropriate training and clinical experience, should refer to an appropriate health professional. If so, referral to an appropriate health professional is required. It is the Board's view that the use of diagnostic instrumentation, such as Surface Electromyography or Thermography, is not considered appropriate in the diagnosis of childhood conditions. (Refer to the Board's Guidelines on sEMG)

#### **(10) Recording the Diagnosis**

**(A)** The diagnostic recording and formulation challenge encompasses the following issues:

- (i) Medico-legal requirements
- (ii) Chiropractic specific functional diagnoses
- (iii) Specific health issues - pathological, pre existing or previously not recognized functional diagnoses
- (iv) Specific health issues, identifiable syndromes and clinical relationships
- (v) Concomitant conditions
- (vi) Symptom recording and physiological evaluation
- (vii) Differential diagnoses
- (viii) Initial diagnosis
- (ix) Ongoing/working diagnosis

- (x) Biopsychosocial issues
- (xi) The natural history of health conditions
- (xii) Formulation of a management plan
- (xiii) Identification of validated clinical outcome measures

**(B)** The nature, severity and prognosis of a paediatric condition may be less static than that of an adult. Information conveyed must not be misleading and must not be constructed to distress the parent or patient.

### **(11) General Principles in the Treatment of Children**

**(A)** All treatment should be based on an appropriate working diagnosis and any potential benefit should be weighed up against any potential harm. Treatment should be based on the best scientific evidence available, including non-chiropractic therapy, and the natural history of the condition being treated.

**(B)** The underlying objective of treatment should be based on the welfare of the patient – as mandated by The Health Professions Registration Act 2005 (Vic).

**(C)** Potential scenarios following the initial history and examination:

- (i) Referral – due to identification of a ‘red flag’
- (ii) Referral to another health professional where the condition is outside the scope of chiropractic therapy and/or the expertise or training of the chiropractor
- (iii) Acute Care Treatment
- (iv) Rehabilitation Treatment
- (v) Supportive Treatment
- (vi) Discharge or referral, due to success or failure of care plan

### **(12) Procedures in the Physical Treatment of Children**

**(A)** The following aspects need to be taken into consideration when adjusting or manipulating the paediatric patient:

- (i) Patient size: The smaller the patient the less the force to be applied. There is a greater need for specificity and contacting only the necessary area/segment.

- (ii) Anatomical developmental variations: Manipulative or adjustive procedures must cater for developing spine and skeleton in the child. For example, the mastoid process in infants is not yet ossified, therefore, occipital adjustments should be superior to this region. Adjustment of the sacroiliac and lumbar spine should not involve the extension of the hip.
- (iii) Increased flexibility: The paediatric patient has greater overall flexibility of spinal and other joint structures and less muscular resistance/protection. Therefore, the use of gentle, precise, shorter lever techniques, or appropriately modified mechanically assisted manipulations or adjustments, would be more appropriate than manual techniques utilising long lever forces, particularly of the cervical spine, or those that involve extreme ranges of motion e.g. supine or prone rotary breaks. Treatment should be performed in the most gentle and non-confrontational way. Parental involvement could be utilised by using the parent to stabilise and/or comfort the child during treatment.
- (iv) Hypermobility. The commonly hypermobile joints of the paediatric patient, particularly the knees and shoulders, should NOT be manipulated or adjusted.

### **(13) Scope and Appropriateness of Care**

**(A)** Many paediatric musculoskeletal conditions are amenable to chiropractic care, either alone, or in conjunction with other health care professionals.

**(B)** Care or advice for non-musculoskeletal conditions (such as nutrition, exercise, infant feeding, toileting regimes/use of charts) requires more than just chiropractic adjustments or manipulations. Referral to an appropriate health professional is required unless the Chiropractor has relevant and adequate training and experience in the provision of care or advice in such areas.

**(C)** Some parents seek chiropractic care for “Type O” conditions for their children. The Board is of the view that there is currently an overwhelming lack of good quality scientific evidence to support the use of spinal manipulation in the treatment of most of these conditions. Should a complaint be made against a chiropractor, which relates to the treatment of such conditions, then it is incumbent on the practitioner to demonstrate

to the Board that the treatment provided is substantiated by sound scientific evidence of efficacy.

#### **(14) Planning and Management of Paediatric Care Plans**

(A) Planning chiropractic management of children, consideration should be given to:

- (i) Chiropractic care alone may be insufficient and adjunctive procedures and/or involvement of other health care professionals may be warranted
- (ii) The frequency and duration of care for children is usually less than that required for an adult
- (iii) Improvement of adverse signs and symptoms in children usually occurs more quickly than for adults
- (iv) Informed consent requirements mean that parents should be provided with information about the proposed treatment and any possible adverse effects, including any adverse side effects, and any alternative treatment options.

(B) Whilst a preventive or health promotion focus is to be encouraged at a population level (e.g. advice on healthy lifestyle, injury prevention), active treatment in the absence of convincing clinical reasons is not considered necessary to maintain good health. Whilst the consumer has a right to choose, parents are often anxious about their children's current and future health. The subsequent potential for exploitation of this parental anxiety may result in the provision of unnecessary services. Regular chiropractic checks or treatment of children without symptoms or signs are not supported by current scientific evidence and is viewed by the Board as unnecessary and inappropriate.

#### **(15) Screening Children for Health Problems**

(A) 'Screening' for health problems may be associated with harms such as false positives which may generate anxiety, resulting in unnecessary treatment.

(B) The results of any test or procedure used with screening must be valid, reliable, and reproducible.

(C) It is not appropriate for the health professional who conducts a public screening to offer to provide intervention for identified problems - this represents a conflict of

interest. Further, chiropractors must have the pre-requisite training and experience in the conditions being investigated in such screenings.

**(16) Special Considerations for Management of Neonates**

**(A)** The practitioner should be especially mindful of:

- (i) The importance of obtaining a comprehensive case history from the parent
- (ii) The clinical presentation is more likely to be non-musculoskeletal in nature, such as colic.
- (iii) Obtaining specific and objective measures is a complex process, requiring competency and experience.
- (iv) A distressed parent of a distressed neonate is often vulnerable
- (v) There is a paucity of quality research in relation to chiropractic interventions.
- (vi) Possessing the required level of training and experience in diagnosis and treatment of non-musculoskeletal conditions of the neonate
- (vii) The available evidence substantiating chiropractic interventions
- (viii) The appropriate sections of this document with respect to:
  - (a) Scope and Appropriateness of Care
  - (b) Planning and Management of Paediatric Care Plans
  - (c) General Principles in the Treatment of Children
  - (d) Other published Board Guidelines

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