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II. Documentation of hands-on techniques past and present.

A. History of the hands-on nomenclature and documentation:

The practice of hands-on treatment regroups different families of technique which have been classified in earlier chapter as

- HVLA (High Velocity Low Amplitude Hands-on Treatment)
- LVHA (Low Velocity High Amplitude Hands-on Treatment)
- LVLA (Low Velocity Low Amplitude Hands-on Treatment)

HVLA Hands-on treatment may address the treatment of the spine (SMT: Spinal Manipulative Therapy) or the extremities (EMT: extremity manipulative therapy). The categorization of HVLA spinal manipulation (involving a thrust) seemed important as it usually requires a higher precision by the doctor for its adequate application and the clinical implication of a poor performance is more serious.

Several things may be documented in the practice of HVLA Hands-on Treatment of the spine: the vertebral positioning (listings) and the technique itself.

This latter is a field which has been poorly addressed for many years.

HVLA were performed mostly among two professional groups: Chiropractors and Osteopaths.

Documentation of HVLA in the chiropractic profession

Most doctors using HVLA vertebral manipulation cannot duplicate the technique performed by a colleague on a patient by solely relying on the colleague's notes; the technique used for treatment is rarely documented for others to duplicate.

Up until now, the major documentation was involving what is commonly called **a spinal listing** and consists of a nomenclature describing abnormal joint position and movement and written in various abbreviated formats.

Doctors have assumed that the position of the vertebrae was the most clinically relevant factor for the patient; nothing was mentioned on **the technique** used to correct the listing.

This idea of relegating the technique used as of secondary clinical value is challenged by the author who feels that **it the most important clinical data, the one directly pertaining to the treatment**; it should be documented extremely well for the simple fact that the same listing may be corrected by many different techniques, and not all of them will bring the same result.

Some chiropractic authors have approached classification of techniques through either publications or conference^{1f}. No system has been proposed up until now for daily use.

Most of the names used for chiropractic techniques in chiropractic colleges are partially descriptive in a certain way of the positioning adopted either by the patient or the doctor, and many colleges have created proprietary notes for their students, such as Chicago² and New York College.³ This resulted in the use of different names between different colleges to describe very similar adjustive techniques. To communicate among themselves, chiropractors from different schools had and still have to use names given by the organizers of national private seminars such as Gonstead⁴, motion palpation⁶ or by companies selling chiropractic equipment⁷. If someone never attended any seminars and had only his regular chiropractic college education, there is a good chance that unless he demonstrates the technique, his listener will not know what he is talking about.

Documentation of HVLA in the Osteopathic Medical profession:

The osteopathic profession⁸ has no better track record, with the important nuance that manipulation is not the main bread and butter of an osteopathic practitioner.

The mainstream medical profession in the USA and abroad at large is more interested in manipulation as an adjuvant to other therapies; furthermore, the medical profession has a tendency to minimize the importance of specificity. Consequently, the exact reproducibility of the technique loses most of its clinical interest for a medical doctor. Some medical authors are even extremely critical of the use of specific adjustments, such as the Cyriax school of thought⁹: ***“The method that claims to lead to specific localization in both diagnosis and treatment are scientifically unacceptable”***. Other medical authors, such as R. Maigne,¹⁰ have described semi-specific manipulative techniques as initially used by chiropractors without giving them a standard classification. The medical profession, as other professions, has not developed a standardization of manual techniques.

^{1f} Kevin M. Bartol (June 1993) presented his system of classification at the Seattle, Washington, conference in 1990. The Bartol classification for the categorization of techniques was based on the method of delivery. The big problem of this classification: it did not serve much the purpose of documenting SOAP notes in the daily practice of a doctor; the classification was organizing an algorithm of chiropractic techniques for academic and research purposes. Furthermore, the Bartol classification created groups but did not attribute a name to each technique.

² Chiropractic Techniques, Supplement to States copyright 1975 National College of Chiropractic

³ DeGiacomo F.P: Textbook of Chiropractic Technique, LSR Learning Associates, Inc. Plainview, New York, 1981.

⁴ Herbst Roger: Gonstead Chiropractic Science and Art. SCI-CHI Publications

⁵ Plaugher Gregory: Textbook of Clinical Chiropractic, Williams & Wilkins, Maryland 1993.

⁶ Schafer & Fay: Motion Palpation and Chiropractic Technique 2nd edition, Motion Palpation Institute, Huntington Beach CA, USA, 1990.

⁷ Kim Christensen, Clinical Chiropractic Biomechanics, Educational Division Foot Levelers Inc, 2nd Edition, Dubuque, Iowa, U.S.A 1984.

⁸ Greenman Philip. E.: Principles of Manual Medicine, Second Edition, Williams & Wilkins, Maryland 1996

⁹ Ombregt, Bisschop, Ter Veer, Van de Velde: A System of Orthopaedic Medicine, page 82 WB Saunders Company, 1995.

¹⁰ Maigne Robert: Douleur d'origine vertebrale et traitements par manipulations, Expansion Scientifique Francaise, Paris, 1977

In conclusion, HVLA is not documented with enough precision for duplication by any of the professions currently using it at large.

What about the documentation rendered for LVHA and LVLA?

Those techniques are slower and accordingly they are perceived as less aggressive to the patient. Their documentation is always general in nature.

The categorization of LVHA and LVLA manipulation seems less important as it usually requires less precision by the doctor/therapist for their adequate application and the clinical implication of a poor performance is more obscure. Physical therapists practice them among other things for rehabilitation of injured extremities.

They include broad spectrum of hands-on techniques and the few examples below are designed just to outline their wide diversity:

Example 1 of LVHA: Low Velocity High Amplitude Hands-on treatment:		
passive range of motion at the knee		
Picture of pt sitting knee flexed	Picture of pt sitting Knee extended	
Process to perform technique above:		
Example 2 of LVHA		
Patient passive, doctor active: stripping of muscle using special instrumentation		
Example 3 of LVHA: Low Velocity High Amplitude Hands-on treatment:		
Patient active, doctor active: stripping of muscle using only the doctor's thumb		
Picture of pt Using thumb to release shoulder	Picture of pt sitting Knee extended	
Example 4 of LVHA: Low Velocity High Amplitude Hands-on treatment:		
Post neural facilitation to stretch the hamstrings		
Pat supine step1	Pt supine step 2	

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In the physical therapist SOAP notes, usually little is indicated of the patient's position or of the doctor's position, but such information is not as important in LVHA LVLA as the clinical response is at large much less dependent on factors such as the doctor's position.

Example of LVLA: Low Velocity Low Amplitude Hands-on Treatment		
Picture of pt on block	Picture of pt receiving trigger point therapy with a tool	

The practice of hands-on technique across profession and even inside a single profession stays undocumented from most of the notes produced. It is still impossible to duplicate a treatment from the notes generated by a doctor/therapist. There is not a universally accepted system of recording hands-on technique. This results in a situation a bit similar to what was the naming of plants in the middle age a different name for each region; as a result, the pharmacopeias (mostly derived from the plants) stayed stagnant for centuries.

The development of a plant classification resulted in the development of modern allopathic treatment.

Historical analogy with the binomial nomenclature (nomenclature of the living organism):

In 1758, Carl Von Linnaeus established the system of binomial nomenclature, which later was accepted as a worldwide standard to name any kind of living entity. Suddenly, it permitted scientists to communicate with ease and prompted the modernization of research. What is binomial nomenclature? It is a shorthand, two-part naming system (genus and species) used for identifying specific organisms. These names usually include some Latin and often describe some characteristic of the organism¹¹.

Previously, there had been no clear-cut distinction between the name of a species and its description.

The manipulative profession has encountered the same problem for the past hundred years, with no clear-cut distinction between the name of a technique and its description. The same technique may be called by a different name, depending on the school or the profession using it. No real study can be performed on the effectiveness of any technique, as it is impossible to know exactly what is talked about. Lawrence, one of the most published chiropractic authors stated "....one of the greatest challenges facing the chiropractic profession today is simply to

Commented [1]: these two sentences sound the same??

¹¹ The rules of nomenclature are codified in the *International Code of Zoological Nomenclature* (3rd edition) published by the International Commission on Zoological Nomenclature in 1985

learn how to communicate with one another.”¹² It has been one of the single most frustrating impediments to the development of many branches of the manipulative field. There is high hope that a clear system of codification will bring, not only to the manipulative field but also to the rehabilitative field, the much-needed outcome assessment based on technique type.

The DuBarry System introduces a system of classification based on seven main variables, which also could be called a septanomial system, by analogy to the Linnaeus system. This septanomial system should evolve as the years go by as did the *Systema-Naturae* of Linnaeus which grew from a slim pamphlet into a multivolume work.

B. Basic principle of a technical chart:

What is a technical chart?

In a single document, the technical chart regroups different chiropractic techniques that we may use on any patient in our office. The patient or the insurance company may ask for this document at any time.

It gives a standard name with a biomechanical description to any technique used in our office. It assigns a proprietary number to each of the techniques used.

It is the same chart which is used and photocopied for all our patients.

It requires the use of a computer only once a year.

What is the purpose of a technical chart?

With a single number entered in our SOAP notes, the technical chart documents the techniques performed on a patient that day.

By matching the numbers in our daily SOAP notes with our technical chart, anyone can duplicate the positioning of the technique performed on a given day. (Anyone means you, the doctor, the insurance company, etc..)

Why should you use a technical chart?

1. For the doctor:

It saves a great deal of time.

It increases precision, security, and professionalism to an unequalled level.

It is the most cost-effective solution available.

It is the only effective way for doctors from different schools to communicate about a patient anywhere in the world.

It allows the doctor to take time off and still maintain continuity in the care of his own patient while his practice is covered.

It allows the doctor to refer out to another doctor without the need to call and explain what was done.

It brings security as it offers the best shield against malpractice claims.

It brings a faster reimbursement with less denial as it shifts the burden of proof from the doctor to the insurance company.

It is the only universal system currently existing in the world.

¹² Lawrence D. Editorial: Toward a common language. J Manipulative Physiol Ther 1988; 11:-2

2. For the patient:

The continuity of treatment is warranted even if the patient changes doctors; this is extremely important in a managed care society where patients change health plans with every new job. In the new fast-growing multi-doctor practice, the patient is guaranteed the same continuity of treatment no matter which doctors treat him. The patient can carry the technical chart from his/her doctor's office with him/her as he/she travels.

3. For the insurance company:

It allows the carrier to standardize chiropractic documentation for better outcome assessment and better peer-review, in a word: better management. It allows the carrier to shift a patient between doctors and still keep continuity in the treatment of the patient. It allows doctors from different fields to communicate; an osteopath, a medical doctor, a physical therapist can all have a fair idea of what has been performed on this patient by a chiropractor. It permits the chiropractic management company to better market its service to the health insurance company by truly managing the documentation.

4. What about an office that does not use the technical chart?

Over 95% of all chiropractic doctors do not document the adjustment or manipulation performed on a patient (this is an estimate from the author experience as no statistical data is currently available on this subject); 80% will not remember what was done two weeks later, the vast majority can describe what they did only through the phone and not in writing. Finally, the same vertebrae or articulation can be treated with many different techniques. Each technique may give a different result, but still nothing is entered to this effect in the daily notes.

	For a more complete description in PP of this classification	https://vimeo.com/202306845 https://drive.google.com/file/d/0B7yIRwWbLJ0IcS1MNVFBUThHekE/view
Comments		

III. Documentation using the simplified “DuBarry System” of Classification of Hands-on techniques (using 7 variables)

- It will describe for duplication any Hands-on technique: HVLA, LVLA, LVHA so it may bring a communication tool for any hands-on technique used by a chiropractor, Physical Therapist or Osteopath.
- It consists of seven primary variables all separated by a slash mark.
- Whatever the technique described, there should be a total of seven slash marks in the name.
- Directly below, and for each primary variable, there is a secondary variable, separated from the top primary variable by a horizontal line such as in a mathematical fraction.
- This name can also be presented in a **seven-column table with two rows**. The superior will be called the numerator (primary variable), the inferior row denominator (secondary variable).
- **Primary variables** are the “most significant” variables used in the description as a hands-on technique; the “less significant” ones are called **secondary variables**.
- By convention, the primary variables are used **at the top of each column** (numerator location), while the secondary variables are used at the bottom (denominator location).
- The most “significant” variables will depend primarily on the body part being treated; those body parts are divided in two groups: the **core** and **the extremities**. The core is inclusive of the spine, the head, and the pelvis.

For reason of simplicity, in the next chapter, “**Understanding How to Read the Simple Name of a Hands-on Technique**” gives the reader a quick approach to name a sitting thoracic technique used by most chiropractors. This description is not complete but enough to start with the system and still offers a good differentiation.

In the following section, “**Describe Any Hands-on technique**” will give every precision to be inclusive of any technique.

A. Simplified system to name a technique on a seven variables base

The practice of hands-on treatment regroups different families of technique which have been classified as

HVLA (High Velocity Low Amplitude Hands-on Treatment)
LVHA (Low Velocity High Amplitude Hands-on Treatment)
LVLA (Low Velocity Low Amplitude Hands-on Treatment)

Those techniques are very different but using the same system to classify them all would be helpful in many ways.

B. What is the Main Interest of this Classification?

There is the need to compare different techniques side-by-side to rate their respective effectiveness regarding a condition, their appropriateness for a specific patient, doctor's morphology, or their easiness to be applied. This cannot be accomplished if we do not have a way to name a technique on paper.

The full classification addresses every hands-on treatment for every part of the body and allows for the writing of a technical name for each technique, which enables the reader to differentiate one technique from another.

This whole classification system is much more complex than the one currently presented in this shortened chapter. This shortening has been done knowingly for the purpose of simplicity to first address the technique of this book, and then to give the reader the appetite to go further.

A more complete description is available as a PowerPoint presentation and the electronic version of the complete system is built-in the software DocuRehab (www.docurehab.com).

C. Technique Name:

Consists of **seven** primary variables all separated by a slash mark.

Whatever the technique described, there should be a total of **six slash marks** in the name delimiting seven interspaces.

*****/**/**/**/**/**/****

This name can also be presented in a seven columns table.

a.

--	--	--	--	--	--	--

The most "significant" variables will depend primarily on the body part being treated.



This is the first space in the technique name, and it is made of a variable. The responses to a question will establish the name of the variable.

--	--	--	--	--	--	--

sitting /*******/*******/*******/*******/*******/*******

--	--	--	--	--	--	--

What is the position of the doctor in space?

The response to this question gives us the first main variable. It will fill the top row of the second column.

The doctor can be seated, standing back, standing front, squatting, Heron stance, fencer stance, etc...

Commented [2]: heron stance? i cannot find this on google, and have never heard of it

sitting / standing back /*/***/***/***/*****

C. Patient's Contact

This is the third column in the technique name.

The variable of the third column will respond to the following question:

--	--	--	--	--	--	--

What is the primary patient contact?

The “primary patient contact” is the contact taken nearest to the anatomical area being treated.

This contact can be a bony landmark or an anatomical landmark.

Many contacts exist: thoracic vertebrae, thoracic spinous process, thoracic articular process, etc...

sitting / standing back / thoracic/*/***/***/*****

D. Doctor's Contact

This is the fourth column in the technique name.

The variable of the fourth column will respond to the following question:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the primary doctor's contact?

The “primary doctor contact” is the contact on the doctor’s hand or body part taken nearest to the anatomical area being treated.

Index, calcaneal, pisiform, sternum, etc.

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sitting / standing back / thoracic / sternum /*/***/*****

If the doctor uses an instrument to create the motion, then the type of instrument used is described.

E. Patient's Movement (if any):

This is the fifth column in the technique name.

The variable of the fifth column will respond to the following question:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the primary movement that the patient is instructed to perform?

In the case of HVLA, the patient's movement is fully passive and exceedingly small. Accordingly, this field is left empty, but remember in the name, we will see two slash marks with nothing in between.

sitting / standing back / thoracic / sternum / /*/***/*****

F. Doctor's Movement

This is the sixth column in the technique name.

The variable of the sixth column will respond to the following question:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the primary movement of the primary doctor contact?

In the case of the thoracic, it will be: push, pull, lift, etc...

sitting / standing back / thoracic / sternum / / lift /*/***/*****

G. Patient's Final Position

This is the sixth column in the technique name.

The variable of the seventh column will respond to the following question:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the final position from the patient's initial core position?

In the case of an HVLA technique (manipulation, adjustment), because there is almost no motion from the pre- to post-thrust position (Low Amplitude), this field is left empty.
Remember: in the name we will see the last slash mark with nothing after.

sitting / standing back / thoracic / sternum / / lift /

To know how to visually “see” the technique from a name written with this nomenclature, you just need to remember the different sequential steps to perform a manipulative technique:

1. Patient Position
2. Doctor Position
3. Patient Contact
4. Doctor Contact
5. Patient Movement
6. Doctor Movement
7. Patient Final Position

A few more rules.

- If the patient's initial position is the same as its final position, then the final position is not mentioned in the name and left blank.
- If there is the need for a sub-variable in order to better define the primary variable, then a line is drawn below the primary variable and the sub-variable or secondary is placed below as in the quotient of a fraction.

The interest of such a nomenclature are multiple:

You can organize techniques by family:

Sitting / / / / / Supine	Describe all the techniques which start with the patient seated and ends with the patient supine.
Sitting / Standing / / / /	Describe all the techniques which start with the patient seated and the doctor standing.
$\frac{\text{standing}}{\text{Arm crossed}} / \text{Standing} / / / /$	Describe all the techniques with the patient standing, arms crossed and the doctor standing.

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	Interest of a family of technic	https://vimeo.com/345294659/f9404b1c4c
Comments		

D. The main thoracic techniques described with their name:

Standing
Crossed arms / Standing
Behind / Thoracic / Sternum // Traction /



Standing
Hands on neck / Standing
Behind / Thoracic / Sternum // Traction /



Standing
Fists on lumbar / Standing
Behind / Fists / Abdomen // Traction /



Standing
Crossed arms / Standing
Front / Thoracic / Fist // Push /



Sitting
Crossed arms / Standing
Behind / Thoracic / Sternum // Traction /



Sitting
Hands on neck / Standing
Behind / Thoracic / Sternum // Traction /



Sitting
Hands on neck / Standing
Behind / Thoracic / knee // Traction /



Sitting / Standing
Back / Thoracic / Index // Push /



Prone / Standing
At Side / Thoracic / Thumb // Push /



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Prone / $\frac{\text{Standing}}{\text{At side}}$ / Thoracic / Bi-thenar // Push /



Supine / $\frac{\text{Standing}}{\text{At side}}$ / Thoracic / Bi-thenar // Push /



Supine / $\frac{\text{Standing}}{\text{At side}}$ / Thoracic / Fist // body drop /



Assis / $\frac{\text{Standing}}{\text{At side}}$ / Thoracic / 2 fist // Unroll / supine



$\frac{\text{Supine}}{\text{Bridge}}$ / $\frac{\text{Standing}}{\text{At side}}$ / Thoracic / Bi-thenar // Push /



$\frac{\text{Supine}}{\text{Flexed knee}}$ / $\frac{\text{Standing}}{\text{Knee inserted}}$ / Thoracic / Bi-thenar // Push /



IV. Documentation using the full “DuBarry System” of classification of hands-on techniques (using 14 variables).

A. Patient initial position

This is the first column in the technique name, and it is made of several variables. The responses to several sequential questions will establish the name of those variables.

Those variables will be entered by order of importance starting from the top row of the column.

Variable of the top row of the first column will respond to the following question:

1	2	3	4	5	6	7

1. Are we treating an area of the core or of the extremities?

- If it is the core, then what is the position of the core? We will describe a spatial position of the core, such as: seated, standing, prone, supine, etc.

Patient positions: primary options of the core			
			
Standing	Wall standing	Square stance	Standing butterfly
			
Standing surrender	Prone	Supine	Supine curl
			
Supine tent	Supine bridge	Seated	Saddling
			
Side lying	Knee Chest		

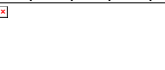
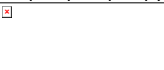
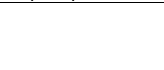
- If it is an extremity, then **what is the position of this extremity?** We will describe a spatial position of this extremity such as: neutral, flexed, extended, etc.

2. Variable of the bottom row of the first column will respond to several questions:

1	2	3	4	5	6	7

To describe the patient position secondary variable:

- If we are treating an area located on the core:
We need to ask ourselves and respond to the following question:
What equipment was used to bring this patient to this spatial position?
It can be a bench of different height, a Hi-Lo table in different positions, a chair, or just nothing.

Patient position: secondary options			
			
TL down P updrop The thoracolumbar piece is down and the pelvic piece is up with the drop cocked.	TL downdrop P updrop The thoracolumbar piece is down with the drop cocked, and the pelvic piece is up with the drop cocked.	TL up P downdrop The thoracolumbar piece is up, and the pelvic piece is down with the drop cocked.	TL updrop Pdowndrop copy
			
TL updrop Pupdrop copy	TLup Pupdrop copy	TLupdrop Pdown	
			
Cox table	Leander table		

- If we are treating an extremity:
We need to ask ourselves and respond to the following question:
what is the position of the core?

B. Doctor Position

This is the second column in the technique's name, and it is made of several variables. The responses to several sequential questions will establish the name of those variables.

Those variables will be entered by order of importance starting from the top row of the column.

Variable of the top row of the second column will respond to the following question:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the position of the doctor in space?

The response to this question gives us the first main variable; it will fill the top row of the second column.

The doctor can be seated, standing, squatting, ect.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Seated	Square stance	Fencer stance	straddling
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lounge stance	Heron stance	Kick start stance	

Variable of the bottom row of the second column will respond to several questions:

1	2	3	4	5	6	7
---	---	---	---	---	---	---

What is the position of the doctor body in relation to this patient?

The response to this question gives us the second variable; it will be the beginning bottom row of the second column.

To answer this question, we may need to know the position of the patient:

A. If the patient is sitting or standing, then the doctor is in front, in back or on the side of his patient.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back	Back 45	Side 90	

B. If the patient is prone or supine, then by convention the patient's body is divided into three areas. The doctor's body can be at:

The Cephalad level (abbreviated with the letters **CE**)

The Middle level (abbreviated with the letters **MI**)

The Caudad level (abbreviated with the letters **CA**)

What is the orientation of the doctor's body in relation to the orientation of the patient? Or in other words: toward which direction is the doctor facing?

There are four main directions that the doctor can face:

Facing the Cephalad direction (toward the patient's head), abbreviated with the letters **CE**

Facing the Caudad direction (toward the patient's feet), abbreviated with the letters **CA**

Facing the Medial direction (toward the patient's body), abbreviated with the letters **ME**

Facing the Lateral direction (away from the patient's body), abbreviated with the letters **LA**

What is the angle of the doctor's body? Or in other words:

What is the angle created by the sagittal plane of the patient's body, and the sagittal plane of the doctor's body?

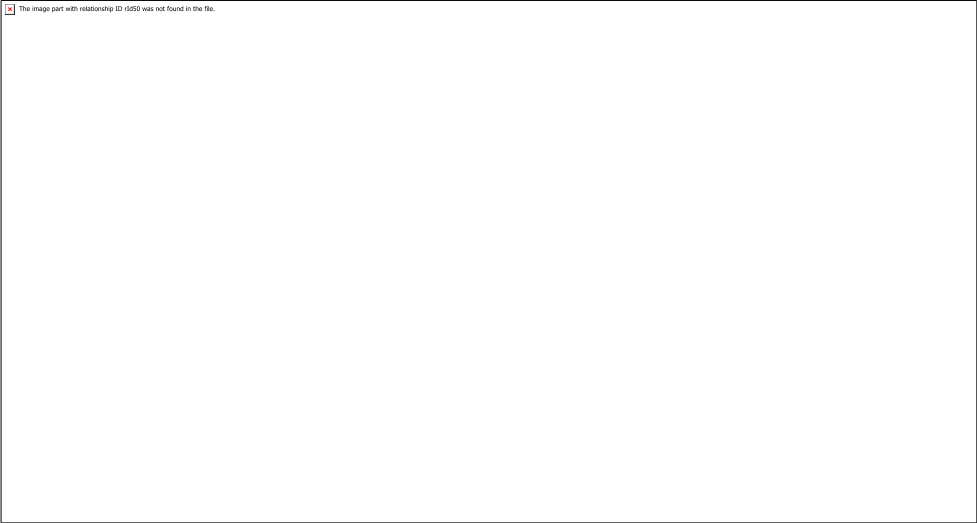
By convention, only three angles have been retained as important:

0 degree

45 degree

// Parallel

Commented [3]: in the red text next to the picture, it should be "anatomical"--unable to edit for some reason



The bottom row of the 2 nd column = doctor position in relation to his patient	
	Cephalad Facing Caudad 45 or CEFACA 45 Doctor's position in relation to the patient's anatomical area Angulation in relation to this vector

Commented [4]: unable to read table d/t overlapping

	CEFACA 0 Cephalad Facing Caudad		CEFACA //
	CEFACA 45		CEFACE
	CEFACA 90		

Cervical module: p 22

	CAFECE 0		CAFECE //
	CAFECE 30		
	MEFAME 90		MEFACA 45
	MEFACE 45		MEFACA //
	MEFACE //		

Summary for describing doctor's position step by step

1. To describe the doctor's position (primary variable): we need to ask ourselves '**What is the position of the doctor in space?**'
The doctor can be seated, standing, lying down, etc...
2. To describe the patient position (secondary variable), we will define what is the position of the doctor's body in relation to the patient's body position. This description is done in three parts:
Part A: Defining the patient's position, ask the question: **what is the position of the patient's core in space?**
 1. If the patient is sitting or standing, then the doctor is in front, in back, or on the side of his patient.
 2. If the doctor is prone or supine, then by convention the patient's body is divided into three areas. The doctor's body can be at:

- a. The Cephalad level (abbreviated with the letters **CE**)
- b. The Middle level (abbreviated with the letters **MI**)
- c. The Caudal level (abbreviated with the letters **CA**)

Part B: ***Toward which direction is the doctor facing?***

If the patient is prone or supine, there are four main directions that the doctor can face; in other words, the doctor will face a certain direction.

Facing the Cephalad direction (toward the patient's head), abbreviated with the letters **CE**

Facing the Caudad direction (toward the patient's feet), abbreviated with the letters **CA**

Facing the Medial direction (toward the patient's body), abbreviated with the letters **ME**

Facing the Lateral direction (away from the patient's body), abbreviated with the letters **LA**

Part C: ***What is the angle created by the sagittal plane of the patient's body, and the sagittal plane of the doctor's body?***

Three angles have been retained as important:

0 degree

45 degree

// Parallel

C. Patient contact

What is the primary patient contact?

1	2	3	4	5	6	7
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The "primary patient contact" is the contact taken nearest to the anatomical area being treated.

This contact can be a bony landmark or an anatomical landmark.

What is the secondary contact?'

1	2	3	4	5	6	7
---	---	---	---	---	---	---

- The “secondary contact” is away from the “primary contact”.
- A “secondary contact” can be active and participate in the dynamic of the movement; in this instance, it will be called “active secondary contact”.
- A “secondary contact” can also be passive, and not participate in the movement dynamically, but just stabilize a patient’s body part; in this instance, it is called “passive secondary contact”. It is a synonym on the doctor’s side of indifferent hand contact, passive hand contact, or stabilizing hand contact.
- There may be only one “secondary contact” or several “secondary contacts”; in this case, we speak of secondary and tertiary contacts. The contacts are then ranked in relation to their functions, starting with the question “which one is active?” and if not sufficient, asking the next question, “which one is the strongest?”
 1. First active contact is ranked before passive contact.
 2. The contact involving the most force is ranked before the contact involving less force.
- By convention, in the DuBarry System, an “active secondary contact” will always be described before a “passive secondary contact”.

The contact can be either on the doctor or on the patient. Some publications use the phrase **Contact Point**, or the abbreviation **CP**, to describe the contact by the doctor, and the words **Segmental Contact Point**, with the abbreviation **SCP**, to describe the contact on the patient. I find those abbreviations confusing, as they do not mention the doctor or the patient, and I far prefer the abbreviations **doctor contact** and **patient contact**. Those are the abbreviations used in the DuBarry System and in the software.

D. Doctor Contact

What is the primary doctor’s contact?

1	2	3	4	5	6	7

The “primary doctor contact” is the contact on the doctor’s hand taken nearest to the anatomical area being treated.

If the doctor uses an instrument to create motion, then the type of instrument used is described.

The various contacts have been classified in several categories:

- Simple anatomical landmark

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- Compound anatomical landmark
- Metaphoric contact description
- Instrumentation for contact

The secondary doctor contacts:

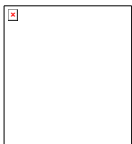
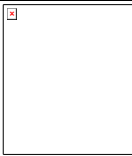
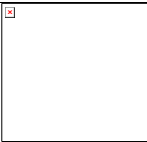
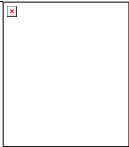
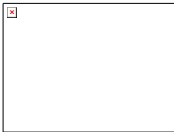
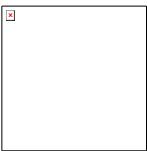
What is the secondary doctor's contact?

1	2	3	4	5	6	7

Will first describe the secondary active doctor contact, if this contact is not present, it will describe the secondary passive doctor contact.

These options are classified in four categories:

- Simple anatomical landmark
- Compound anatomical landmark
- Metaphoric contact description
- Instrumentation for contact (can be an Activator, an Arthrostim)

Example of Doctor's Contact				
Finger tuff	Finger tuff hook	Finger tuff assisted	Finger tuff hook assisted	
				
Thumb tuff	Thumb screw	Edge index DIP	DIP Gun	
				
PIP Gun Contact	Calcaneal	Assisted pisiform (toggle recoil)	Finger plier	
				
Cradle	Chin-traction grip	Hand grip	Ear cupping	
				
Scratch hand	Mastoid finger hook	Finger-fanned		
				

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E. Patient movement (if any):

1	2	3	4	5	6	7

In the case of HVLA, the patient's movement is fully passive and very small; accordingly, this field is left empty.

In the case of LVHA (Low Velocity High Amplitude), the patient movement is more substantial, and this field should be filled. This is used to describe rehab exercises one-on-one.

Primary:

What is the primary movement that the patient is instructed to perform?

1	2	3	4	5	6	7

Secondary:

What is the quality or secondary characteristic of the movement performed by the patient?

1	2	3	4	5	6	7

F. Doctor movement

1	2	3	4	5	6	7

What is the primary movement that the doctor performs?

b.

1	2	3	4	5	6	7

With the HVLA, this is the main motion induced during the thrust with the most common being:

In the cervical: traction, rotation

In the thoracic: traction, compression, rotation

In the lumbar: axial traction, flexion, rotation

With LVLA, this motion can be:

Resistive in the case of isometric exercises.

What is the quality or secondary characteristic of the movement performed by the doctor?

1	2	3	4	5	6	7

With the HVLA, this is the secondary motion induced during the thrust.

G. Patient final position

1	2	3	4	5	6	7

The final position is considered identical if a HVLA has been performed and the patient's body motion is very small; accordingly, the field will stay empty.

With Low Velocity High Amplitude movement such as in rehab exercises, this field will be always filled. Example: with a rehab of the elbow, we will have the "patient initial position" as flexed and the "final patient position" as extended.

1	2	3	4	5	6	7

1	2	3	4	5	6	7

In the case of an HVLA technique (manipulation, adjustment), because there is almost no motion from the pre- to post-thrust position (Low Amplitude), this field is left empty.