



PROFESSIONAL NOTES

New Research Results – Chronic Back and Leg Pain

New data from a major US back pain study show that patients with chronic back pain and referred leg pain below the knee – a group often excluded from trials of manipulation – have significantly better results under usual chiropractic care than usual medical care.

This is in terms of both reduced pain severity measured by Visual Analogue Scale (VAS) and reduced disability measured by the Revised Oswestry Disability Questionnaire. Chiropractic patients did significantly better during the first 3 months and this improvement was maintained during follow-up over 3 years. These results are especially important since this was a large, interdisciplinary, practice-based study principally funded by the US Department of Health and Human Services. Additional funding was from FCER and NCMIC. Further details are:

1. Principal investigators were Mitchell Haas, DC, from the Western States Chiropractic College, Portland, Oregon and Bruce Goldberg, MD, from the Depart-

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WHO GUIDELINES ON CHIROPRACTIC EDUCATION AND PRACTICE

Protection of a Separate and Distinct Profession

A. INTRODUCTION

IN MAY, THE WORLD HEALTH Organization (WHO) – the division of the United Nations responsible for global health and healthcare systems, including providing policy advice to governments on the health professions and manpower or human resources – released its first-ever policy document on the chiropractic profession. This contains draft guidelines on chiropractic education.

These draft guidelines are being reviewed by leaders in chiropractic education worldwide, and other healthcare and government authorities, and will lead to final education guidelines to be published by this time next year. WHO is also preparing guidelines on the safety and effectiveness of chiropractic treatment.

2. Why is this happening and what is its importance to individual chiropractors and the profession? Let's begin to answer those questions with a few facts:

(a) Also in May a medical group in Buenos Aires, Argentina commenced a 200 hour postgraduate course in chiropractic for medical doctors, to be completed over a series of weekends during the period of 8 months to December 2004. The promoters of this course claim it is approved by university authorities in Argentina and WHO's regional body for the Americas, the Pan American Health Organization (PAHO). There are similar courses planned in Europe (e.g. Romania) and Asia (e.g. South Korea).

(b) In Germany last year a US chiropractor Dr. Mark Styers, deciding he knew better than the German Chiropractors' Association, commenced a 12 weekend 432 hour chiropractic program for a category of therapists known in Germany as heilpraktikors. His course, known as the American Institute of Chiropractic,

is offered in Hamburg. Non-chiropractors in Berlin have commenced a Berlin School of Chiropractic.

Since the practice of chiropractic is not separately regulated in Germany, many non-chiropractors claim to offer chiropractic treatment and are willing students for these new programs. There have been more cases of injury following 'chiropractic manipulation' reported in Germany during the past two years than in the rest of the world – but not a single one of these cases has involved a duly qualified chiropractor.

3. These developments are symptoms of the fact that non-invasive manual healthcare, with its comparative safety, effectiveness and high patient satisfaction, is burgeoning worldwide and that chiropractic is seen internationally as the leader in the manual arts. As a result, in the many countries where the practice of chiropractic is not regulated by law, a variety of healthcare providers are able to claim to provide chiropractic education and services. The chiropractic profession will obviously have great difficulty trying to control that situation alone. It must gain the support of the highest authorities possible in protecting the integrity and distinctiveness of chiropractic education and practice.

This indicates the importance of the steps now being taken by WHO to develop technical information on chiropractic education and practice. These arise from a partnership on this matter between WHO and the World Federation of Chiropractic (WFC), and in the context of a broad new WHO Strategy to promote the acceptance and rational use of traditional, complementary and alternative forms of healthcare within national healthcare systems.

This issue of *The Chiropractic Report* provides summary background information on WHO, its developing policies

and activities relevant to chiropractic, and the new draft guidelines on chiropractic training or education that, when finalized, will be influential in Argentina, Romania, South Korea, Germany and with governments in all countries where chiropractic education and practice is not fully established and regulated.

B. WHO

4. The WHO has always been regarded as the most effective and successful arm of the United Nations, and governments throughout the world turn to WHO for advice on health policy and legislation. Its core structure is as follows:

(a) As with the United Nations, WHO's voting members, who provide its core budget, are 192 independent nations and their governments. They are represented by an Executive Board, which meets twice a year, and ministers of health and other government delegates meet once annually at the World Health Assembly in Geneva, Switzerland, in May.

(b) WHO staff are found at:

(i) The administrative headquarters in Geneva, Switzerland.

(ii) Six regional offices – for Africa (Brazzaville, Congo), the Americas (Washington, DC, USA), the Eastern Mediterranean (Cairo, Egypt), Europe (Copenhagen, Denmark), South East Asia (New Delhi, India) and the Western Pacific (Manila, Philippines).

(iii) Doing field work in individual countries, building infrastructure, managing specific programs and completing research.

(c) Just as vital to the success of WHO as its core support of governments is the support of a large network of non-governmental organizations or NGOs. They provide the very substantial extra-budgetary funds, technical expertise and human resources that make many of WHO's programs possible.

For example, the Bill and Belinda Gates Foundation recently gifted \$1 billion to WHO. A large amount of WHO's work in Africa and Latin America is possible because of partnerships with the hospital and healthcare network of the Catholic Church and with World Vision.

NGOs establish informal and working relationships with WHO and then, after some years and if they meet WHO's criteria, are admitted into official relations and may participate in all WHO

meetings, including the Assembly and Executive Board meetings. The World Federation of Chiropractic was given official relations status in January 1997. Currently there are 189 NGOs in official relations, typically representing:

- Charities and religious groups – e.g. World Vision International, OXFAM, the Save the Children Fund.

- Consumer and special interest groups – e.g. International Organization of Consumers Unions, Rotary International, The International Association of Lions' Clubs, International Pharmaceutical Federation.

- Health professionals – e.g. international federations representing chiropractic (World Federation of Chiropractic), dentistry (World Dental Federation), medical doctors (World Medical Association), midwives (International Confederation of Midwives), nurses (International Council of Nurses), physical therapists (World Confederation for Physical Therapy), and many medical specialties (e.g. International Society of Physical and Rehabilitation Medicine, World Federation of Neurology, World Organization of Family Doctors).

(d) Finally, a further part of WHO's structure is a large network of collaborating centers in universities and other centers throughout the world. Each WHO department or program has collaborating centers providing expertise in that field. As yet there is no chiropractic collaborating center.

Ultimately WHO is strong and a respected source of policy because it has the wide and pervasive support in the health sector as described above.

5. Prior to the last 10 years WHO paid little attention to alternative approaches to health care generally, and chiropractic specifically. That changed in the 1990s when two forces came together:

(a) The first, found mainly in the developing world, was what WHO called 'traditional medicine'. This includes traditional Chinese medicine (China), ayurvedic medicine (India), unani medicine (Middle East) and a wide variety of herbal, physical and spiritual healthcare approaches found in Africa and Latin America.

In many countries the majority of people primarily use these traditional medicine (TM) approaches. Leaders from these countries have long called for WHO to put more resources into TM but prior to

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the last decade the Geneva headquarters only had an office of two staff members and minimal funding. Western medicine dominated the organization.

(b) The second force, emerging in the 1990s, was the rise to prominence of complementary and alternative medicine (CAM) in the developed world. New research revealed widespread use and support of chiropractic, acupuncture, homeopathy, naturopathy/herbal medicine and other approaches labelled CAM.

Faced with these two forces, illustrated in Figure 1, WHO's Traditional Medicine Team was finally strengthened. It was now led by Dr. Xiaorui Zhang from Beijing, an influential nominee from China who had previously chaired the Chinese government's National Council for Traditional Medicine. With enhanced funding Dr. Zhang promoted TM/CAM, increased her staff, and in May 2002 launched WHO's first ever policy initiatives expressly supporting TM/CAM – the *WHO Traditional Medicine Strategy 2002-2005* (WHO TM/CAM Strat-

egy). This was formally approved by the Executive Board in January 2003 and by the full Assembly in May 2003, when Dr. Efstathios Papadopoulos of Cyprus, as Secretary-Treasurer of the World Federation of Chiropractic, became the first chiropractor ever to address the World Health Assembly in Geneva. The WHO TM/CAM Strategy, published in WHO's six official languages (Arabic, Chinese, English, French, Russian and Spanish), specifically includes chiropractic, and the new draft guidelines on chiropractic education arise from it. It is available electronically in English at: <http://www.who.int/medicines/library/trm/strategytrm.shtml>

C. WHO TM/CAM STRATEGY

6. The strategy document opens with these words:

Traditional, complementary and alternative medicine attract the full spectrum of reactions — from uncritical enthusiasm to uninformed skepticism. Yet use of traditional medicine (TM) remains widespread in developing countries, while use of complementary and alternative medicine (CAM) is increasing rapidly in developed countries. In many parts of the world, policy-makers, health professionals and the public are wrestling with questions about the safety, efficacy, quality, availability, preservation and further development of this type of health care.

It is therefore timely for WHO to define its role in TM/CAM by developing a strategy to address issues of policy, safety, efficacy, quality, access and rational use of traditional, complementary and alternative medicine.¹

Elsewhere in its Summary of the Strategy, WHO explains that the reasons for the “widespread and growing use” of CAM include “concern about the adverse effects of chemical medicines, a desire for more personalized healthcare and greater public access to health information”.²

7. The Strategy then describes WHO's role and action steps in more detail. Its role is described as:

- Facilitating integration of TM/CAM into national healthcare systems.
- Producing guidelines for TM/CAM.
- Stimulating strategic research into TM/CAM.
- Advocating the rational use of TM/CAM.
- Managing information on TM/CAM.

Specific action steps appear in the Policies and Actions Checklist seen in Figure 2. These include the development of training or education guidelines and the establishment of registration and licensing of providers to support safety, efficacy and quality. The list of NGOs given by WHO as assisting in the TM/CAM

Figure 2. Policies and actions checklist

Safety, efficacy and quality

- Establish registration and licensing of providers.
- Establish national regulation and registration of herbal medicines.
- Establish safety monitoring of herbal medicines and other TM therapies.
- Provide selective support for clinical research into use of TM for treating country's common health problems.
- Develop national standards, and technical guidelines and methodology, for evaluating safety, efficacy and quality of TM.
- Develop national pharmacopoeia and monographs of medicinal plants.

Access

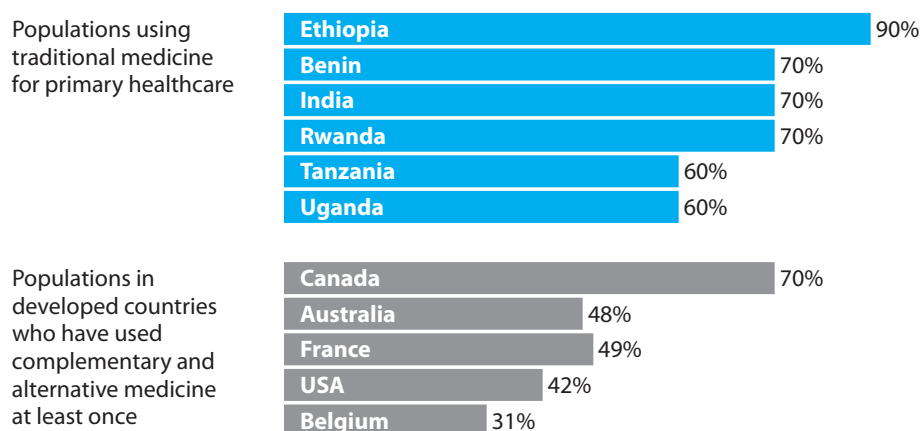
- Identify safe and effective TM therapies and products.
- Support research into safe and effective treatment for those diseases which represent the greatest burden, particularly for poorer populations.
- Recognize role of TM providers in providing healthcare.
- Optimize and upgrade the skills of TM providers.
- Protect TM knowledge through recording and preservation.
- Cultivate and conserve medicinal plants to ensure their sustainable use.

Rational use

- Develop training guidelines for country's most commonly used TM therapies.
- Strengthen and increase organization of TM providers.
- Strengthen cooperation between TM providers and other health care providers.
- Make reliable information on proper use of TM therapies and products available for consumers.
- Improve communication between health care providers and their patients concerning use of TM.

Reprinted from: *Traditional Medicine – Growing Needs and Potential, WHO Policy Perspectives on Medicines, May 2002, WHO.*

Figure 1. Many developing country populations use TM to help meet health care needs, while many populations in developed countries have used CAM at least once



Sources: Eisenberg DM et al, 1998; Fisher P & Ward A, 1994; Health Canada, 2001, World Health Organization, 1998; and government reports submitted to WHO.

Reprinted from: *Traditional Medicine – Growing Needs and Potential, WHO Policy Perspectives on Medicines, May 2002, WHO.*

New Research Results – Chronic Back and Leg Pain

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ment of Family Medicine, Oregon Health and Science University, Portland, Oregon, and the study involved 2,870 acute and chronic patients with low-back pain of mechanical origin. For this study chronic was defined as a current episode of pain of at least 7 weeks duration.

2. Patients received treatment in 51 chiropractic clinics (60 treating chiropractors) and 14 community clinics (111 treating medical doctors in general practice) in Oregon. They received usual care. Salient features of chiropractic care were “spinal manipulation, physical therapy, exercise plan, and self-care education.” Salient features of medical care were “prescription drugs, exercise plan and self-care advice. About 25% were referred for physical therapy.”

3. A practice-based prospective, observational research model was chosen for this unusually large, multicenter study – as opposed to a randomized controlled trial – for two reasons. First, such a practice-based model was appropriate for the research questions being asked (relating to a wide range of normative data on practice patterns – e.g. socio-demographic, psychosocial, health status, economic and care seeking variables) and is appropriate for the long-term follow-up of patients. Second, results from this type of research can more readily be applied or generalized to usual practice in the healthcare system.

4. This trial, for which patients were enrolled over a two year period from 1994 to 1996, has already yielded a number of scientific papers – this most recent paper published in JMPT deals with the important parameters of pain and disability, followed over a period of four years.

5. All groups of patients, acute and chronic, under chiropractic and medical care, improved during the study. For acute patients there was only a modest advantage for chiropractic care over medical care during the first 12 months. However, there were clinically important advantages in pain and disability achieved at 1 and 3 months for chronic pain patients who received chiropractic care.

Most dramatic and clinically important differences were seen for chronic pain patients with leg pain radiating below the knee. Differences between chiropractic and medical patients included an “adjusted mean differences range from 18.2 to 21.7 (on the 100 point VAS) in the first year for pain . . . and 9.7 to 13.9 [on the Oswestry, where 5% improvement is significant] over three years for disability.”

(Haas M, Goldberg B et al. (2004) *A Practice-Based Study of Patients with Acute and Chronic Low Back Pain Attending Primary Care and Chiropractic Physicians: Two-Week to 48-Month Follow-up*, J Manipulative Physiol Ther 27(3):160-169).

Back and Neck Pain – An Important New Systematic Review

Quite apart from the 70 or more randomized controlled trials (RCTs) themselves, there have been over 50 reviews of the trial evidence on the effectiveness of spinal manipulation (SMT) and mobilization (MOB) for back and/or neck pain.

It is tempting to yawn and pass on when hearing of yet another systematic review – there are so many rules for assessing the literature today, and reviewers are so cautious and conservative in their comments. One trial can produce a black and white result, but averaging many of them in a systematic review leads you to shades of grey.

However, in this evidence-based era, strong systematic reviews from leading researchers carry heavy policy significance that can rapidly translate into better or worse access to patients and reimbursement for what you do in chiropractic practice. Therefore clinicians should be aware of an important new systematic review published in *The Spine Journal*, important because:

- It is from established experts, led by Gert Bronfort, PhD DC from Northwestern Health Sciences University, Minneapolis, Minnesota. Dr. Bronfort’s co-authors are Mitchell Haas, DC MA, Western States Chiropractic College, Portland, Oregon, Roni Evans, DC MS, also of Northwestern and Lex Bouter, PhD, from the Vrije University Medical Center, Amsterdam.
- Given the conflicting conclusions of earlier evidence reviews, it reassesses the evidence according to more stringent criteria. For example, an RCT had to have 10 or more subjects receiving SMT and/or MOB to be included, and the main measurement of results “had to be explicitly patient-oriented” (e.g. patient-rated pain, global improvement, low-back or neck disability, recovery time, work loss, medication use and functional health status).

Additionally the review covered all literature not only in English, but also Danish, Swedish, Norwegian and Dutch – representing countries that have produced much valuable research in recent years.

- On the basis of the 43 trials with best scientific ratings and therefore included in the review, Bronfort et al. conclude that “recommendations can be made with some confidence regarding the use of SMT and/or MOB as a viable option for the treatment of both low-back pain and neck pain.” That represents scientific language for saying that the use of chiropractic adjustment, both high-velocity (SMT) and low-velocity (MOB) is evidence-based, appropriate and generally as good as or better than anything else for patients with acute and chronic neck and back pain in the absence of red flags (e.g. fracture, infection, other medical pathology, etc.)

See the full paper for the many specific findings. One, for example, relating to a mixed population of patients with acute and chronic LBP, is that “SMT/MOB provides either similar or better pain outcomes in the short and long term when compared with placebo and with other treatments such as McKenzie therapy, medical care, management by physical therapists, soft-tissue treatment and back school.” The new study from Haas, Goldenberg et al. reviewed above, adds further support to that finding.

With respect to acute neck pain the evidence is currently inconclusive for all treatments because of lack of studies, but for those with chronic neck pain “there is moderate evidence that SMT/MOB is superior to general practitioner management for short-term pain reduction”, and the trials suggest that SMT offers “similar pain relief to high technology rehabilitative exercise in the short and long term.” It is clear from the

evidence generally, including Bronfort's other publications in recent years, that a combination of SMT/MOB and exercise is best for most patients with chronic back or neck pain.

(Bronfort G, Haas M et al. (2004) *Efficacy of Spinal Manipulation and Mobilization for Low Back Pain and Neck Pain: A Systematic Review and Best Evidence Synthesis*, The Spine Journal 4:335-356).

Spine Stability – Which Muscles are Important?

A new study from Dr. Stuart McGill's respected centre at the University of Waterloo, Canada, questions the clinical practice of isolated training of a specific muscle or group of muscles in rehabilitation to promote spinal stability.

A careful analysis seeking to identify which torso muscles primarily stabilize the lumbar spine during loading found that no single muscle dominated – individual roles of muscles constantly changed across tasks, and the muscles work in synergy. Smaller, intersegmental spinal muscles are important and efficient but, as loads increase, so does the need for the stronger global muscles.

Clinically “if the goal is to train for stability, enhancing motor patterns that incorporate many muscles rather than targeting just a few is justifiable”. It is a “clinical misconception that at any given moment a single muscle can provide the necessary stability to the lumbar spine”.

(Kavcic N, Grenier S, McGill SM (2004) *Determining the Stabilizing Role of Individual Torso Muscles During Rehabilitation Exercises*, Spine 29(11):1254-1265.)

Whiplash – The Cervical Disc as an Injury Site

Approximately 50% of whiplash patients report chronic pain 15 years after the trauma and, despite intensive research – much focusing on the facet joints and spinal ganglia – “the injury mechanisms underlying whiplash-associated disorders remain unknown.”

So say Panjabi, Ito et al. from the Yale University School of Medicine, New Haven, Connecticut, reporting a new study looking at injury mechanisms of the cervical intervertebral discs during whiplash.

They used a whole intact cervical spine with a surrogate head to test deformation of the disc during flexion/extension testing and report:

- Peak 150° fiber strains and disc shear strains exceeded sagittal physiologic levels at 3.5 g and were greatest at the posterior region of C5-C6.
- The cervical intervertebral disc may be at risk for injury during whiplash because of excessive 150° fiber strain, disc shear strain, and anterior axial deformation.
- The presence of nerve endings in the outer anulus fibrosis makes disc injury a plausible aetiology of neck pain. Disc injury may be the cause of acute pain and muscle spasm, but “could also lead to disc degeneration, facet osteoarthritis and chronic neck pain.”
- The mechanism of muscle spasm observed in some whiplash patients may be related to sub-failure injuries of the disc.
- Clinical studies have implicated the facet joints as the source of chronic pain in approximately 50% of whiplash patients

– however there may be a combination of facet and disc injury and other research demonstrates “that anulus fibrosis injury can lead to disc degeneration and facet joint osteoarthritis”.

(Panjabi MM, Ito S, et al. (2004) *Injury Mechanisms of the Cervical Intervertebral Disc During Simulated Whiplash*, Spine 29(11):1217-1225.)

World Notes – Southeast Asia. No country in the region has legislation recognizing and regulating the practice of chiropractic. However, chiropractic is established and respected, and leaders predict legislation, university-based chiropractic education and substantial growth for the profession over the next decade.

Malaysia. The Malaysian Chiropractic Association, led by President Dr. Thomas Ong of Kuala Lumpur, a Logan College graduate, represents 23 or over 90% of chiropractors in practice in the country. The practice of chiropractic is legal but not regulated, though negotiations for legislative recognition are well advanced. *Contact:* Dr. Thomas Ong, tomnkl@hotmail.com

Singapore. Singapore only has 15 chiropractors, but chiropractic practice is legal and well established. This was clear at the time of the World Federation of Chiropractic Council meeting in Singapore last month, where a cocktail reception hosted by the Chiropractic Association (Singapore) and King Koil was attended by association members and government representatives. All chiropractors belong to the association, led by Dr. Janet Ruth Sosna, a Palmer graduate and the senior leader of the profession in the region. The Singapore government is presently focused on regulating the much larger profession of traditional Chinese medicine, but has indicated that it will progress to the regulation of chiropractic following that. *Contact:* Dr. Janet Ruth Sosna, dr_sosna@pacific.net.sg

Thailand. The Thailand Chiropractic Association, representing almost all 18 chiropractors in practice, has Dr. Oat Burana of Bangkok, an LACC/SCUHS graduate, as President. Dr. Burana represents the profession on a Ministry of Health Chiropractic Sub-Committee formed two years ago to develop detailed recommendations on legislation to legalize and regulate the practice of chiropractic. This was against the background of four prosecutions of chiropractors for practising medicine without a licence, but then a subsequent government decision to recognize the chiropractic profession. *Contact:* Dr. Oat Burana, dr_oat@hotmail.com

Indonesia. Chiropractic is newest in the region in Indonesia though it is reported by the pioneers as having great potential. The several chiropractors there are expatriates from Australia and Canada led by Australian Dr. Tony Dawson, a Palmer graduate who practises in Bali. The government introduced umbrella legislation for complementary medicine in January 2003, including chiropractic as one of the 15 disciplines mentioned, and the next step is development of specific laws and regulations for chiropractic. *Contact:* Dr. Tony Dawson, white_lotus@eksadata.com

All the above Southeast Asian countries have wealth, large populations and a history of acceptance and use of alternative approaches to health. There is clearly a future need and opportunity for the development of chiropractic healthcare.

Figure 3. Organizations working on traditional medicine issues

Nongovernmental organizations (NGOs)

Worldwide, many NGOs are working in the field of traditional medicine. Just a few examples are given here.

Cochrane Collaboration: <http://www.cochrane.org/cochrane/general.htm>

Ford Foundation: <http://www.fordfound.org/>

PRO.ME.TRA: <http://www.prometra.org/>

World Wide Fund for Nature: <http://www.panda.org/>

World Conservation Union: <http://www.iucn.org/>

Global professional associations

Liga Medicorum Homeopathica Internationalis(International Homeopathic Medical League): <http://www.lmhi.net/>

World Federation of Chiropractic: <http://www.wfc.org>

World Self-Medication Industry: <http://www.wsmi.org/>

Specific initiatives also exist

Global Initiative for Traditional Systems of Health: <http://users.ox.ac.uk/~gree0179/>

Research Initiative on Traditional Anti-malarial Methods: http://mim.nih.gov/english/partnerships/ritam_application.pdf

From: Traditional Medicine – Growing Needs and Potential, WHO Policy Perspectives on Medicines, May 2002, WHO.

Reprinted from: Traditional Medicine – Growing Needs and Potential, WHO Policy Perspectives on Medicines, May 2002, WHO.

Strategy includes the World Federation of Chiropractic (Figure 3)

D. WHO GUIDELINES - CHIROPRACTIC

8. Not surprisingly, given Dr. Zhang's background, the first TM/CAM guidelines prepared by WHO under her leadership were in the field of acupuncture and are:

(a) *Guidelines on Basic Safety Training and Safety in Acupuncture*³ (1999 – available at:

<http://www.who.int/medicines/library/trm/acupuncture/who-edm-trm-99-1/who-edm-trm-99-1en.shtml>)

(b) *Acupuncture: Review and Analysis of Reports on Controlled Clinical Trials*⁴ (2002).

These documents predated the current formal WHO TM/CAM Strategy.

9. WHO has now moved to the general fields of herbal therapies and manual therapies and, after negotiations between WHO and WFC, as a first step in manual therapies, specifically to chiropractic. Reasons given by Dr. Zhang in her letter dated May 10 to those in governments, chiropractic associations and others worldwide receiving the draft chiropractic education guidelines for review are:

Manual therapy is one of the most popularly used forms of TM/CAM. However, most countries have not yet established education, proper training programs, examination and/or licensing systems for this practice. In order to protect patients and to promote qualified practice of TM/CAM, WHO will, in cooperation with professional NGOs, develop a series of basic training guidelines of manual

therapies. Among manual therapies, chiropractic is among the most popularly used and some countries already have university education programs set up. For this reason, the basic training guidelines in chiropractic were prepared first amongst other manual therapies.

10. The chiropractic profession, with just cause, always becomes apprehensive whenever third parties become involved in the development of information or guidelines relative to chiropractic education and practice, and the content of WHO's Acupuncture Guidelines reinforced that concern. This is because the Acupuncture Guidelines provide for full education for traditional fulltime practice of acupuncture, but also provide for the use of acupuncture in Western healthcare as a set of complementary techniques based on 200 hours of study. There was understandable fear that WHO might produce similar guidelines for chiropractic education.

As a result the WFC:

a) Provided WHO with extensive information concerning the chiropractic paradigm of healthcare, the established accredited standards of education that had been recognized in legislation in all countries where the profession is regulated, due emphasis on the separate and distinct status of the profession, and a glossary of chiropractic terms, and

b) Negotiated an arrangement under which any experts retained by WHO to prepare the draft guidelines would be duly qualified chiropractors with expertise in education and the regulation of chiropractic practice.

11. It would be inappropriate now to comment in detail on the draft *Guidelines on Basic Training and Safety of Chiropractic* released by WHO in May because this is a first draft document receiving limited circulation for review. There will be at least two more drafts before the document is finalized. However these things can be said about the draft guidelines:

(a) They start with a focus on the distinct philosophy and theories of chiropractic and an emphasis on the defining roles of the spine, nervous system and subluxation.

(b) They establish CCE accredited education as the gold standard for chiropractic education worldwide – and the only truly acceptable standard.

(c) They acknowledge that, as has already happened in countries such as Brazil, Chile and Japan, there can be some interim educational programs offered in countries where there has been no accredited chiropractic education, such education is now planned, and there are health professionals already practising as chiropractors in an unregulated environment. However in these cases:

- Professionals with extensive prior health education (e.g. medical doctors, kinesiologists, physical therapists) would need a minimum of 1800 hours chiropractic education over 2-3 years with not less than 1000 hours of clinical experience. (The educational programs in Argentina and Germany already mentioned are plainly unsatisfactory.)

- There should be plans to commence full chiropractic education at the earliest possible opportunity, with the preliminary/conversion program for the pioneering group of chiropractors then being phased out.

12. WHO has asked for written response on these draft guidelines by July 31. In accordance with normal WHO consultation process a second draft of the guidelines will then be prepared and circulated for comment, and then a third draft will be prepared for review and discussion at a consultation meeting to be

held early in 2005. Following that meeting the final draft will be prepared and published.

Although the WFC has argued that any WHO guidelines on chiropractic should deal with education, safety and effectiveness in one document, it is likely that – as with acupuncture – evidence of effectiveness will be dealt with in a second document.

E. CONCLUSION

13. In a recent development international leaders of osteopathy met with WHO to argue that osteopathy should be dealt with in the same guidelines as chiropractic, rather than being included with other manual therapies or dealt with later. In response Dr. Zhang called a meeting of chiropractic and osteopathic leaders in Geneva on May 24, 2004 at which the WFC was represented by Dr. Paul Carey (Canada), WFC President, Dr. Philippe Druart (Belgium), President, European Chiropractors' Union, Dr. Peter Dixon (UK), ECU Past-President and Mr. David Chapman-Smith, WFC Secretary-General. WHO rejected the arguments of the osteopathic profession and decided to proceed with the separate guidelines for the chiropractic profession.

14. Chiropractors may now be optimistic that they will soon have WHO guidelines on chiropractic education and practice that:

- Encourage their governments to recognize and regulate chiropractic healthcare.
- On a basis that helps duly qualified chiropractors in Argentina, Germany and worldwide persuade their governments that short-term programs for medical doctors and others are inappropriate, unsafe and unacceptable for their citizens.

15. When the founders of the WFC, led by Dr. Gary Auerbach of the International Chiropractors' Association (ICA), first visited WHO in the mid-1980s they found nothing in WHO's library on chiropractic, an information and policy gap with respect to the profession, human resources planning and other policy development ignoring chiropractic, and a visibly cool reception. Twenty years later the profession is officially represented within the NGO structure of WHO and has tangible policy support within the framework of WHO's TM/CAM Strategy.

If the Ministers of Health, for example, from Croatia or Italy or Thailand or Malaysia today seek advice on whether or not chiropractic should be recognized in their healthcare systems – and all these countries are currently considering chiropractic legislation – today they receive policy support from WHO rather than the former discouragement and opposition.. This represents a major and important change in an era in which both chiropractic and the manual arts in general have new public acceptance and growth internationally.

If you, as an individual chiropractor, are a member of the American Chiropractic Association, the International Chiropractors' Association, the Canadian Chiropractic Association, the Chiropractors' Association of Australia, the British Chiropractic Association or any one of the 81 national associations that comprise the World Federation of Chiropractic (WFC), give yourself a deserved pat on the back for your role and that of your leaders in forming a representative international organisation to protect and advance the interests of the profession.

Since it was established in 1988 the WFC has given the profession an effective voice at WHO and in the development of health professions at the international level. This is your best possible guarantee that chiropractic will remain a separate and

distinct profession worldwide, and that – unlike osteopathy for example – when you refer patients to a colleague in another country over the next generation he or she will be practising the same profession as you in substance as well as name. TCR

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- 3 *Guidelines on Basic Training and Safety in Acupuncture*, WHO/EDM./TRM/99.1 (1999), World Health Organization, Geneva. Available electronically at: <http://www.who.int/medicines/library/trm/acupuncture/who-edm-trm-99-1/who-edm-trm-99-1en.shtml>
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Dr. Efstathios Papadopoulos from Cyprus, Secretary-Treasurer, World Federation of Chiropractic at the World Health Assembly, Geneva, May 26, 2003, when he became the first chiropractor to address a WHO Annual Assembly.



The 2003 WFC delegation to the World Health Assembly. (left to right) Dr. Denis Alemi, Vice-President, French Chiropractic Association, Mr. David Chapman-Smith, WFC Secretary-General, Dr. Gary Auerbach, USA, WFC Past-President, Dr. David Koch, Vice-President for International Affairs, Palmer College of Chiropractic, Dr. Mathieu Gontard, President, French Chiropractic Association, Dr. Paul Carey, Canada, WFC President, Dr. Medhat Alattar, President, Egyptian Chiropractic Association, Dr. Efstathios Papadopoulos, Cyprus, WFC Secretary-Treasurer, and Dr. Rand Baird, USA, Chair, WFC Health-for-All Committee.



**WFC Consultation on Identity
Notice of Electronic Survey of Chiropractors
October 2004**

From a public perspective, what is the core identity or role of the chiropractic profession in healthcare? Are chiropractors mainstream, alternative, primary care providers, specialists and what is the best brand or identity for the profession? These are some of the questions to be answered by the World Federation of Chiropractic's consultation on identity.

For more details on this important project see the January 2004 issue of this Report or visit www.wfc.org and click on Identity Consultation.

A major part of the consultation is a survey of individual chiropractors internationally, using a questionnaire that has been pilot tested and will go live in October. On this:

- The survey will be completed electronically via the WFC's website: www.wfc.org
- It will take you 20 minutes, and replies will be anonymous and confidential. Respondents will use a personalized code that allows them to complete the survey once.
- The WFC is presently establishing a database of emails from national associations and other sources – each email address will get notices and a code in late September enabling completion of the survey.
- To guarantee your participation – send your name, college and year of graduation, and email address to identity@wfc.org now – and at latest by August 28, 2004. The email address will then be entered in the database.

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**Saving and Supporting the History of Chiropractic
Why Not Join the Association for the History of Chiropractic?**

www.chirohistory.org

The Association for the History of Chiropractic (AHC), formed in 1980 and dedicated to preserving the history of chiropractic, is based in the USA at Palmer College. It has been impressive in recording history in its journals and other publications. Understandably most of the history has been from the USA.

The AHC, however, is truly international in scope. It has affiliated organizations in Australia and Canada, and this year held its annual meeting in Mexico – at the chiropractic school at the State University of Ecatepec Valley (UNEVE), Mexico's new government-approved and state-funded of chiropractic educational program. The meeting was devoted to the history of the profession in Latin America. The papers presented appear in this month's July 2004 edition of the AHC's twice annual journal *Chiropractic History*, and they feature photos and accounts of the chiropractic pioneers in Bolivia, Brazil, Colombia, Ecuador, Mexico and Panama.

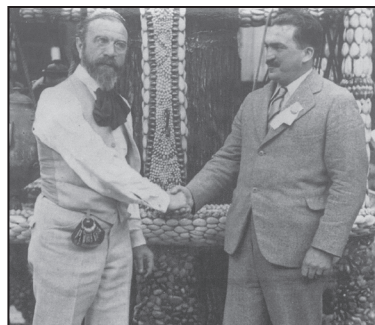
Impressive books published by AHC include Joseph Keating's *BJ of Davenport: The Early Years of Chiropractic*, superbly researched, extremely readable and acknowledged by former Palmer College President, Dr. Jerome McAndrews, as both scholarly and "as complete a story of BJ's life as has ever been told."

Annual membership of the AHC is US\$75.00 (in North America), \$85.00 (elsewhere – the extra covers journal mailing costs). The application form is at the website or can be obtained from:

Alana Callender
Executive Director, AHC
1000 Brady Street, Davenport, IA 52803, USA
Tel: 563-884-5474, Fax: 563-884-5616
E: callendar_a@palmer.edu

Why not join the AHC today, both for the direct benefits you will receive and to support the saving and recording of chiropractic history? Member benefits include:

- A membership directory, newsletter and two issues of *Chiropractic History* (July and January).
- Access to other AHC books and publications.
- Notice of and attendance at meetings – including voting and other rights at AHC's annual meeting and history conference.
- Additionally, see the website for contacts with related organizations in Australia and Canada and publications available. Back issues of *Chiropractic History* are strongly recommended.



"Then we are both in agreement, BJ. We shall both join the AHC immediately".

Francisco Montañón-Luna, DC, 1921 graduate of the Palmer School of Chiropractic and first chiropractor in Mexico in 1922. Dr. Montañón-Luna practised in Mexico City

for 46 years until his death in 1968. His descendants are now fourth generation chiropractic students at UNEVE.