The Chiropractic Report

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Professional Notes

Padraig Harrington Interview

Padraig Harrington of Ireland has just been voted *Golfer of the Year* by his colleagues on the PGA Tour. In 2008 he won 2 of the 4 majors – the British Open and the US PGA Championship.

For the past 12 years Harrington has been accompanied on tour by Australian chiropractor Dr. Dale Richardson, and the December issues of the *FICS News* (the quarterly publication of the Fédération Internationale de Chiropratique du Sport, the international body representing sports chiropractic) carries a fascinating interview with Harrington and Richardson. Highlights include:

• Before he had regular care from Dr. Richardson, Harrington was missing 4 or 5 tournaments a year from chronic golfing injuries – now he doesn't lose attendance at any.

• He had a quite serious hand injury

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CAM or Mainstream?

Where is the Chiropractic Profession, Why is This Important?

A. Introduction

COMPLEMENTARY AND ALTERnative medicine (CAM) is a term coined by the Scottish physician and homeopath David Reilly in 1987. It has subsequently been used by the medical profession, and therefore healthcare policy makers and the media, to describe all healthcare interventions not generally taught in medical or paramedical schools – including those of the chiropractic profession.

Since the 1980s there has been a dramatic increase in the use of CAM in the developed world, and chiropractic has been seen as the leading example of a profession making the transition from CAM to mainstream care. Has the CAM label or identity been a help or a hindrance to chiropractic, and what should be done about it at this point in time?

Two recent events illustrate the significance and complexity of these questions:

a) The first is the World Health Organization's Congress on Traditional Medicine held in Beijing November 7-9, 2008. Traditional medicine (TM) is the term WHO uses for CAM. In opening the Congress, WHO Director-General Dr. Margaret Chan, addressed the reasons for "the striking increase" in the use of CAM in affluent societies, and called for governments to adopt policy to promote the use of TM/CAM in primary care in their national healthcare systems.[1]

Manual healthcare generally, and chiropractic in particular, were a major part of the Congress with the World Federation of Chiropractic (WFC) organizing one of the four technical symposia – a two-day Symposium on Manual Methods of Healthcare. During the Congress government delegates from 72 WHO member countries passed a Beijing Declaration calling upon all countries to recognize and regulate CAM professionals and for the closer integration of TM/CAM and "conventional medicine providers" as in China.[2]

b) The second recent event is the December 10 publication by the National Center for Health Statistics (NCHS), US Department of Health and Human Services (DHHS) of its 2007 survey on the use of CAM by Americans – use by each of adults and children during the past 12 months.[3] There is much that is good news for the chiropractic profession:

• As in the last survey by the NCHS, in the year 2002, CAM was used by a large percentage of the population – by about 4 in 10 (38.3%) of adults during the 12 month period.

• This was principally for the musculoskeletal problems that represent a large part of chiropractic practice – with back problems (17.1%), neck problems (5.9%) and joint problems (5.2%) leading the way.

• Chiropractic care appears to be the single most common "therapist-based intervention" used by adults and children.

However on a careful reading there is much that is a concern and that drives one to the conclusion that institutional bias against the chiropractic profession is alive and well within the DHHS. Prime examples are:

• **Definition.** The new report says that "by definition CAM practices are not part of conventional medicine *because there is insufficient proof that they are safe and effective*" (emphasis added). That is a new and disturbing definition. It is also indefensible. According to the report doctors of chiropractic seem to be the most commonly used CAM providers in the US, they are principally used by patients for musculoskeletal disorders,

and there is at least as much evidence supporting the safety and effectiveness of chiropractic management for these disorders as there is for any "conventional medical" treatment. [4,5]

• **No data on Chiropractic.** Even more disturbing is the downgrading of chiropractic from a profession to a technique coupled with the gathering and reporting of data on chiropractic and osteopathy together, rather than each alone. The survey for 2002 asked the public about its use of "chiropractic care". The survey for 2007 asked about use of "chiropractic or osteopathic manipulation".

2. Accordingly in this Report we look at facts on CAM. the significance of the WHO Congress and the new DHHS National Survey, and what the chiropractic profession should do to accelerate its transition from CAM to mainstream – at a time when various developments suggest that national healthcare systems will have a place for professions such as chiropractic and naturopathy and traditional Chinese medicine within mainstream services – that is to say professions that offer a different philosophy of health and approach to the prevention and management of some of the most prevalent and chronic lifestyle disorders.

3. Before we embark on that it should be made clear that the CAM label or identity is one given to the chiropractic profession by others, rather than coined or accepted by the profession itself. In 1996/1997 the WFC surveyed its member national associations, then in approximately 80 countries worldwide, and found a strong consensus that chiropractic should be viewed as an integral part of mainstream healthcare services, rather than complementary and alternative healthcare or medicine. Respondents agreed, however, that the profession was in fact viewed by government and medical authorities in almost all countries as CAM.

B. Facts on CAM

4. **Definition.** There is no agreed definition and CAM covers *alternative* health care systems based on principles that conflict with anatomy and physiology as understood in modern medicine (e.g. Indian Ayurvedic medicine and traditional Chinese medicine and homeopathy), *complementary* approaches to healthcare based on the same approach to anatomy and physiology as in modern medicine (e.g. chiropractic, massage therapy, osteopathy) and many self-help approaches (yoga, weight loss programs, relaxation techniques, spiritual healing).

The definition used by Eisenberg et al. from Harvard for their 1991 and 1997 national surveys in the US was "medical interventions not taught widely at US medical schools or generally available at US hospitals." [6] In the U.K. the British Medical Association's definition of CAM has been "those forms of treatment which are not widely used by the orthodox health care professions, and the skills of which are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health care courses." Writing on CAM in 1993 the BMA regarded acupuncture, chiropractic, herbalism, homeopathy and osteopathy as the five most developed CAM disciplines and those with "the potential for greatest use alongside orthodox medical care." [7]

Accordingly the essence of CAM, which groups together many professions, therapies and products with no commonality of principle, is that it is health care methods not generally taught in the core curriculum of medical schools. The new US DHHS survey and report lists 36 forms of CAM under four categories:

• Alternative medical systems (e.g. acupuncture, Ayurveda, homeopathy, naturopathy, traditional healers)

• Biologically-based therapies (e.g. chelation therapy, diet-based therapies, natural products)

• Manipulative and body-based therapies (e.g. chiropractic, massage, movement therapies)

• Mind body therapies (e.g. biofeedback, meditation, yoga, tai chi, energy healing)

5. **Why Patients Use CAM.** This issue has been examined most thoroughly in Europe by Furnham[8] and in the US by Astin.[9] They agree and their survey findings are confirmed by a national poll in Canada. [10] In summary:

a) The two dominant factors for CAM users are dissatisfaction with medical care for their current complaint (the push factor – pushing them towards CAM), and belief in the effectiveness of the CAM approach (the pull factor – attracting them to CAM). The second factor is the dominant one. They are pulled towards CAM because it is "more natural, effective, relaxing, sensible and one can take an active part in it."

b) However, CAM users do not reject orthodox medicine and do not have "noticeably different health belief models compared with similar patients who are exclusive users of orthodox medicine." The studies show that CAM patients are a normal cross-section of the population shopping for health.

Consumer commentators agree. In *Reclaiming our Health* [11] John Robbins, whose first book was *Diet for A New America*, links the rise of CAM in the US to dissatisfaction with the "medicalization of life" arising from a combination of factors – those mentioned by him include ignoring the inherent powers of the body, removing personal control of health and freedom of choice often in circumstances where 'dominator medicine' is less effective than CAM

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and has unacceptable costs, risks and side effects.

C. WHO Congress

6. Until the 1990s the World Health Organization (WHO) paid little attention to TM/CAM, despite the fact that the majority of people in many developing countries receive most of their care from traditional healers. That changed with the dramatic growth of CAM in the developed world from the mid-1980s.

WHO's TM office was strengthened, now being led by Dr. Xiaorui Zhang from Beijing, former President of the Chinese government's State Administration of Traditional Chinese Medicine (SATCM). With increased staff and funding, WHO and Dr. Zhang launched a first and comprehensive policy supporting the development and integration of TM/CAM in national health systems – titled the *WHO Traditional Medicine Strategy 2002-2005* (the WHO TM/CAM Strategy). This Strategy specifically included chiropractic, and WHO invited the World Federation of Chiropractic (WFC) to assist with respect to the chiropractic profession.

It was pursuant to this Strategy that WHO published its *Guidelines on Basic Training and Safety in Chiropractic* in 2005. Under agreements between WHO, the WFC and its member associations these have now been published in 15 languages – most recently Turkish and Chinese. The Guidelines endorsement of the profession and its educational standards is proving most significant with governments in countries where chiropractic practice has not previously been recognized and regulated by law.

Since the launch of its TM/CAM Strategy WHO has been inviting all member countries to report annually on their progress on integrating TM/CAM into their national healthcare systems, and planning a first World Congress on TM/CAM. Beijing was the preferred site because of the example of China – which has the fullest integration of traditional and modern medicine in its hospitals and overall healthcare system.

7. Key elements of the November 7-9 Congress in Beijing were:

a) Host sponsorship from the Chinese Ministry of Health and its SATCM.

b) An International Forum attended by government delegates and representatives of international organizations of health professionals, including the WFC. Countries from all world regions reported on integration of TM/CAM in their national healthcare systems. They then approved a Beijing Declaration which defined TM as including CAM and called for respect and the development of TM/CAM. See Table 1 for the central clauses of the Declaration.

c) Four technical symposia – on acupuncture, herbal medicines, manual healthcare and consumer education. WHO asked the WFC, as the representative of a leading discipline in manual care, to organize and administer the Symposium on Manual Methods of Healthcare (Manual Care Symposium). See below for more on this.

d) A public exhibition of TM/CAM at the International Exhibition Centre in Central Beijing. A new 5-minute video on chiropractic produced for the WFC by Palmer College and dubbed in Chinese was shown continuously at the WHO booth.

e) Visits to TCM hospitals. Delegates visiting the Wangjing Hospital of the China Academy of TCM had demonstrations of chiropractic patient assessment and treatment.

8. The significance of the Manual Care Symposium is that this was the first time ever that leaders of professions based on manual care and coming from different cultures worldwide have met to share their history, principles and practice. At the Symposium:

a) There were 30 minute lectures/demonstrations by leaders of manual disciplines coming from Asia (Chinese tuina, Korean chuna, Japanese judo therapy, Thai nuad), Europe (naprapathy, Swedish massage therapy, French bonesetters), Latin America (hueseros, sobadores) and North America (chiropractic and osteopathy).

b) The foremost authorities spoke on the research status of Asian and Western manual healthcare – Professor Yan Juntao of Shanghai, President, Association of Tuina of China, and Dr. Scott Haldeman of Los Angeles, neurologist and chiropractor, Chair, WFC Research Council.

c) Conclusions were that there was much more widespread practice of manual healthcare historically and currently than anyone had appreciated, and that although there were significant differences in theory, educational levels and approaches to practice, there was also much commonality between practitioners. "I feel like I've just met my long lost cousins", was the comment on one chiropractic college leader at the conclusion.

d) WHO officials, government delegates and other professions present clearly saw the chiropractic profession as the most developed in the field of manual healthcare.

e) With osteopathy, chiropractic also had the longest history of organized education and practice. One often hears

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Table 1: **Beijing Declaration – Main Clauses**

The introductory clauses explain that traditional medicine may also be called alternative and complementary medicine. For the full text go to the Newsroom at www.wfc.org or www.who.int.

Participants at the WHO Congress . . . hereby make the following Declaration:

I. The knowledge of traditional medicine, treatments and practices should be respected, preserved, promoted and communicated widely and appropriately based on the circumstances in each country.

II. Governments have a responsibility for the health of their people and should formulate national policies, regulations and standards, as part of comprehensive national health systems to ensure appropriate, safe and effective use of traditional medicine.

III. Recognizing the progress of many governments to date in integrating traditional medicine into their national health systems, we call on those who have not yet done so to take action.

IV. Traditional medicine should be further developed based on research and innovation in line with the "Global strategy and plan of action on public health, innovation and intellectual property" adopted at the Sixty-first World Health Assembly in Resolution WHA6l.21 in 2008. Governments, international organizations and other stakeholders should collaborate in implementing the global strategy and plan of action.

V. Governments should establish systems for the qualification, accreditation or licensing of traditional medicine practitioners. Traditional medicine practitioners should upgrade their knowledge and skills based on national requirements.

VI. The communication between conventional and traditional medicine providers should be strengthened and appropriate training programmes be established for health professionals, medical students and relevant researchers.

Padraig Harrington Interview

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before the British Open last year. "On Thursday it didn't look like I would be playing and Dale did a great job of getting me ready." He went on to win – successfully defending his win and title in 2007.

• Harrington and Richardson are on tour together 20 weeks annually – and while Harrington has a healthcare team in Ireland, Dr. Richardson is his only health professional on tour.

• He describes his average day while on tour, preparing for and playing in tournaments:

"Essentially I do 45 minutes of stretching, stability, core work to get warmed up, then have a shower and head for the golf course. After breakfast I spend about 20 minutes with Dale checking that everything is working right and doing a little bit of stretching, then I spend an hour warming up at the range hitting shots.

I go and play about 4-5 hours on the golf course depending on time constraints and energy levels. I could then spend a couple of hours practicing. In my earlier days it was 4 hours practicing now I keep it to an hour maybe 2 hours depending on the time of the year and the conditions. Then I spend another hour with Dale getting some treatment. That would be my day – I probably would get back in the gym as well if I have the time in the evening."

Harrington in a "headlock" while he sits on his golf bag. Here Dr. Richardson uses traction for a neck problem on the course at the US PGA 2002.

• Says Harrington "One thing I know through experience is that I need to keep having constant treatment, even when I have weeks off, because I can see even though I would be injury-free for say a couple of weeks, I can feel symptoms building up, and if I don't deal with those early signs I'm going to be in trouble."

For the full interview visit www.fics-sport.org and go to Publications. The December FICS News has much other sports chiropractic information of interest including:

• An interview with Dr. Ted Forcum of Oregon, President, American Chiropractic Association Council on Sports Injuries and Physical Fitness, speaking of his own practice and experience and serving with the US Olympic Team in Beijing.

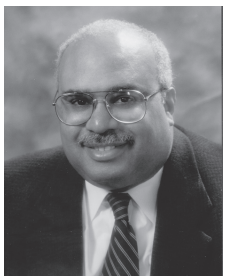
• A report on preparation of a FICS team of 30 sports chiropractors for the 8th World Games in Taiwan in July. The World Games are for 35 sports seeking admission to the Olympics.

• A preview of the FICS Symposium and Tom Hyde Dinner to be held in Montreal on Wednesday April 29, 2009, the day before the World Federation of Chiropractic's 10th Biennial Congress. Speakers include Ron Froehlich, President, International World Games Association, Dr. Jack Taunton, Chief Medical Officer, Vancouver Olympics and Dr. Robert Armitage, Head, Chiropractic Services, Vancouver Olympics.

• An article that explains the roles of FICS and local chiropractors in arranging chiropractic services for international games events held in your country.

If you want regular information on sports chiropractic, education and practice opportunities, and to support the development of sports chiropractic consider now becoming an individual member of FICS – an application form is at www.fics-sport.org and the cost is only US$50.00.

WFC Montreal Congress – Georges Benjamin to Speak



Dr. Georges C. Benjamin

The World Federation of Chiropractic and Canadian Chiropractic Association are pleased to announce that Dr. Georges Benjamin, Executive Director, American Public Health Association (APHA) has accepted an invitation to address the WFC's 10th Biennial Congress in Montreal, April 30-May 2, 2009. Dr. Benjamin, who will speak about the work of the APHA and its chiropractic division and the role of the profession in public health, is a prominent leader, practitioner and administrator in public health based in Washington, DC.

Dr. Benjamin has been APHA Executive Director since December 2002, and came to that position from a post as Secretary of the Maryland Department of Health. He is an internist who graduated from the University of Illinois College of Medicine and started his medical career as Chief, Acute Illness Clinic, Madigan Army Medical Center in Tacoma, Washington. He subsequently moved to Washington DC and served as Chief of Emergency Medicine at the Walter Reed Army Medical Center. He has been most supportive of the development and work of the chiropractic division at the APHA.

Dr. Benjamin has been a late addition to the Saturday program which now includes:

• Heiner Biedermann, MD of Belgium on the relation between function vertebral pathology and morphological development in infants, and Jeanne Ohm, DC on chiropractic care during pregnancy. Biederman and Ohm also present a workshop on assessment and management of infants.

• Brian Gleberzon and Amy Freedman, MD of Canada on quality of life for seniors – respectively diet, fall prevention and wellness; and collaborative care for musculoskeletal disorders.

• David Eisenberg, MD on integrated chiropractic and medical care at a Harvard teaching hospital.

• Christian Genest Boudreau, DC of Chiropratique sans Frontiers and Sister Brigette Yengo, DC MD of the Congo on chiropractic outreach to the world.

• An optional headache/neck pain grand rounds discussing clinical cases and led by Canadian chiropractic experts.

• Optional workshops by Mark Charrette, DC (lower extremity techniques), Reed Phillips, DC and Ron Rupert, DC (FCER's DC Consult online clinical practice resource) and David Marcarian, MA (the current validity and role of static and dynamic EMG and digital ROM).

• A Congress closing address from Gerard Clum, DC – *Where We Have Come From and the Road Ahead.*

For all information and registrations for this 3-day celebration of chiropractic, visit www.wfc.org/congress2009.

Research Notes

1. **US - New Best Practices for Low-Back Disorders**. The November/December issue of JMPT publishes an excellent and new best practices document for chiropractic management of patients with low-back disorders – one that will be welcomed by many clinicians because of the authoritative support it gives to patient-based rather than payer-based care. It also emphasizes that evidence-informed care involves not only research evidence but also individual clinical expertise – "and neither alone is enough" say these best practices, quoting one of the founders of evidence-based medicine, Dr. David Sackett.

There is a powerful accompanying editorial by Jay Triano, DC PhD, now Dean of Research, Canadian Memorial Chiropractic College, Toronto, pointing out that the new best practices are patient-centered and view under-treatment (forced on providers by administrators and payers) as an equal problem to over-treatment. Rigid guidelines and templates are inappropriate because they don't address "the individual context" for each patient and clinical decision. Elements of that context include case complexities; best available evidence; the provider's expertise and experience; the patient's preferences and beliefs.

Randomized controlled trials should not be the sole basis of practice benchmarks says Triano – problems with them are that they focus on easily measurable items only, ignore context and the skill of the provider, minimally acknowledge the confounding effects of placebo healing properties, and ignore patient actions and preferences. Additionally poorly performed RCTs are more misleading than well-performed cohort studies.

(Triano, JJ (2008) *What Constitutes Evidence for Best Practice?* J Manipulative Physiol Ther 31:637-643 and Globe GA, Morris CE, Whalen WM et al. (2008) *Chiropractic Management of Low Back Disorders: Report from A Consensus Process*, J Manipulative Physiol Ther 31:651-658).

2. **US – Clinical Competence and Emotional Development.** An interesting new article from neurologists and a psychiatrist at Johns Hopkins School of Medicine argues that professional and clinical competence in the management of pain patients requires both cognitive and emotional skills – and that current models of physician/patient interaction "are inadequate for most clinical encounters because they do not consider emotional effects". Of more concern, current medical education focuses on cognitive skills alone and actually reduces student empathy and emotional development – "clearly, improved attention to the emotional development of medical trainees is critical to the delivery of effective pain care".

The authors present a new model of clinical training for medical students which identifies cognitive expertise, emotional preparation and reflective capacity as critical components. They argue that it should be used immediately. "The phenomenon of the emotionally under-developed medical student is an open secret of academic medicine." Although doctors of chiropractic have done comparatively well in terms of empathy, patient relations and patient satisfaction this paper clearly contains warnings and advice for all health professions.

(Burinson BB, Agarwal AK, Haythornwaite JA (2008) *Cognitive Expertise, Emotional Development and Reflective Capacity: Clinical Skills for Improved Pain Care*, Journal of Pain 9(11):975-983).

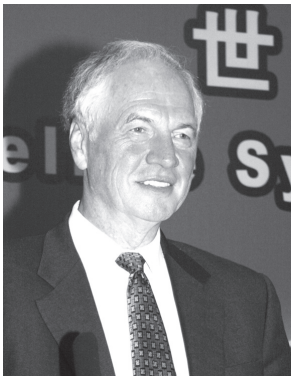
how tuina, Chinese massage/manipulation, has been practised for over 2000 years. However, as Dr. Chen Ying-Wu, Head, Tuina Department, Shuguang Hospital, Shanghai University of Traditional Medicine explained, this was on an apprenticeship basis similar to community bonesetters worldwide. The first formal tuina school opened in 1956, the first bachelor's program commenced in 1979, and the first master's degree program in 1986.[13]

9. The significance of the WHO TM/CAM Congress is that it highlights, and takes to a new level, the benefits the chiropractic profession is clearly receiving from being labeled CAM by others. These benefits flow from being part of a larger social and healthcare movement that brings the profession much greater attention than it could gain by itself. Therefore, in summary:

a) **Consumer Research.** From the 1980s there have been numerous surveys of public use of and satisfaction with chiropractic services that would not otherwise have been done.

b) **Government Reports and Policy Developments**. There have been important reports promoting the acceptance, integration and increased use of chiropractic services. Examples are the Lannoye Report [14] commissioned by the European Parliament and then approved in 1997, which called for the recognition and regulation of the major CAM disciplines throughout Europe, and in the UK the CAM Report of the House of Lords Science and Technology Committee in 2000. [15] An important feature of the House of Lords Report is that chiropractic was defined as a Group I "principal discipline" within CAM with most potential for integration into the National Health Service. The Committee recognized that chiropractic was a profession with its own distinct diagnostic methods, not a therapy, and should not be grouped with CAM methods and disciplines lacking any credible evidence base.

c) **Legislation**. These reports and policy developments for CAM have led to legislation to recognize and regulate the profession. In Europe, since the Lannoye Report, there has been such legislation in Belgium, France, Italy and Portugal – countries with relatively few chiropractors and a history of strong lobbies against them by organized medicine. There would have been no recognition of chiropractic without the wider context of CAM.



Left: *Dr. Stathis Papadopoulos of Cyprus, President, World Federation of Chiropractic addresses the WHO Congress in Beijing.*

Below: *Professor Yan Juntao, President, Association of Tuina in China.*

Below left: *Dr. Scott Haldeman, Chair, WFC Research Council.*

d) **Research**. The past decade has finally seen the first significant public funding for chiropractic research in a number of countries, but again this has usually been because of the CAM movement. US federal funding has come through a new division of the National Institutes of Health, the National Center for Complementary and Alternative Medicine (NCCAM) formed to promote research into CAM.

e) **Integration of Education and Clinical Services.** Finally in many countries the focus on CAM has produced a climate that is leading to much greater integration of chiropractic education in public universities and chiropractic services into mainstream care. As an example in Mexico City the Universidad Estatal del Valle de Ecatepec (UNEVE) commenced the first state-funded acupuncture and chiropractic education in the 1990s, and graduating doctors of chiropractic have a one year clinical internship in state hospitals. In the US chiropractic services are much more widely available in public, private and university hospitals as well as interdisciplinary primary care clinics and networks – in this largely private healthcare system the public has spoken and the overall trend of the times is towards integrated care.

10. What is the ongoing significance of WHO support and the Beijing Congress? WHO is the United Nations agency for health, and enjoys a high reputation. Its members are virtually all countries worldwide and most of their governments seek advice on health matters from WHO – including the status of health professions. WHO would have little if any policy on chiropractic if the profession was not part of TM/CAM – internationally the profession remains too small in the overall matrix of healthcare. However, because the profession is part of CAM it currently has strong policy support from WHO.

However this support, as for example in the WHO Guidelines on Chiropractic, and the WHO TM/CAM Strategy, had relatively low profile until The Beijing Congress and could be seen as largely staff-based. The Beijing Congress, and in particular the Beijing Declaration, changes that. WHO's TM/CAM Strategy is now entrenched, it has been formally and unanimously adopted by a large meeting of member nations. The Beijing Declaration will remain a focal point of reference in the years ahead. Further, WHO has identified three major fields of TM/CAM – acupuncture, manual care and herbal and other natural medicines – and chiropractic is being seen as the most developed discipline and WHO's major partner in the field of manual care.

D. New US Survey

11. We now turn to look at the negative aspects of the CAM label. Dr. Margaret Chan, WHO, governments, commissions and ultimately patients may call for greater recognition and support for CAM, but it is those who are in day-to-day control of healthcare funding, research and delivery systems who often have the final say. The policy framework may be sound, but administrators will decide if policies are implemented.

Experience shows that this is where the CAM label is restrictive, and that this is why chiropractic must move beyond it. As mentioned earlier the new US National Health Statistics

Report on CAM illustrates the problem. Details of the report are:

a) The CAM use survey was part of a more comprehensive survey on health conducted by the National Center for Health Statistics for the US Department of Health and Human Services (DHHS).

b) There was a large nationally representative group surveyed – 75,764 persons representing 29,915 families. They were asked during 2007 what use they had made of CAM during the past 12 months. Results included:

i) Approximately 40% (38.3%) used CAM in the past 12 months. Most common was use of non-vitamin natural products (17.7% - e.g. fish oil or omega 3; glucosamine, Echinacea).

ii) Most common practitioner-based CAM was "chiropractic or osteopathic manipulation" (8.6%) which compared with 7.5% for "chiropractic care" in the 2002 survey. Next were massage therapy (8.3% - 5% in 2002) and yoga (6.1% - 5.1% in 2002). Acupuncture was 1.4% (1.1% - in 2002).

iii) Almost 1 in 5 (18.7%) of white adults had used manipulative and body-based CAM, but fewer Asians (11.1%), Hispanics (6.7) and African-Americans (6.5%). However, whatever race and ethnicity, more than 1 in 5 had used this form of CAM if education level was a bachelor's degree (20.7%) or a master's degree or higher (23.6% - nearly 1 in 4).

iv) As in 2002 CAM was most commonly used for musculoskeletal problems – leading causes were back problems (17.1%), neck problems (5.9%), joint pain/stiffness/arthritis (8.7%) and headaches (2.6%).

v) Notably, whereas once CAM use was mainly in younger adults, there is now fairly consistent use up to age 69.

vi) For children (age 0-17), surveyed separately for the first time, approximately 1 in 9 (11.8%) had used CAM. Most common practitioner-based CAM was chiropractic or osteopathic manipulation (2.8%) but use of this doubled (5.7%) where a parent was also using CAM. There was similar doubling for other use of CAM – natural products, yoga and homeopathy leading the way.

Principal reasons for CAM use were back or neck pain (6.7% or more than half of the 11.8% who used CAM), head or chest cold (6.6%), anxiety or stress (4.8%) and "other musculoskeletal" (4.2%). Interestingly, the survey had no category giving general wellbeing or prevention as the reason for use of CAM.

c) In summary these figures show that the American public sees that there is a major role for CAM generally, and chiropractic specifically, in the management of defined health problems. Surveys from Canada, Europe, Australia and elsewhere demonstrate the same thing.

12. But there is no indication that those officials and researchers in the DHHS and NIH who designed, approved and reported this new survey are responding positively to the apparent needs of the public. Questions are:

- Who made the astounding decision not to include "chiropractic care", the most commonly used practitioner-based form of CAM in the previous survey – and to combine "chiropractic and osteopathic manipulation"?
- Why are CAM practices still being called "unconventional" and "therapies," and now being defined as having "insufficient proof that they are safe and effective"?
- Is spinal manipulation by MDs and PTs "conventional" because they are, and "unconventional" by chiropractors because chiropractic is CAM? If a funding agency within the DHHS has research funds available for one randomized controlled trial of spinal manipulation, and two proposals are received from medical and chiropractic researchers respectively, are these funds going to go to the conventional/mainstream applicants or the unconventional/CAM ones"?

E. Discussion

13. The bias against CAM and chiropractic we see in the above report is seen more dramatically in many other places. In the US in recent years one thinks of the delivery of chiropractic services under the Medicare program by DOs and PTs, and the litigation required to correct the problem. There have been persistent efforts by the Department of Defense to frustrate the will of Congress to establish chiropractic services at military health facilities. There was the well orchestrated and successful campaign by political medicine to prevent the intended school of chiropractic at Florida State University. In all of this, and similar problems for the profession internationally, we are of course looking at market protection by political medicine and its allies in health administration. As a recent expert report for the Bone and Joint Decade by Walsh, Brooks, et al.[16] points out:

- Internationally musculoskeletal problems are the second most common reason that patients seek medical care and in the "vast majority of countries account for up to 20% of a typical primary care practice".
- These problems account for "a quarter of overall cost of illness on a global scale".
- Even excluding trauma, they are responsible for "roughly 25% of the total expense of illness in developed nations".
- In the last 5 years in the US the costs associated with musculoskeletal conditions increased 18% to $254 billion.

Spinal and musculoskeletal care are big business. Those controlling research and practice in the field are understandably concerned to maintain control.

14. There is a clear pattern to control mechanisms adopted, and chiropractic is advancing best where that pattern is broken. The first way of controlling CAM and chiropractic is to define it as unconventional and unproven. The next step is denying significant public funds for education and research. This is achieved by keeping the profession out of public universities and creating limited access to limited research funds – as in the NCCAM in the NIH in the US. The third step is downgrading professions in CAM to techniques and products that can be acquired and delivered by the medical profession. Therefore acupuncture, spinal manipulation, homeopathy and naturopathy will become medical adjuncts. Fortunately for chiropractic the art of manual assessment and treatment is not as easily learned by physicians as the alternative use of needles (acupuncture) and natural products.

15. Fair-minded individual medical leaders, of whom there are many, have indicated the path chiropractic must follow to avoid this containment. Marc Micozzi, MD PhD, writing in the official journal of the American College of Physicians and specifically in the context of chiropractic and spinal manipulation notes:

"As physicians are becoming increasingly willing and able to

justify referral for complementary care . . . we must foster the development of training, research and clinical protocols to support integration . . . in a way that promotes favorable clinical outcomes.

"Alternative medicine can benefit from the kind of support from which mainstream medicine has benefited over the years. When all is said and done, what works will no longer be called *mainstream* or *complementary*—it will just be called *good medicine*."[17] (emphasis added).

16. Where the profession has taken this path, and has promoted access to the public funding it deserves for education, research and its services, it has achieved most mainstream acceptance and greatest access for patients. Therefore for example:

a) In Denmark the Danish Chiropractors' Association made a commitment in the 1980s to establish research capacity, public funding for university education and interdisciplinary research, and informed participation in health policy circles. The profession is fully established within the Danish healthcare system and is not viewed as CAM.

b) In Canada in the past decade the Canadian Chiropractic Association (CCA) has built similar research capacity, with matching funds from the CCA and the federal government, and with the goal of establishing chiropractic research chairs in medical schools and other health science faculties at major universities in each Canadian province. These researchers and the chiropractic PhD students working with them are currently attracting greater annual research funds than the profession in any other country, and are establishing the conditions for full transition from CAM to mainstream.

c) A similar development is underway in the US, negotiated principally by the American Chiropractic Association. This is the establishment of chiropractic mainstream services at military and veterans' administration hospital/health facilities throughout the country. This, particularly when it can be supported by chiropractic education at a few state universities, will accelerate the transition to mainstream funding, acceptance and identity.

17. In summary, to have access to the public funds it deserves for education, research and practice, and must have to compete successfully within healthcare in this era, the chiropractic profession must participate in mainstream structures. Most chiropractors will and should remain in private clinics serving patients as they now do, but everyone in the profession should support fuller integration in publicly funded universities, primary care services and hospitals. There are of course other factors – for example establishing a clearer identity and role in health care, improved self-regulation in some jurisdictions – but the key is a greater level of participation in conventional education/research/practice structures and the recognition and funding that will bring. TCR

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