The Chiropractic Report

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Professional Notes

VA Commences Chiropractic Residencies

In a most significant development for the chiropractic profession in the USA the Veterans Health Administration, federally funded and the largest healthcare system in the country, has announced that it will commence funding one year postgraduate residencies for chiropractors in its hospital and other facilities commencing next year.

Many other established health professions have such residencies. The optometry profession regards the establishment of VA residencies 20 years ago as the pivotal moment in its development and acceptance in the US healthcare system. The majority of US medical and dental students complete their clinical training in VA facilities. They will now meet not only VA staff chiropractors but VA chiropractic residents.

The VA request for proposals released in July allows the many VA facilities throughout the country with existing chiropractic services and student training to apply for three years of funding – three

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The Prescription Drug Debate

Should the Chiropractic Profession Remain Drug Free?

A. Introduction

ANYONE WHO ASSERTS THAT the issue of whether or not doctors of chiropractic should seek prescription rights is a simple one for the profession with an obvious answer is either unaware of the relevant facts and arguments or unreasonable.

There are strong arguments both ways. To illustrate how complex the situation is consider these facts:

• The World Federation of Chiropractic, representing national associations of chiropractors throughout the world, has clear policy against the use of prescription drugs in chiropractic practice. See Figure 1. This was first passed by the Assembly of Members in 1997, and reaffirmed unanimously in 2003.

• In the USA in the past month, at a chiropractic summit in Seattle on November 7, the thirty-nine organizations and colleges representing the leadership of the profession in the United States (they are listed at www.chirosummit.org) passed a unanimous resolution that no Summit organization promoted the inclusion of prescription rights in the scope of practice of chiropractic, and that all organizations in the Summit "support a drug-free approach to healthcare".

• On the other hand opinion surveys of individual chiropractors show they are divided on the issue. Ten years ago an opinion survey in North America, by McDonald, Durkin et al. and comprising a random sample of 1,102 chiropractors, reported that approximately 1 of 2 thought chiropractors should be permitted to write prescriptions for over-the-counter (OTC) (54.3%) and musculoskeletal (48.8%) medications.[1] Some state organizations are pursuing prescription rights and a new Florida Chiropractic Physician Association has been formed with the principal goal of "fighting to advance your rights to include prescriptive authority in your practice."

• Turning to other countries, in Switzerland, the first country outside North America to pass legislation to recognize and regulate chiropractic practice – in Zurich in 1939, doctors of chiropractic have had limited prescription rights since 1995. Surveys published in 2003 and 2010[2,3] report a majority of practicing chiropractors agreeing that these rights have proved an advantage for the profession and supporting extension of these rights to analgesics and muscle relaxants. ChiroSuissse, the national association, is campaigning for these rights. (See more on the Swiss surveys below.)

• In other European countries such as Denmark and the UK a lively and challenging debate continues. In the UK a 2009 postal ballot of members by the British Chiropractic Association (BCA) asked whether or not the BCA should pursue prescribing rights. The context was that the government was enabling regulated professions other than medicine to apply for limited prescription rights relevant to their scopes of practice and patient population. Some, including physiotherapy, were applying for such rights.

The response rate to the BCA survey was not strong, approximately 1 in 3 (33%), but almost 80% of those responding were in favor. At the BCA Annual General Meeting in Bristol this past September retiring BCA President Dr Richard Brown presented his arguments against the BCA and the profession seeking prescribing rights. A number of members spoke to each side of the argument, giving cogent reasons for their positions.

2. In summary the issue of whether or not to seek to change education, legislation, and practice to include rights of

use of prescription medication is a large and complex issue for a profession for which "without drugs and surgery" is central to its history and brand. Therefore in this issue we review the arguments for and against, and then present these conclusions:

- Overall it is not in the best interests of patients or the profession for the chiropractic profession to seek to change its undergraduate education and its practice to include the use of prescription drugs within the standard chiropractic scope of practice.
- Individual chiropractors wanting to have prescription rights in specialized hospital and other practice settings should be entitled to have these, but only after completing an appropriate post-graduate education and qualification similar to other chiropractic and medical specialty qualifications.

Before further discussing the issues, and the arguments for and against, let us review some of the evidence of the opinions of individual chiropractors in more detail – in the US and Swiss surveys already mentioned.

Figure 1. WFC Policy Statement

Use of Prescription Drugs

Approved by the Assembly of the World Federation of Chiropractic

Orlando, April 30, 2003

Whereas the scope of chiropractic practice includes the management of patients with acute and chronic headache, neck pain and back pain and other neuromusculoskeletal disorders;

And whereas some of these patients may at times benefit from the use of prescription drugs and, as a result, a small minority of chiropractors has advocated seeking an expansion of the scope of chiropractic practice to include rights to prescribe drugs;

And whereas the art, philosophy and science of chiropractic have always emphasized the inherent recuperative power of the body to heal itself without the use of drugs or surgery and the legal scope of practice of chiropractic in all jurisdictions is based upon that premise;

And whereas it is desirable that there be international consistency in the essential components of the practice of chiropractic;

Now therefore it is resolved by the World Federation of Chiropractic that for reasons of chiropractic principle, patient welfare and interdisciplinary cooperation the practice of chiropractic does not include the use of prescription drugs, and chiropractic patients who may benefit from prescription drugs should be referred, where appropriate, to a medical doctor or other suitably qualified health care practitioner.

B. McDonald Survey — USA

3. The 2002 McDonald, Durkin et al. survey, published under the title *How Chiropractors Think and Practice*[1], was a broad opinion survey of the attitudes of North American chiropractors on many aspects of philosophy and practice. It confirmed the study hypothesis that most chiropractors display considerable unity on how they think and practice, and that differences within the profession have been exaggerated. They found "surprising unity" when you went to practicing chiropractors as opposed to leaders and special interest groups, and concluded that "the profession needs to review and modify century-old stereotypes".

However, McDonald, Durkin et al. found largest disagreement on the issue on which they thought they would find strong agreement – whether or not there should be use of medication in chiropractic practice.

Principal investigator was William McDonald DC, MSEd, a Palmer College graduate who has done much before and since to heal divisions in the profession. Co-investigators included Keith Durkin PhD and Stephen Iseman PhD from the Institute of Social Research, Ohio Northern University and Mark Pfefer DC, MS, Director of Research, Cleveland Chiropractic College. This was a written survey sent to a systematic random sample of 1,102 chiropractors in the United States, Canada and Mexico. There was a response rate of 63.3%. Respondents were asked to rate themselves as one of the following:

- **Broad scope:** allows a wide array of manual and other clinical procedures for diagnosing and treating both symptoms and neuromusculoskeletal conditions. Some in this camp would include minor surgery, obstetrics and prescribing medications.
- **Middle scope:** tends to combine subluxation adjusting with other conservative treatment and diagnostic procedures.
- **Focused scope:** emphasizes the detection and adjustment of verterbral subluxations to restore normal nerve activity to musculoskeletal and visceral tissues. Some in this camp oppose therapeutic modalities, extremity adjusting, and diagnostic procedures.

Approximately half (46.4%) rated themselves middle scope chiropractors, between broad scope (34.3%) and focused scope (19.3%). Interestingly, the majority of graduates from colleges with a reputation for promoting a traditional philosophy of chiropractic and focused scope did not rate themselves as focused scope practitioners. For example, approximately 2 in 3 of Life College graduates (68.1%) described themselves as broad scope (23.2%) or middle scope (44.9%) practitioners. Results of the survey included:

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a. **Issues Other Than Medication**

i. The overwhelming majority of respondents agreed with continued clinical use of the term verterbral subluxation complex (88.1%) and that the adjustment should not be limited to musculoskeletal conditions (89.8%) and for North America McDonald et al. concluded that overall "the profession presents a united front regarding the subluxation and the adjustment".

ii. There was a "united front" concerning differential diagnosis at new patient exams (93.4%) and the appropriateness of offering patients a broad spectrum of clinical services. "Orthotics (97.7%), clinic-based exercise (96.9%), vitamins (96.7%), acupressure (94%), therapeutic modalities (93.5%), and herbs (91.1%) are just a few of the many services recognized by a super-majority of chiropractors."

iii. McDonald et al. report that "on most issues, broad scope and focused scope chiropractors differ more in degree than in kind." For example, asked "In what percentage of visceral ailments is the vertebral subluxation a significant contributing factor" responses were 55.8% (broad scope respondents), 61% (middle scope), and 81.5% (focused scope).

b. **Medication Issues**

i. To get opinions from chiropractors on the value of medications generally the survey asked "of all pharmaceutical prescriptions filled annually, what percentage is clinically beneficial". Responses were 48.4%, 39.4 and 27.9% respectively for broad, middle and focused scope practitioners. In other words the value of medications is recognized – the issue of concern is frequency of use.

ii. On the matter of prescription rights for chiropractors approximately 1 in 2 thought chiropractors should be permitted to write OTC prescriptions (54.3% - including 77.1% of broad scope chiropractors, 17.6% of focused scope) and prescriptions for musculoskeletal medicines (48.8% - 71.3% of broad scope chiropractors, 19.2% of focused scope). Of Life College graduates 1 in 3 supported prescription of OTC (33.3%) and musculoskeletal (35.3%) medicines. Figures for Palmer graduates were similar. Again, a difference in degree, not in kind.

C. Robert and Wangler Surveys — Switzerland

4. Chiropractic practice is more fully integrated into the national and cantonal (equivalent of state) healthcare systems in Switzerland, a country of 8 million people and 26 cantons, than in the USA. Chiropractic is one of the five primary health care professions recognized and included in the Swiss Federal Law on Medical Professions – the others are dentists, pharmacists, physicians and veterinarians. Chiropractic services are included and funded under compulsory health insurance held by all residents, and chiropractic education is at the University of Zurich with public funding and support.

Since 1995 Swiss doctors of chiropractic have been authorized to prescribe what are known as C-list oral and topical medications for analgesia and arthritic/rheumatic conditions. These are available to patients as over-the-counter (OTC) drugs without prescription, but are reimbursed by insurances if prescribed by chiropractic or medical doctors.

5. In 2000 Robert[2] conducted an opinion survey of Swiss chiropractors on current and future use of prescription medication rights (the Swiss Survey). In 2009 Wangler, Zaugg and Faigaux, practising Swiss chiropractors led by Martin Wangler DC, MME, Director of Academic Affairs, European Academy of Chiropractic, repeated the survey in the Canton of Berne (the Bernese Survey). The Swiss Survey was larger than the Bernese Survey (245 vs. 47) but had a significantly lower response rate (51% vs. 77%). The Swiss Survey reports opinions after five years' experience of limited prescription rights, the Bernese Survey after 14 years.

Identical questions were asked in both surveys as follows:

Question A. Chiropractors have some limited privileges on prescription of medication (C-list): Do you consider this privilege as an advantage for the chiropractic profession? *Results:* There was agreement by 72% in the 2009 Bernese Survey. This compared with agreement by 84% of Swiss chiropractors from all other cantons (i.e. non-Bernese) in the Swiss Survey in 2003.

Questions B. Do you think that the profession should aim at extending this privilege to some specialties of the B-list (additional NSAIDs, muscle relaxants, and analgesics)? *Results:* 58% agreed in the Bernese Survey, which compared with 77% in the Swiss Survey. Of the 58%, the rates of support for seeking additional specific medications were NSAIDs 95%, analgesics 80% (this represents only 46.4% of all respondents in the Bernese Survey – 80% of the 58% agreeing to Question B) and muscle relaxants 55% (31.9% or 1 in 3 of all respondents). In other words there was firm support for extending rights to other NSAIDs but fewer than half supported seeking the right to prescribe analgesics muscle relaxants.

Questions C. Do you perceive medication as a necessary component of our treatment? *Results:* In the Swiss Survey in 2000 80% of chiropractors agreed, whereas in the Bernese Survey in 2009 a majority of 59% did not.

6. Further observations are:

a. Respondents to the Bernese Survey were a representative sample in terms of age, experience (66.7% having over 10 years in practice), gender, hours worked and solo or group practice.

b. Asked about how frequently they used their right to prescribe NSAIDs, 1 in 10 (11.4%) said often, 9 in 10 said seldom (48.6%) or never (40%).

c. Asked about how often in the past week patients had asked for recommendations or prescriptions for OTC medications most reported 0 – 5 times. Wangler et al. report that "the Bernese group actively prescribes medications at least once a week, although significantly less than asked for by their patients."

d. Strongest agreement on specific situations for recommending medications in chiropractic practice that were listed in the Bernese Survey, were acute cases where no range of motion can be achieved (72% agreement), helping patients who cannot sleep because of pain (92%) and as an adjunct to core chiropractic treatment to speed up recovery from pain (72%).

e. Because the Swiss Survey in 2000 had a different sample of chiropractors from the Bernese Survey in 2009 it is not possible to draw the conclusion some may be tempted to draw from the raw figures above – that experience of limited prescribing rights has led chiropractors to see these rights as less desirable or necessary. What is clear is that such experience has not led

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VA Commences Chiropractic Residencies

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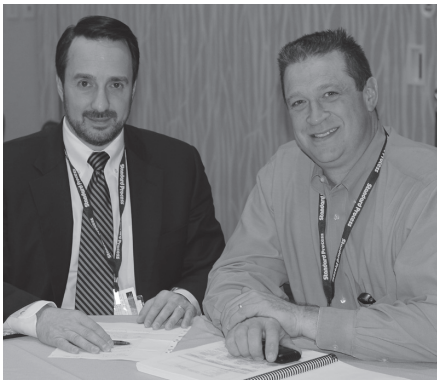
consecutive 1-year residencies. The target start date for the first cycle of residents is July 2014, and it is anticipated that 4-5 VA facilities will be awarded funding during first year.

Congratulations are due to many organizations and individuals in the profession for this historic achievement. These include the American Chiropractic Association, which has led the political campaign for increasing inclusion of chiropractic services in the VA over the past 15 years, and Dr Reed Phillips, Chair, and his colleagues who sat on the VA Chiropractic Committee negotiating the original terms of inclusion.

Also to be congratulated are the doctors of chiropractic who have served both in VA facilities and Department of Defense facilities, producing and documenting impressive results. Deserving particular recognition is Dr Anthony Lisi of the University Of Bridgeport College Of Chiropractic who is overall Director of the VHA Chiropractic Service and is on staff at the VA West Haven Medical Center in Connecticut.



*Dr Anthony Lisi, Director VHA Chiropractic Service (*left*) with Dr Paul Dougherty, one of the New York Chiropractic College faculty members who serve at five VA facilities.*

New Research

1. **Switzerland – Chiropractic for Neck and Arm Pain with Disk Herniation.** There is still little evidence supporting chiropractic manipulation, or any form of manual therapy, for patients with neck and arm pain and cervical disk herniation (CDH). Therefore the importance of this new study from Peterson, Schmid et al. from Switzerland just published in JMPT which reports clinical success with chiropractic adjustment for both acute and chronic pain patients. Points are:

a. This was a well-designed, prospective cohort study following a line of patients rather than a controlled trial with comparison groups.

b. The purpose of the study was to investigate the results of chiropractic manipulation in a regular out-patient chiropractic practice for acute and chronic neck and arm pain patients "with cervical radiculopathy from MRI-confirmed CDH."

c. Patients were 50 consecutive adult patients seen at a 3-person private chiropractic practice and presenting with neck pain and moderate to severe arm pain; sensory, motor or reflex changes corresponding to the involved nerve root; at least 1 positive orthopedic test for cervical radiculopathy; and with MRI-proven CDH at the corresponding spinal segment.

d. Treatment was a standardized cervical adjustment or manipulation delivered by one of the three chiropractors. Treatment was repeated 3-5 times per week for the first 2-4 weeks and 1-3 times per week thereafter until the patient was asymptomatic. Patients could take over-the-counter pain medications but there were no other treatments.

e. Outcome measures, scored at baseline and at 1 and 3 months, were two pain numeric rating scales for neck and arm pain, the Neck Disability Index and the patient's global impression of change.

f. Results included:

i. At 2 weeks 55.3% of all patients were significantly improved, none being worse. At 1 month 68.9% and at 3 months 85.7% were significantly improved no patients being worse.

ii. A higher proportion of acute patients (symptoms 4 weeks or less), experienced clinically relevant improvement and this was faster compared with those who were sub-acute or chronic. However "at 3 months 76.2% of the sub-acute/chronic patients reported clinically relevant improvement," with no patients reporting they were worse. Peterson et al. point out that 30-35% pain reduction on NRS pain scores is considered clinically relevant, but that reduced NDI scores at 3 months in their study far exceeded that – being between 66% and 75%.

g. In the Discussion at the end of the paper points made by Peterson et al. include:

i. While the natural history of patients with acute pain from CDH radiculopathy is quite favorable, this is not so for chronic patients. The chronic patients in their study – defined as having pain for at least 4 weeks but in fact having average duration of pain of 298 days or approximately 42 weeks – had very good results.

ii. Results were much better than for Kolstad et al. in the only published study of treating chronic CDH radiculopathy patients with cervical nerve root blocks – 2 blocks consisting of a corticosteroid and an anesthetic. 24% of patients had a 25% reduction in NRS score at 6 weeks and 4 months after injection. Kolstad et al. patients were slightly more chronic, all having had symptoms for at least 3 months.

(Peterson C, Schmid C et al. (2013) *Outcomes From Magnetic Resonance Imaging-Confirmed Symptomatic Cervical Disk Herniation Patients Treated With High-Velocity, Low-Amplitude Spinal Manipulative Therapy: 3-Month Follow-Up.* J Manipulative Physiol Ther 2013;36:461-467)

2. **Australia – Two Significant New Studies on Safety.** These studies have two important conclusions:

i. That spinal manipulative therapy (SMT) for the lumbar region is safe and that isolated case reports of serious adverse events (e.g. disk herniation, fracture, cauda equina syndrome) have limi-

tations, are anecdotal and do not allow inferences to be made about causation by SMT. It follows, therefore, that there is no evidence that SMT causes or gives rise to a risk of disk herniation.

ii. That the many less severe time-limited adverse events of chiropractic treatment of the spine are experienced equally by those receiving sham manipulation – suggesting that many such events may be related to natural history.

Jeffrey Hebert DC, PhD, Norman Stomski, PhD, Simon French, PhD, MPH, BAppSc(Chiropractic), and Sidney Rubinstein, DC, PhD, chiropractic researchers from Australia and the Netherlands, have performed a thorough and impressive literature review of all relevant studies in English, German, Dutch or Swedish published up to January 2012 (2046 studies) to assess reported serious adverse events following lumbopelvic SMT delivered by any type of provider (e.g. chiropractic, medical, physiotherapy, osteopathic, lay person). Points are:

a. They defined a serious adverse event as "an untoward occurrence that results in death or is life-threatening, requires hospital admission, or results in significant or permanent disability."

b. They found 41 studies reporting on 77 cases, the most common of which were cauda equina syndrome (38% - 29 cases) and lumbar disk herniation (30% - 23 cases) and fracture (9% - 7 cases).

c. Importantly: "The anecdotal nature of these cases does not allow for causal inferences between SMT and the events identified in this review." Further, "important case details were frequently unreported" – including technique, specific details of the adverse event, time from SMT to the event, other factors contributing, etc.

d. There will be isolated cases of serious adverse harm but the incidence of these "is thought to be extremely low" and "recent systematic reviews of randomized controlled trials, cohort studies, and a patient survey have failed to identify a single serious adverse event following lumbopelvic SMT."

e. Based on a few isolated cases of disk herniation and the mechanical nature of SMT observers might recommend avoiding the use of SMT because of suspected potential for disk herniation. "However it is unreasonable to make such a recommendation based solely on knowledge derived from anecdotal cases." Additionally, Hebert et al. point out, the value of any therapy requires knowledge of the additional domains of:

• Clinical effectiveness. "…current evidence suggests that SMT is likely to benefit patients with known lumbar disk herniation, with randomized trials reporting SMT to be superior to sham and equivalent to microdiscectomy."

• Cost-effectiveness.

• Magnitude of risk, absolutely and relative to other treatment options.

f. British PT and medical researchers Carnes et al., in a systematic review published in Manual Therapies in 2010, found no major adverse events after lumbopelvic SMT, and the following relative risk (RR) of mild to moderate adverse events:

• There was a similar risk to that from exercise.

• There was a lower risk than with drug therapy.

Accordingly, here is your latest evidence to challenge and answer anyone saying that risk of disk herniation is a contraindication to SMT.

(Hebert J, Stomski N et al. (2013) *Serious Adverse Events and Spinal Manipulative Therapy of the Low-Back Region: A Systematic Review of Cases* J Manipulative Physiol Ther 2013;xx:1-15)

The second study, by Walker, Hebert et al. and mischievously called the OUCH trial, addresses the frequent minor adverse effects of chiropractic care – much less important because they are generally very temporary and akin to stiffness following exercise and sleepiness and dry mouth with medications. However it is significant as the first trial looking at such adverse events after chiropractic care compared with sham manipulation.

a. A group of 183 adults with spinal pain attending 12 chiropractic clinics in Perth, Australia in August – October 2012 were randomly assigned to 2 groups:

i. Usual chiropractic care (n 92) – 8 chiropractors provided usual care including manipulation.

ii. Sham intervention (n 91) – 4 chiropractors giving at each visit a sham Activator treatment (wound to lowest output and administered on the back randomly through a tongue depressor to disperse any remaining force) and detuned ultrasound (with a hand randomly placed on the spine at the same time to give a hands-on experience).

b. Outcome was measured by a questionnaire as described in the paper. Results were:

• After 2 treatments separated by approximately one week, 33% of the sham group and 42% of the usual care group reported at least one adverse event.

• Common were increased pain (sham 29%, usual care 36%), muscle stiffness (sham 29%, usual care 37%), and headache (sham 17%, usual care 9%).

• This represented no significant differences. There were no serious adverse events.

• Walker et al. conclude that "a substantial proportion of adverse events after chiropractic treatment may result from natural history variation and non-specific effects."

(Walker B, Hebert J et al. (2013) *Outcomes of Usual Chiropractic. The OUCH Randomized Controlled Trial of Adverse Events* Spine 2013;38:1723-1729)

3. **Key Research Papers for the Chiropractic Profession.** Mansholt et al. from Palmer College surveyed 43 academic and research leaders asking what the most essential literature was for doctors of chiropractic, faculty, and students to read or reference. They came up with 43 articles. You can read the full paper on line at www.chiromt.com.

to widespread use of prescription rights or to the conclusion that prescription rights are necessary for the profession.

f. In the Bernese Survey how is it possible that a majority of 72% rate "the privilege to prescribe non-prescription medication an advantage for chiropractic care" yet a majority of 59% say it "is not a necessary component"? One factor may be the authority these rights give doctors of chiropractic to counsel against inappropriate use of medication. That is supported by the figures above.

D. Arguments against Prescription Rights

7. **Fundamental Chiropractic Principles.** Chiropractic was conceived, developed and is practiced throughout the world as a natural healing art, respecting the inherent healing powers of the body and making no use of drugs or surgery. Patients requiring those forms of care should receive them from others. In the words of the Association of Chiropractic Colleges (ACC), representing all chiropractic educational institutions in North America, in its 1996 ACC Paradigm of Chiropractic, unanimously adopted in 1996:

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs and surgery.

The ACC Paradigm, developed to provide future direction for education, practice and research, was subsequently endorsed by the American Chiropractic Association, the International Chiropractors' Association and the World Federation of Chiropractic.

On fundamental chiropractic principles and their relevance to any discussion on use of drugs consider the following eloquent statement from an unlikely source and outside observer. This is Gordon Waddell, the internationally renowned orthopaedic surgeon and back pain specialist, describing the chiropractic profession in his text *The Back Pain Revolution* which presents the basis for best contemporary management of back pain patients. After describing chiropractic's holistic and naturopathic roots he observes:

The naturopathic approach is the opposite of orthodox or allopathic medicine. The allopathic approach considers that disease is due to an external cause overcoming the body's resistance, e.g., germs cause infection. Orthodox medicine's answer is to counter the external cause, e.g., with antibiotics. The naturopathic approach considers that illness is largely due to the person's lowered resistance, e.g., only a few of those exposed to germs become infected. So the answer is to strengthen the person, rather than attack the external cause. Healing depends on mobilizing the innate recuperative powers within the patient.

The emphasis of chiropractic is on natural remedies. It restores musculoskeletal integrity and neurophysiologic function. It stresses a proper diet, lifestyle, and a healthy environment. It uses conservative, safe treatments and avoids drugs and surgery. It helps the patient to understand that his or her illness is the result of the body's failure to maintain a healthy state. Manipulation may stimulate healing, but the patient also has to change and return to more healthy living. It is a patient-centered, hands-on approach that depends on good communication between doctor and patient. Touch and physical contact between doctor and patient help to mobilize this internal healing power. It is wellness-oriented rather than sickness-oriented, and is concerned with the person who is ill rather than the illness that the person has.[4]

8. **Brand and Importance to Patients.** The last generation in the industrialized world has seen new levels of concern about the inappropriate use, side effects, harm and cost of prescription drugs. There has been a corresponding rise in the use of complementary and natural forms of care. Studies of complementary and alternative medicine (CAM) conclude:

- CAM users do not reject orthodox medicine altogether and do not have noticeably different health belief models to those who are exclusive users of orthodox medicine. They are a normal cross section of the population shopping for healthcare – they will use orthodox medicine for broken bones, chiropractic and acupuncture for back pain and headache, and homeopathy for allergies.
- There are two dominant factors in the sharply increased use of CAM – the pull factor (an attraction to holistic and natural care) and the push factor (dissatisfaction with medical care for their current complaint).[5]

With respect to chiropractic, patient surveys, focus groups and everyday office experience all confirm that one of the strong pulling factors is the desire to find an approach to health which can help them to avoid reliance upon drugs and surgery. Mention has already been made of a US Chiropractic Summit meeting in Seattle this month. At this Summit Laura Carabella of the Foundation for Chiropractic Progress (www.f4cp.org) reported on new focus groups held in New Jersey and California to test which brand messages resonated with a representative cross section of adults who were not chiropractic patients. What were the brands or marketing messages that would attract them to chiropractic care? In both focus groups by far the most important messages were:

- Effective management of back and neck pain.
- Without drugs and surgery.

One of the brand pillars of the WFC's identity statements agreed by its member associations is "without use of drugs and surgery, enabling patients to avoid these where possible." See the full identity statements in Figure 2.

9. **Loss of Core Adjusting Skills.** Chiropractic is the profession that has revived, championed and led research and practice of the art of spinal manipulation in the modern era. Expert manual assessment and treatment, with spinal adjustment at the forefront, is the hallmark of chiropractic education and practice.

As anyone knowledgeable about this approach to healthcare attests, there are complex psychomotor skills involved. Attainment of these skills requires extensive time and training. A significant concern with expanding the scope of practice to include use of prescription drugs is that this would lead to reduced or lost adjustment skills, seriously undermining the role and future success of the profession. Several reasons for this include:

- The introduction of substantial additional pharmacology to the undergraduate chiropractic curriculum, in both didactic and clinical education, will necessarily reduce the emphasis on traditional chiropractic management skills.
- Graduates lacking confidence in their manual and manipulative skills are likely to favor drug therapy rather than working at improving their traditional adjusting skills. For older

patients with acute low-back and pelvic pain will a student or a younger practitioner learn a suitable adjusting technique, such as Logan Basic, or reach for a prescription pad? If many chiropractors opt for prescriptions for many years in this situation what will be the distinct and valuable role of the profession in healthcare in the future?

- Other practical considerations aggravate that concern. Prescribing takes less time and effort. The pharmaceutical industry can be persuasive in encouraging use of its products. Particularly in North America risk of litigation is a factor in the use of spinal adjustment. This Report is already aware of cases where patients in the USA have consulted four or more chiropractors before finding one offering high-velocity adjustment techniques.

10. **Impact on Interprofessional Relations.** For patients with the musculoskeletal disorders most commonly seen in chiropractic practice we are in an era of rapidly growing patient-centred, evidence-based and team-based care. This is seen in hospitals from Brazil to Saudi Arabia, in the Military and Veterans Administration healthcare systems in the US, primary family healthcare teams in Canada and the NHS in the UK.

There is need to respect the roles of others. A move by the chiropractic profession to include the use of prescription drugs within its scope of practice has major implications for relationships with medical colleagues, who have long predicted and criticized any such expansion of scope. Such a move is not dissimilar to the reverse situation of medical doctors expanding their scope to include manipulation.

11. **Divisiveness in the Profession.** There is a reason that all 39 US Summit partners have just declared that they do not support the inclusion of any drug prescription rights within the scope of chiropractic practice, notwithstanding that surveys show about half of the profession and therefore many of their members are open to or in favour of this. This is the most divisive issue in the profession and those organizations that have shown any willingness to even entertain a debate have lost membership and been vilified by others.

In the US and internationally the chiropractic profession has substantial unity of opinion and action at the moment, certainly compared with the recent past and with other professions such as acupuncture and osteopathy. That hard-won new level of cooperation, and many potential benefits that can flow from it, will easily founder and be lost with an untimely and broad conflict on the use of drugs.

Figure 2. WFC Identity Statements

1) *Brand Platform (The Pole).* The spinal health care experts in the health care system.

2) *Brand Pillars (The Ground).*

a) Ability to improve function in the neuromusculoskeletal system, and overall health, wellbeing and quality of life.

b) Specialized approach to examination, diagnosis and treatment, based on best available research and clinical evidence with particular emphasis on the relationship between the spine and the nervous system

c) Tradition of effectiveness and patient satisfaction

d) *Without use of drugs and surgery,* enabling patients to avoid these where possible

e) Expertly qualified providers of spinal adjustment, manipulation and other manual treatments, exercise instruction and patient education.

f) Collaboration with other health professionals

g) A patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the self-healing powers of the individual and individual responsibility for health and encouraging patient independence.

3) *The Personality.* The personality should be a combination of:
- Expert, professional, ethical, knowledgeable; and
- Accessible, caring, human, positive

E. Arguments in Favor

12. **The Best Interests of Individual Patients.** This is a significant first argument in favor of doctors of chiropractic having rights of use of musculoskeletal medications within their scope of practice. Evidence-based clinical guidelines and pathways for the management of the vast majority of patients with back and neck pain recommends spinal manipulative therapy, analgesics, patient education and encouragement, continued activity and exercise as first line approaches to management.

As the BJD Neck Pain Task Force emphasized in its widely adopted literature review and report in 2008[6] none of the above treatment approaches is clearly superior to the others, and patient preference will often be the deciding factor – particularly for neck pain and headache patients. Some will prefer a drug free approach with manipulative therapy and exercises. Others who are apprehensive about all manual therapies will prefer medication. Treatments preferred by patients tend to produce better results and should be made available.

Further, as the Bernese Survey indicates, some of these patients progress better with a combined course of spinal adjustment and NSAIDs. The reason Bishop, Quon et al. randomized controlled trial in Canada, which reported that guidelines-based care produced superior results to usual family physician care for acute mechanical low-back pain patients, had four weeks of chiropractic adjustment as a central component of the guidelines-based care. But patients also received medication (acetaminophen).[7]

13. **Ability to Succeed in Spine Care.** A second compelling argument is that chiropractors should have limited prescription rights in their treatment toolbox to compete with other professionals in the non-surgical spine and musculoskeletal marketplace. In different jurisdictions naturopaths, osteopaths, and physical therapists are seeking and achieving prescription rights. Chiropractors must offer as broad a range of evidence-based treatments, not only to meet patient needs but also to compete in privately and publicly funded healthcare plans and systems.

Physical therapists/physiotherapists in various countries, including the UK and Canada and the USA, have new prescription rights in specific practice settings if they have completed appropriate extended training. Their similar role to chiropractors and their similarity of their goals within healthcare systems are illustrated well in a small study just reported by an American physical therapist, Troy McGill in Military Medicine[8].

The purpose of his study was to compare the efficiency and effectiveness of a physical therapist and family physicians functioning as musculoskeletal primary care providers (PCPs) in an active-duty, airforce, outpatient clinic. McGill explains

that PTs in the US military healthcare system are granted additional privileges to normal private practice, being credentialed to:

- Have direct access without referral.
- Order diagnostic laboratory and radiographic/MRI studies (to be interpreted by a radiologist, physician, or orthopedist).
- Prescribe medications limited to NSAIDs, inflammatories, and muscle relaxants.
- Perform and interpret electromyographic/nerve conduction diagnostic studies.
- Admit and discharge patients to/from quarters.

PTs still usually receive patients on referral. In this study McGill saw active duty and contract personnel directly as a PCP. Points are:

a. A retrospective chart review was performed on 150 randomly selected patients who had presented with musculoskeletal complaints over an eight month period to January 2010 – approximately 50 seen by McGill and by each of two family practitioners also serving as PCPs at the base.

b. Results were dramatically different. The return to duty (RTD) rate was 50% greater for the PT patients. Rate of medication and imaging use for PT patients was 24% and 11% - for family practitioner patients it was 90% and 82% respectively. McGill concludes that "using a PT as the musculoskeletal PCP was shown to be an effective and efficient practice model to assess and treat patients with musculoskeletal complaints."

14. **Authority to Reduce Reliance on Medication.** Another argument for expanded training and scope of practice with respect to prescription drugs is that this will give chiropractors the competencies and authority to advise patients against overuse and over-reliance on medication. That is a significant argument in principle, and one can find concrete evidence in support in the Bernese Study. As already discussed, in that study chiropractors with 14 years' experience of C-list prescription rights on average, dissuaded patients from taking medications for their various presenting complaints.

F. Conclusion

15. So there it is – compelling arguments either way, and a complex issue. No one can reasonably attack or belittle anyone arguing for or against the profession moving to obtain limited prescription rights. There are serious but different patient and professional best interests on both sides.

For this Report, however, there is a clear-cut answer. The fundamental principles, philosophy, and brand of the profession, allied with the need to protect, promote and further enhance the traditional manual skills and hands-on nature of chiropractic care, tip the scales against any general expansion into the field of drug prescription rights. Chiropractic should remain a visible champion for natural healing. Additionally, the future will tell us how little we currently know about the physical assessment and management of the neuromusculoskeletal system. The profession's focus in research and expansion of educational curriculum and practice methods should remain firmly on physical and natural methods of care.

As already explained, however, there should be post-graduate education, qualification and opportunities for chiropractors wanting a specialist scope of practice that includes the use of musculoskeletal medications. This will be similar to current specialist qualifications and practice in various diagnostic and treatment fields (e.g. radiology, veterinarian chiropractic, occupational health, sports chiropractic). An appropriate legislative and regulatory framework needs to be developed. This, as for a growing number of health professions, will provide for extended practice rights for those with appropriate post-graduate training. TCR

References

1 McDonald W, Durkin K et al. (2003) *How Chiropractors Think and Practice: The Survey of North American Chiropractors* Institute for Social Research, Ohio Northern University, Ada, Ohio.

2 Robert J. (2003) *The Multiple Facets of the Swiss Chiropractic Profession* Eur J Chiropr 50:199-210

3 Wangler M, Zaugg B, Faigaux E (2010) *Medication Prescription: A Pilot Survey of Bernese Doctors of Chiropractic Practicing in Switzerland* doi:10.101/j.jmpt.2010.013

4 Waddell G (2004) *The Back Pain Revolution* Second Edition, Churchill Livingston, Elsevier Ltd., 60-61.

5 Chapman-Smith D (2000) *The Chiropractic Profession* NCMIC Group, 135-136 and references there given.

6 Haldeman S, Carroll L et al. (2008) *The Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders; Executive Summary,* Spine 33(4S):S5-S7

7 Bishop P, Quon J et al. (2010) *The Hospital-Based Interventions Research Outcomes* (CHIRO) *Study: A Randomized Controlled Trial on the Effectiveness of Clinical Practice Guidelines in the Medical and Chiropractic Management of Patients with Acute Mechanical Lower Back Pain* The Spine Journal, Dec 2010;10(12):1055-64.

8 McGill T (2013) *Effectiveness of Physical Therapists Serving as Primary Care Musculoskeletal Providers as Compared to Family Practice Providers in a Deployed Combat Location: A Retrospective Medical Chart Review* Military Medicine, 178,10:1115.