The Chiropractic Report

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Professional Notes

New Australian Acute Pain Guidelines

In late December Australia became the latest country to publish national guidelines for the management of acute musculoskeletal pain – low-back, thoracic, neck, shoulder and anterior knee pain experienced for up to three months in duration.

These were part of wider clinical guidelines for all acute pain. As with the AHCPR Acute Back Pain Guideline in the US, there are extended full documents (*Acute Pain Management: Scientific Evidence* and *Evidence-Based Management of Acute Musculoskeletal Pain* – 259 pages) and summaries for general practitioners and consumers. All documents can be found at the National Health and Medical Research Council's website www.nhmrc.gov.au.

The musculoskeletal guidelines were developed by a multidisciplinary Australian Acute Musculoskeletal Pain Guidelines Group (the MSP Group), chaired by Professor Peter Brooks, Executive Dean, Faculty of Health Sciences, University of Queensland.

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WFC's Consultation on the Profession's Identity

Why an Agreed Identity is Vital, and Your Role

The profession has not resolved questions of professional and social identity . . . chiropractic stands at the crossroads of mainstream and alternative medicine.

Meeker and Haldeman, 2002.[1]

It is essential to establish a single and unequivocal identity for chiropractic in the minds of the public as soon as possible.

Caplan and Associates, 1994.[2]

A. Introduction

IN RESPONSE TO AN URGENT request from its member national associations, the World Federation of Chiropractic (WFC) has recently appointed a 40-member task force to lead an international grassroots consultation seeking consensus and direction on the most appropriate identity for the chiropractic profession within health care.

From a public perspective, what is the identity or role of the chiropractic profession? When and why does a potential patient think of consulting a doctor of chiropractic? Are chiropractors part of mainstream or alternative health care? Are they primary care practitioners or primary contact specialists like dentists and podiatrists? If the latter, what core identity or brand best describes that specialist role? These are some of the questions the WFC consultation – and the profession – must answer.

2. First steps taken by the WFC since last August include:

- Expert social marketing consultants, Manifest Communications of Toronto, Canada, have been retained.
- A wealth of relevant past research, surveying attitudes and practices of the public and the profession in many countries, has been gathered and reviewed.
- A broadly representative task force, comprising 34 doctors of chiropractic, one student and 5 lay members representing the public, has been established. Co-chairs are Dr. Paul Carey from Canada, WFC President and Past-President of the Canadian Chiropractic Association, Dr. Gerard Clum from the USA, WFC 2nd Vice-President and President of Life Chiropractic College West, and Dr. Peter Dixon from the UK, President of the European Chiropractors' Union and Past-President of the British Chiropractic Association.
- Broad professional support has been obtained. Beyond the support of all major national chiropractic associations there is funding and endorsement from a diverse group of leading chiropractic organizations such as the Association of Chiropractic Colleges representing the academic community, the European Chiropractors' Union, representing the region of Europe, and the Canadian Chiropractic Protective Association and NCMIC Insurance, the profession's leading indemnity insurers in Canada and the USA respectively.

Next May/June all chiropractors will be asked to complete an electronic survey developed by the WFC Task Force and administered by Manifest Communications. Development of this survey, central to the whole exercise, is presently underway and due to be completed by the Task Force at its meeting in California in late February.

3. This issue of *The Chiropractic Report* discusses this major new project – the first worldwide opinion survey of practising chiropractors, and one giving direct voice to their views on the identity of the profession – and also discusses why this project is of such importance to the future of the profession.

B. Background on Identity

4. Recent studies in many countries demonstrate that chiropractors themselves remain undecided about the core

identity of the chiropractic profession in the health care system. Other studies – not surprisingly – show that the public is somewhat confused and, of even more concern, has some very different perceptions of the role of chiropractic than those of the profession itself.

For example a large national study in Canada in 1994 commissioned by the Canadian Chiropractic Association and including focus groups and in-depth interviews with each of chiropractors, chiropractic patients and members of the public that were not patients, found that chiropractors felt that prevention was a major part of their practice and role in health care. However the public – not only non-patients but also chiropractic patients – disagreed. None even mentioned prevention in connection with the use or potential use of chiropractic services. Members of the public rated prevention as important but saw this as related to diet, exercise and lifestyle rather than chiropractic health care.[2]

5. Why is this confusion on identity important? Quite simply, because consumers/patients/customers don't use a product or service that has an unclear identity and purpose and that fails to meet a clear need – as seen and felt by them. Additionally, the identity or brand of a product or service serves to mark out a core market territory and help defend it from competitors.

6. Throughout its history chiropractic has managed to grow despite its divisions and identity problems. However, currently there is much more competition in rapidly evolving health care systems, especially in the developed world, and many expert observers are warning with greater urgency that the profession must now establish an agreed and clear identity or lose market share and momentum in the years ahead. As examples:

(a) 10 years ago in 1994 Kenneth Caplan and Associates, authors of the above-mentioned Canadian study, reported after extensive research that improved identity and image, position, and reputation were essential to the future development of the profession which should "establish a single and unequivocal identity for chiropractic in the minds of the public as soon as possible."

(b) In 1998 the Institute for Alternative Futures (IAF), commissioned by NCMIC Insurance to study then offer insights and recommendations on the future of the chiropractic profession in the USA, described a range of possible scenarios from significant growth and great success to major contraction and "very hard times". The IAF identified the specific areas requiring attention – but emphasized that the starting point had to be a consultation with individual chiropractors, the grassroots profession, to establish a shared identity and vision. "Without a clear and agreed upon role", said the AIF, "the profession will decline and suffer greatly in the near future because of new competitive pressures".[3]

(c) Writing with long experience and mature insight for a medical audience in a 2002 article in the *Annals of Internal Medicine* titled *Chiropractic: A Profession at the Crossroads of Mainstream and Alternative Medicine*, chiropractic leaders Meeker and Haldeman examined the major advances of the profession within mainstream health care in the USA during the past 20 years but noted that chiropractic was still in a "transitional phase". Its future role in the overall health care system remained "controversial". This was because the profession had not resolved "questions of professional and social identity" and remained "at the crossroads of mainstream and alternative medicine."[1]

(d) This "uncertain future" for the profession in the USA, "despite new levels of legitimacy and prominence and various current signs of success", has been analysed most recently by health policy researchers Cooper and McKee from the Medical College of Wisconsin. For a comprehensive study titled *Chiropractic in the United States: Trends and Issues*[4] they drew upon an extensive literature search that included 500 credentialing reports randomly drawn from 11,000 reports submitted by chiropractors to a large chiropractic network between 1993 and 1997. Trends noted by them included:

- Rapidly expanding competition on one side from acupuncturists and massage therapists, and on the other side from other health professionals moving into spinal manual therapy, for the largest groups of patients seen in chiropractic practice – those with low-back pain, neck pain and headache.
- In response, the chiropractic profession expanding beyond its traditional forms of treatment, reaching more deeply into alternative medicine and primary care and "more aggressively marketing natural products and devices".
- With respect to chiropractic's broader role in alternative care, they saw uncertainty about the room for growth, given the competition, and dangers for the profession in chiropractors "moving too far from their core of special knowledge."
- With respect to a wider primary care role, including screening, prevention, health promotion, counselling and coordination of care, they describe challenges of questionable qualifications, inability to prescribe pharmaceuticals or perform minor surgery, restrictions from private insurers and competition from nurse practitioners and physician assistants whose training and services more fully meet the needs of primary care.

All of these concerns are symptoms and not the cause – the underlying disorder, as many expert observers inside and

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outside the profession agree, is the lack of a shared identity and vision.

7. Perhaps nothing makes this clearer to chiropractors, and more clearly demonstrates that identity is a matter that must be resolved internationally, than the issue of the use of prescription drugs within the scope of chiropractic practice. International organizations, such as the Association of Chiropractic Colleges in its 1996 Chiropractic Paradigm and the World Federation of Chiropractic in specific policy posted at its website, firmly maintain the traditional drug-free approach.

However, a January/February 2000 survey of UK chiropractors (all 1418 active in practice, with a response received from 816 or 58%) revealed that 36% agreed that "chiropractors should be allowed to prescribe medication on a restricted basis (e.g. mild analgesics, NSAIDs and muscle relaxants)."[5]

A March 2002 survey of a random sample of 1102 practising practitioners in the US, Canada and Mexico reported that approximately half of North American chiropractors support limited prescription rights for OTC and musculoskeletal medicines in chiropractic practice.[6]

And in Switzerland, where chiropractors have been able to prescribe OTC drugs since 1995 thereby qualifying patients for reimbursement by government and private insurances, a 1999 survey showed that more than 3 of 4 Swiss chiropractors thought this limited prescription right was an advantage for the profession (82%) and should be extended to a limited range of other prescription drugs (76%).[7]

Yes, the need for better consensus on identity is urgent and clear.

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Table 1 **Members of WFC Identity Task Force**

Name and Country	*Nominated by*
Joel Alcantara, USA	International Chiropractic Pediatric Association
Bram B Briggance. USA	Co-chairs (lay person)
Joseph E Brimhall, USA	Council on Chiropractic Education International
Paul F Carey, Canada	WFC Council
Carl Cleveland III, USA	Association of Chiropractic Colleges
Gerard Clum , USA	WFC Council (Co-chair)
Peter Dixon, United Kingdom	WFC Council (Co-chair)
C Kevin Donovan, USA	Congress of Chiropractic State Associations
Philippe A Druart, Belgium	European Chiropractors' Union
Phillip S Ebrall, Australia	Co-chairs (education/research)
Homer E Firestone, Bolivia	WFC Latin American Region
Peter G Furno, USA	Self
Matthew Givrad, USA	Co-chairs (lay person)
Cheryl Hawk, USA	Co-chairs (education/research)
Donald J Henderson, Canada	Self
Espen F Johannessen, Norway	Norwegian Chiropractic Association
Susan King, United Kingdom	Co-chairs (education/research)
David B Koch, USA	Palmer Chiropractic University System
Henrik Lauge Laugesen, Denmark	Danish Chiropractors' Association
Barry J Lewis, United Kingdom	WFC European Region
Pran Manga, Canada	Co-chairs (lay person)
George B McClelland, USA	American Chiropractic Association
William P McDonald, USA	Self
Athol A McLean, Namibia	WFC African Region
Silvano A Mior, Canada	Co-chairs (education/research)
Jean Moss, Canada	Association of Chiropractic Colleges
Greg Oke, New Zealand	New Zealand Chiropractors' Association
Efstathios Papadopoulos, Cyprus	WFC Eastern Mediterranean Region
E Daniel Quatro, USA	New York State Chiropractic Association
Dennis Richards, Australia	WFC Pacific Region
Jean Robert, Switzerland	Co-chairs (education/research)
Louis Sportelli, USA	Co-chairs (Vendor)
Gregory B Stewart, Canada	Canadian Chiropractic Association
Anna Maria Svabo Jorgensen, Singapore	WFC Asian Region
Ann-Liss Taarup, Denmark	Co-chairs (lay person)
Irene G Turner, United Kingdom	Co-chairs (lay person)
Cindy Vaughn, USA	Self
Adrian B Wenban, Spain	Self
Victoria Wheeldon, United Kingdom	World Congress of Chiropractic Students
Stephanie Youngblood, USA	International Chiropractors' Association

The co-chairs of the World Federation of Chiropractic Task Force on Identity – Dr. Paul Carey (left), Dr. Gerard Clum (center), and Dr. Peter Dixon.

New Australian Acute Pain Guidelines

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Professor Brooks also leads the Australian National Action Network for the international 2000-2010 Bone and Joint Decade Initiative. Chiropractic members of the MSP Group were Dr. Philip Bolton (acute neck pain), Dr. Keith Charlton (acute thoracic spinal pain) and Dr. Simon French (acute low-back pain).

These guidelines replace the much-criticized, unbalanced and unpublished draft guidelines developed by the Australasian Faculty of Musculoskeletal Medicine without chiropractic participation. Unlike those earlier unpublished guidelines, they acknowledge a clear role for manual therapy including spinal manipulation. On the other hand they assess the scientific evidence very conservatively and promote pharmacological interventions to a degree not warranted by the evidence review released with the guidelines.

The guidelines incorporate published evidence to January 2003 and points of note include:

a) For acute low-back pain, interventions are rated as having *evidence of benefit* (advice to stay active/activation; patient information/education), *conflicting evidence* (muscle relaxants, NSAIDs and spinal manipulation) or *insufficient evidence* (everything else – including acupuncture, analgesics, exercises, back school, bed rest, injection therapies, lumbar supports, massage, etc.)

b) For thoracic pain, only spinal manipulation has evidence of benefit – a point made clear in the full scientific document but not mentioned in the summary information for general practitioners or consumers.

c) For neck pain, activation, exercises with or without modalities and pulsed EMT are rated as having evidence of benefit, all else including spinal manipulation and pharmacological interventions as having insufficient evidence. However the summary information for GPs notes some benefit from spinal manual therapy, including spinal manipulation.

d) In the full musculoskeletal guidelines, titled *Evidence-Based Management of Acute Musculoskeletal Pain* (the MSP Guidelines) the following terms and definitions are used:

Manual Therapy: The application of physical techniques, which includes but is not limited to, massage, spinal manipulation and mobilisation.

Manipulation (Spinal). Manual therapy technique in which loads are applied to the spine using short or long-lever methods. The spinal joint to which the technique is applied is moved to its end range of voluntary motion, followed by application of a single high-velocity, low-amplitude thrust. Spinal manipulation is usually accompanied by an audible pop or click.

Mobilisation: Mobilisation is the passive application of repetitive, rhythmical, low-velocity movements of varying amplitudes applied within the joint range of motion. The technique includes methods of a singular or repetitive movement and/or stretching of the spinal joints.

Massage: A mechanical form of therapy in which the soft-tissue structures of the low-back are pressed and kneaded, using the hand or a mechanical device. Many different types of massage are performed, including but not limited to, acupressure, deep-tissue therapy, friction massage, Swedish massage, myofascial release, shiatsu, reflexology, *craniosacral therapy*, *trigger and pressure point therapy*. (Emphasis added.)

e) On one hand the 19 page booklet for consumers advises that "both drug and non-drug treatments can be successful in controlling pain" and lists spinal manual therapy ("this involves pressure, movement and mobilization of the spine, for the relief of back and neck pain") as available options. On the other hand there is no specific reference to spinal manipulation and consumers are encouraged to use spinal manual therapy and other non-drug pain relief methods in combination with medicine.

Unlike North American guidelines, in which great care is taken to use inclusive language throughout, these consumer guidelines repeatedly advise the public to consult "the doctor or nurse" – rather than "a health professional" – for severe pain or pain that doesn't get better.

f) The information for general practitioners (58 pages) is also a mixed bag. On one hand spinal manual therapy (SMT) is listed as an option for the treatment of back pain and cervical spine pain. SMT is said to be widely used by a range of health professionals but, on an extremely conservative view of the evidence, it is noted that the scientific evidence for the efficacy of SMT "remains to be established as it has been difficult to obtain definitive evidence of the benefits and risks."

One problem is that there is no such conservatism for pharmacological treatments – in circumstances where the full scientific review gives at least as much evidence in support of the safety and effectiveness of manipulation and manual therapy as for any pharmacological treatment. Drug treatment, not surprisingly, is dealt with first and there is the positive recommendation, for example, that paracetamol "is often effective first line treatment". Where this provides insufficient pain relief "an NSAID may be used" and "oral opiods may be required in the acute stage."

All of these drug treatments, according to the scientific reviews supporting these guidelines, have no better evidence of effectiveness than spinal manipulation, and more evidence of potential serious harm, but there are no guarded comments about "difficulty to obtain evidence" given to general practitioners as for SMT.

A second problem is that, when substantially the same evidence has been reviewed by other multidisciplinary expert teams in countries such as Canada (see the last issue of this Report), Denmark, the UK and the USA, they have come to different conclusions. All have been much more positive, for example, on the evidence of benefit of spinal manipulation for acute (and chronic) back pain. A related difficulty in the new Australian guidelines is the confusing and inconsistent manner in which the evidence for manipulation, mobilisation and manual therapy is assessed and reported.

Looking on the bright side, in Australia, where organized medicine has been as aggressively monopolistic as anywhere, and the previous unpublished guidelines gave no role whatsoever to spinal manual therapy and implied that both chiropractic and physiotherapy were cults, these guidelines represent a significant step towards fairness and inclusiveness and therefore represent an advance for the chiropractic profession. There is obviously still some distance to go down the road, but ultimately Professor Brooks and his team deserve praise. There is much else on acute pain that will be of great interest to all clinicians.

(With respect to organized medicine and chiropractic in Australia, it was only in late 2002 that the Australian Medical Association finally rescinded its policy, first adopted in 1978,that chiropractic was an "exclusive dogma". This policy obviously has a major continuing effect today. For a paper on the history of this policy, including the way it was used to exclude chiropractors from research, workers compensation schemes and other third party funding, see Simpson JK *The Evolution of the Australian Medical Association's Exclusive Dogma Policy on Chiropractic*, Chiropractic History, 2003, 23(2):69-78).

World Notes

1. **Belgium.** In 1999 the Belgian government announced its intention to recognise and regulate the practice of chiropractic. That legislative process remains far from complete but Belgium's 70 chiropractors have seen markedly improved acceptance since that decision. Dr Pierre Mercier, President, Belgian Chiropractors' Union, reports that medical referrals are now common and that this year, for the first time, medical students received a lecture on chiropractic by a chiropractor as part of their mandatory course requirements. This was as part of a new course on complementary and alternative health care at the State University of Ghent, one of the largest universities in the country.

2. **Brazil.** The 37-member chiropractic profession in Brazil will almost double in size next year, with the graduation of approximately 35 students from the inaugural class at the University Anhembi Morumbi (UAM) in São Paulo, and will then double again the following year with graduating classes from both UAM and Feevale University in Novo Hamburgo.

In preparation for this growth the Associação Brasileira de Quiropraxia, in partnership with UAM and Feevale, has had a sustained campaign for the past three years to gain legislative recognition for the chiropractic profession. Draft legislation was referred for consideration by three standing committees that look at all legislation for health professionals. In November, in a committee room in Brasilia filled with chiropractic students and supporters, the draft legislation was unanimously approved by the most difficult committee, the Work Commission, which is required to approve any new occupation receiving legislative recognition. The Bill now goes to the Justice Commission before being returned to the legislature.

3. **Canada**. In Ontario there has been a recent government grant of $1.95 million to support pilot projects that include chiropractic services within multidisciplinary primary health care centres, the basic new structures being developed during primary health care reform in the province. Dr. Silvano Mior of the Canadian Memorial Chiropractic College has been retained by the Ministry of Health to help design and evaluate these projects.

Nationally the Canadian Chiropractic Association (CCA) and its provincial divisions are co-sponsoring two major initiatives, firstly a project to replace and update the CCA's 1993 clinical guidelines and secondly a 2003-2004 media campaign thought to be the largest ever launched anywhere by the chiropractic profession. The high-profile Lewis Inquest in Toronto, being followed by chiropractors worldwide, is near its end. As we go to press the jury has retired to consider its verdict and recommendations, and is expected to report in mid-January. For an overview of all the CCA's program and activities, and reports on the inquest, visit www.ccachiro.org.

4. **Greece.** The national association, the Hellenic Chiropractors Association (HCA) with 20 members, has Dr Katerina Moustaka (Life West 1998) of Athens as its new President. Because several students are expected to return to enter practice in the near future, the HCA is experiencing steady growth. Dr Moustaka, who also holds a medical degree, advises that chiropractic is still not well-known in Greece and is resisted by the medical community, realities which she and the HCA are now trying to change with a more active public relations program.

Although the practice of chiropractic is not recognised by law in Greece, no legal action has been taken to restrict chiropractors since a case against three doctors of chiropractic for practising medicine without a licence was dismissed in the early 1990s. This case established, among other things, that spinal manipulation was not a medical act in Greece.

Dr Moustaka advises that few MDs have interest or training in manual medicine but that there is a new organization led by physical therapists titled the Hellenic Manipulative Therapy Association. Contact for Dr. Moustaka: chirokatgr@hotmail.com.

5. **Singapore**. The Chiropractic Association (Singapore), with the World Federation of Chiropractic, is sponsoring a two day technique seminar by renowned technique author and instructor Professor Tom Bergmann of Northwestern Health Sciences University, June 11-12, 2004. For full details of the program, registrations, accommodation, etc. visit www.wfc.org.

6. **United Arab Emirates (UAE***)*. Dr. Sassan Behjat, Coordinator, National Center for Complementary and Alternative Medicine, Ministry of Health, advises that there are 10 doctors of chiropractic in the UAE which now has licensing exams for chiropractic practice. Anyone who has graduated from an accredited chiropractic program and has two years of experience in practice is eligible to sit these licensing exams and obtain a work permit. For more detailed information visit www.moh.gov.ae.

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C. WFC Consultation

8. **Background.** For reasons apparent from the above discussion the WFC Council decided at its annual meeting in June 2002 that the WFC should consider a broad consultation on identity. As a result this was a major agenda item at the WFC's Assembly of members in Orlando, Florida in April 2003.

In a two hour plenary session on April 30 delegates heard invited presentations from Dr. Andrew Lawrence, President, Chiropractors' Association of Australia, Dr. Peter Dixon, President, European Chiropractic Union, Dr. Cheryl Hawk an educator and researcher then with Palmer College, and Dr. Louis Sportelli, President, NCMIC Insurance, which had commissioned the 1998 report from the Institute for Alternative Futures. All agreed that the profession lacked a clear identity within health care and that this was now a major problem. Following debate there was unanimous support from the Assembly delegates for a WFC initiative to address this problem urgently on an international basis. It was also agreed, however, that this was a sensitive and potentially divisive issue and that there needed to be a transparent and fair process assisted by independent expert consultants.

9. **Task Force**. As a result the WFC established a 40 person task force to lead the consultation, constructed as follows:

(a) 3 established and representative leaders as co-chairs – Dr. Carey, Dr. Clum and Dr. Dixon.

(b) 9 doctors representing the WFC world regions of Africa (1), Asia (1), Eastern Mediterranean (1), Europe (1), Latin America (1), North America (3) and the Pacific (1), nominated by the WFC Council members elected to represent those regions.

(c) 3 doctors representing the US Congress of Chiropractic State Associations (1), the European Chiropractors' Union (1) and the World Chiropractic Alliance (1).

(d) 8 doctors representing the international academic and research communities, nominated by the Association of Chiropractic Colleges (2), the Council on Chiropractic Education International (1) and the Task Force co-chairs (5).

(e) Up to 12 others chosen by the co-chairs from those in the profession and students who, individually or on behalf of an organization, answered a call for applications to serve on the Task Force (i.e. open or wildcard members).

(f) A representative of major vendors to the chiropractic profession.

(g) 5 lay members to be nominated by the co-chairs, each bringing appropriate expertise to the Task Force.

See Tabnle 1 for the names of the 40 members appointed to the Task Force. Their bios and photos may be found at www.wfc.org. Originally there were to be only up to 7 wildcard members but so many applications were received that this was increased to 12. The 5 strong lay representatives include Professor Pranlal Manga of Canada, renowned health economist and lead author of the 1993 M*anga Report*,[8] and Ms. Ann Liss Taarup of Denmark, President of the Danish Pro-Chiropractic Association and the European Federation of Pro-Chiropractic Associations.

10. **Task Force Terms of Reference**. These are "to direct and facilitate an inclusive and comprehensive international consultation with members of the profession and other relevant parties on the public identity of the chiropractic profession, and to then report back to the World Federation of Chiropractic with findings and recommendations".

11. **Timeline**. Through to the end of February 2004 the Task Force, with the assistance of consultants Manifest Communications and WFC staff, are assessing past relevant surveys/research and developing methods and procedures for an international consultation during 2004. From February 26 to 28, 2004 the Task Force meets at Life Chiropractic College West, Hayward, California, to finalize methods and materials. It should be noted that this meeting is open to observers – for details visit www.wfc.org.

It is expected that the electronic survey of chiropractors internationally, a centerpiece of the consultation, will take place in May/June 2004. Results of this and other research will be finalized during the second half of 2004. A second meeting of the Task Force is scheduled for January 2005, and the Task Force will then report to the WFC's 8th Biennial Assembly to be held in Sydney, Australia, June 14-15, 2005. This is immediately prior to the WFC's next biennial conference to be held June 16-18 at the Sydney Convention Centre.

12. **Task Force Meeting February 26-28, 2004**. The first day of the meeting will be devoted to hearing from marketing experts, members of the public and representatives of special publics (e.g. the medical and nursing professions) on their perspectives on the identity and role of the chiropractic profession. Thereafter chiropractic perspectives will be examined, and a central task will be agreement upon the exact and appropriate content of the questionnaire to be administered to individual chiropractors. Successful design of this survey instrument will obviously be crucial to be effectiveness of the consultation.

13. **The Public's Point of View**. Whatever identity members of the profession might prefer, any effective identity chosen must not only reflect chiropractic education, competencies and legal scope of practice but also the other realities and dictates of the health care marketplace.

Foremost among these dictates, as all marketing professionals know and advise, is the public's point of view. That is why the first day of the Task Force meeting is dedicated to exploring the evidence on this. That evidence is actually quite extensive and consistent worldwide. See www.wfc.org for more complete summaries of the evidence and references, but for example:

WFC Consultation on Identity

Visit www.wfc.org and click on identity consultation for full details including:

- Background information
- Ongoing notices and reports
- Details of the 40 Task Force members
- Bibliography and summaries of research relevant to identity*
- How you can participate
- Attendance at the Feb 26-28, 2004 meeting as an observer

**If you are aware of relevant research in your country (e.g. surveys of the public or the profession) not listed, please contact WFC Communications Manager, Dr. Eleanor White at ewhite@wfc.org.*

(a) Studies in many countries show that the great majority of patients consult chiropractors for pain from neuromusculoskeletal problems, principally back and neck problems, headaches and extremity joint problems. Surveys in diverse countries such as Australia, Canada, Denmark. Italy, the Netherlands and the USA report that only 1-5% of chiropractic patients present with non-neuromusculoskeletal problems.

(b) In Australia a 1990 telephone survey of a random sample of 310 members of the public commissioned by the state government's health department in Western Australia revealed that:

- 8% had visited a chiropractor during the past 12 months, 32% at some time in the past.
- Both patients and non patients felt that the management of back pain was the one area in which chiropractors were better trained and more effective than medical doctors. Most who had not visited a chiropractor said they were prepared to do so. When asked what for, most common responses were back, neck, spine (60%), joints (24%), muscular pain (20%) and headaches (7%). Only 4% would visit a chiropractor "to maintain good health". No non-NMS conditions rated over 1%.
- Of the 30% (n 104) who had visited a chiropractor, common reasons were back problems (61%), neck problems (23%), headache (7%), extremity problems (11.5%). The highest non-NMS reason was breathing/asthma (2%) and only one person (1%) gave the reason for his/her visit as health maintenance.
- Approximately 3 out of 4 of all respondents interviewed agreed that chiropractic had an important place in the total health care system (72%) and that chiropractic services should be available in hospitals (71%) and an overwhelming majority (89%) agreed that chiropractic services should be covered by the government health plan, Medicare.
- Asked if chiropractors should diagnose general health conditions in a similar way to general medical practitioners, an overwhelming majority of 92% disagreed (79%) or said they did not know (13%).[9]

(c) In Canada the provinces of Alberta and British Columbia in Western Canada have the highest recorded utilization of chiropractic services worldwide at approximately 18% of adults annually. In a September 1999 telephone survey of public attitudes by Criterion Research, commissioned by the College of Chiropractors of Alberta, the profession's licensing body in Alberta:

- In a random sample of 400 adults, 204 (51%) were current or past users of chiropractic services and 20% had visited a chiropractor during the past year. Asked "the reason why they sought chiropractic treatment" users listed a variety of neuromusculoskeletal pain syndromes including headaches/migraines. Asked the circumstances in which they would consider using chiropractic services, non-users cited neuromusculoskeletal pain syndromes exclusively.
- The great majority of users and non-users (80%) agreed that they only visit a health care provider "when they have pain or symptoms." Furthermore, although 91% agreed that they participate in health promoting activities, a large majority (69%) actively disagreed that they would go to a health provider to optimize their health.

(d) In the UK in June 2000 the government Department of Health, following a literature and policy review, published information for the public on common forms of complementary and alternative health care including chiropractic, which it described as follows from its public perspective:

- "Chiropractic diagnoses and treats mechanical disorders of the joints, muscles and ligaments of the body by manual adjustment. Laboratory tests and x-rays are sometimes used as an aid to diagnosis. Chiropractic is based on the premise that dysfunction of the spine, pelvis and extremity articulations may disturb associated nerve function. This in turn may lead to specific types of pain syndromes, and in some cases, ill health. If a patient is deemed suitable for chiropractic care, treatment will consist mostly of specific manipulation adjustments."
- There is positive evidence of the effectiveness of both chiropractic and spinal manipulation for back pain, neck pain, back pain associated with dysmenorrhea and headaches.
- Chiropractors are trained to a high standard in the use of manipulative treatment and other supportive measures, as well as in diagnosis for the exclusion of underlying disease — including the use of radiology.

(e) In the US, consistent with the above, the Trends Research Institute advised the Foundation for Chiropractic Education and Research in a 1996 report on image and identity that "chiropractors tend to be regarded by the public as specialists". Just as the average person "automatically associates the optometrist with eyes, the dentist with teeth, the podiatrist with feet", he or she associates "the chiropractor with back pain".

All of the above studies and statements, which reflect the general public's perspective of the profession in various countries, paint a consistent picture. That picture, naturally enough, does not reflect the full scope of chiropractic principles and practice and is therefore less than professionally satisfying for chiropractors. Its emphasis on pain rather than function and general health will cause significant discomfort to most chiropractors, especially to those who want to challenge the market principle that "the customer is always right" and assert an identity not understood by a public principally concerned with pain.

D. Conclusion

14. For the past few decades chiropractic has been moving steadily from an alternative and marginal status to legitimization within mainstream health care. In some countries, such as Canada, Denmark and the UK, that process is far advanced with chiropractic schools affiliated with universities and services delivered and funded complementary to medicine within mainstream health care services. There appears to be national consensus in these countries on a market identity that emphasizes the profession's expertise with neuromusculoskeletal disorders, especially spinal problems.

In the US a threefold increase in patient numbers during the 1990s from 3.6% to 11% of adult population per annum,[1] increased collaboration with other professions in research and practice, and now federal law expanding funding for chiropractic services under Medicare and the military and veterans' health care systems, is moving chiropractic inexorably into the mainstream. However in many other countries where the profession is newly established chiropractic remains marginal and alternative.

15. This evolution or transition of the chiropractic profession has produced conflicting emotions and responses within the profession in all countries. As Meeker and Haldeman observe,

many in the profession are embracing "the values and behaviors of a mainstream health care profession", such as commitment to interdisciplinary cooperation and science-based practice, but others hold to the attitudes and identity of an alternative health care profession. This is why the profession has remained at the crossroads – "significant attitudinal barriers" have left it with an undetermined role and identity.

Perhaps the fundamental choice for chiropractors is whether to embrace or resist the new role within mainstream health care that the world wants to give them. The views of leaders and some specific groups are well known, and remain divergent. The WFC consultation on identity, which will include the first opinion survey of the grassroots profession internationally, will determine whether or not the broad majority of individual chiropractors has now come to a consensus on a core appropriate public identity within health care.

The exciting prospect of such an agreed identity is that it would provide a much needed and chosen common path from the crossroads, and a starting point for a united, consistent and effective approach to the promotion, development and growth of the chiropractic profession in every country. TCR

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9 For references and more complete summaries for this and other research referred to in this paragraph visit www.wfc.org.

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7. **United States of America**. 2003 was a red letter year for expansion of chiropractic services in major federally funded program. Following increased development of chiropractic services to the military and veterans earlier in the year, a coalition of chiropractic organizations led by the American Chiropractic Association (ACA) produced a major victory in December when President Bush signed into law the *Medicare Drug Reform Act*. In what ACA Chairman, Dr George McClelland, describes as "chiropractic's biggest win ever on Capitol Hill" the new Act authorizes four two-year pilot projects designed to test expanded access to chiropractic services for US seniors under Medicare.

Instead of coverage being limited to manual manipulation, Medicare beneficiaries in these pilot projects will have the freedom to choose a chiropractor to provide all customary and necessary chiropractic services. It was pilot projects such as these that led to broad inclusion of chiropractic services for veterans, and the profession is confident of a similar result under Medicare. Additionally the new Act increases payments for chiropractic services under Medicare in 2004 and 2005, rather than an imposing of an earlier planned cut of 4.5%.