THE CHIROPRACTIC REPORT

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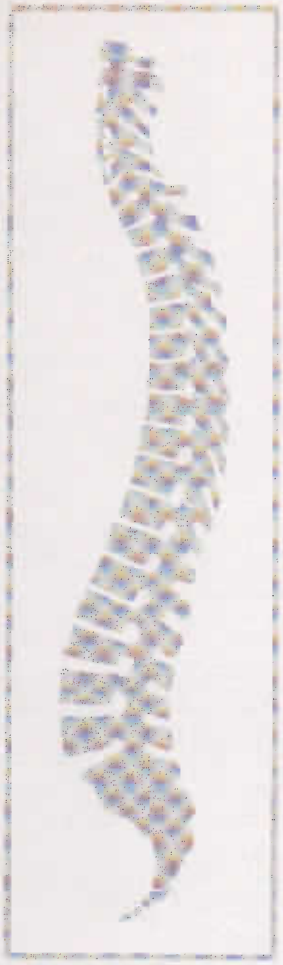

Professional Notes

Cost Effectiveness – New Australian Workers Compensation Study

"*Mechanical Low-Back Pain: A Comparison of Medical and Chiropractic Management Within the Victorian Work Care Scheme*," Phillip S. Ebrall, Chiropractic Journal of Australia (June 1992) 22(2):47-53.

In the United States there have now been 14 studies of state WCB records to compare the cost of chiropractic and medical management of workers with low-back sprain/strain. This category of claim is the most frequent (approximately 30% of all claims) and most expensive (50–60% of overall claims cost, because of the high cost of chronic back problems) for workers compensation boards.

These studies show that chiropractic management is highly cost-effective, resulting in :

1. Significantly shorter time off work.

2. A 45–55% saving in overall claims costs (treatment and compensation) – which translates into millions of dollars annually for even the smaller compensation funds.

This new study of workers compensation back injury claims from the state of Victoria, the first published in Australia, confirms U.S. results and reports these benefits of chiropractic management:

1. A 58% cost saving per claim ($963 vs

continued on page 5, column 2

THE CHIROPRACTIC WORLD – MAJOR CURRENT DEVELOPMENTS

WFC, WHO, Japan, new colleges, new recognition, the 1993 World Congress

A. Introduction

1. Chiropractic was essentially a North American profession until the 1970s. Since then its international growth has been remarkable. Did you know:

• There are now national associations of chiropractors in 52 countries (Figure 1) all members of a World Federation of Chiropractic formed in 1988 that is now involved in major collaborative projects with the World Health Organization.

• The model for chiropractic legislation in Europe, which has no defined scope of practice, is becoming more common worldwide than the North American model.

• Leadership on public funding for chiropractic education is coming from Australia and South Africa, and next year the Technikon Natal in Durban produces the first doctors of chiropractic to graduate from a chiropractic college in Africa.

• Best estimates are that there are now approximately 9,000 chiropractors in Japan.

This Report reviews current international developments looking at legislation, education, guidelines for practice, the growing authority and activity of the World Federation of Chiropractic, and the rapidly changing chiropractic profession in Japan.

B. Legislation

2. Legislation recognizing and regulating the practice of chiropractic exists in 15 countries, including all states/provinces of Australia, Canada and the United States. (See Figure 2).

In many countries with an established chiropractic profession, such as England and Japan, practice is legal without legislation. However quality of care issues, which arise when practitioners with lesser training at unaccredited colleges begin using the title "chiropractor," eventually force legislation in the public interest. Legislation is pending in:

a) **Israel.** A draft Chiropractic Act is before the Knesset, but is not supported by the national association, the Israel Chiropractic Society, because of a dispute concerning diagnostic scope.

b) **Hong Kong.** At a formal luncheon she hosted for executive officers of the Hong Kong Chiropractors' Association and World Federation of Chiropractic in July, Secretary for Health Elizabeth Wong predicted that the draft Chiropractic Ordinance now before the Hong Kong legislature would become law during the next six months. The Bill, which will become the first chiropractic legislation in Asia, provides a broad scope of practice and self-regulation. Chiropractors will be entitled to use the title doctor in English. The only outstanding point of dispute between the government and the profession relates to Chinese title.

c) **Trinidad & Tobago.** Dr. Learie Graham, President, Chiropractic Association of Trinidad & Tobago, a graduate of the former Bebout College of Chiropractic in Indianapolis who has practised in his native Trinidad since 1965, reports that during the past year the Minister of Health has requested and received an extensive position paper on chiropractic and meetings are continuing with a view to recognition of the profession by legislation.

d) **United Kingdom.** Chiropractic has a long history and is well accepted in the United Kingdom. In recent years the issue of regulation by legislation has become important because an unaccredited school established by a former patient, the McTimoney School of Chiropractic, has produced graduates who practise as chiropractors on the basis of an unacceptable education by British and international chiropractic standards.

Dr. Ian Hutchinson, Past-President and Chairman, Legislative Committee, British Chiropractic Association, confirms that following a year's intensive work a legislative Working Party has reported back with acceptable draft legislation that will likely become law during the next parliamentary session. This will "grandfather" McTimoney chiropractors by placing them on a second register and requiring them to meet additional educational requirements within a five year period. Legislative recognition in the U.K. will strengthen chiropractic throughout the European community.

Scope of Practice

3. There are two distinct approaches to scope of practice in legislation for chiropractic and other health disciplines:

a) Defining a specific scope of practice in the legislation, which is then restricted to duly licensed or registered practitioners. This is the traditional approach to chiropractic and other health disciplines' legislation in North America.

b) Leaving scope of practice undefined and unmentioned. (There may be a prohibition against use of drugs or surgery but, depending upon the terms of the medical practice

legislation, even this may be unnecessary). Under this legislative approach it is title only that is protected – practitioners can call themselves chiropractors/doctors of chiropractic or hold themselves out as practising chiropractic only if they have specified educational qualifications and are duly licensed or regulated pursuant to the Chiropractic Act. The details of scope of practice are left to the self-regulatory board established by the legislation.

This is the European and British model and is becoming the norm outside North America. It is found in Switzerland, the Scandinavian countries, the Australian states, New Zealand, and the draft Chiropractic Act in the United Kingdom. This approach has a number of benefits:

i) It avoids the compromised and unacceptable statement of scope of practice that often results from lobbying by competing interest groups prior to legislation.

ii) It allows flexibility and evolution.

iii) Experience suggests it provides a better climate for interprofessional cooperation and third party reimbursement – everyone focuses on the services actually provided by the profession rather than an artificial form of words frozen in time.

In some U.S. states the defined scope of practice is the practical equivalent of the European model, providing "*the practice of chiropractic includes all diagnostic and treatment methods taught in accredited colleges of chiropractic.*" If the local political climate in your jurisdiction requires a definition of scope this is clearly the best and most appropriate.

C. Education

4. In 1989 the Technikon Natal in Durban, Republic of South Africa, commenced a government supported five year chiropractic undergraduate professional program. Substantial initial funding also came from the Chiropractic Association of South Africa (CASA). The first class graduates next year and there is such support for chiropractic education that the Technikon Witwatersrand in Johannesburg is currently negotiating with CASA and the government to establish a second fully funded chiropractic program in South Africa. Other developments in the past two years include:

a) **Accreditation.** During the past year a Council on Chiropractic Education (Europe), President of which is Dr. Pierre Gruny of France, has been formally constituted. This means there are now separate but affiliated accrediting agencies in Australasia, Canada, Europe and the United States.

At the invitation of the United States CCE, Japanese educational leaders attended a special meeting in Dallas in February 1991 to discuss standardization of educational programs in Japanese chiropractic colleges. South Africa is following CCE guidelines but has its school accredited by government agencies rather than a separate chiropractic body.

b) **Australia.** Since 1990 Australia's two chiropractic programs have become fully integrated in universities and publicly funded. These courses, which now lead to university degrees on an equivalent basis to dentistry and medicine, are at:

i) *School of Chiropractic, RMIT University, Melbourne.* This program, formerly at the Phillip Institute of Technology and under a faculty led by Professor Andries Kleynhans, was originally established by U.S. trained chiropractors in Australia.

ii) *School of Chiropractic, McQuarrie University, Sydney.* This program, under Professor Rod Bonello, has its origins with Australian trained chiropractors and the Sydney College of Chiropractic and Osteopathy.

c) **Canada.** Canada's sole chiropractic program, which graduates approximately 150 chiropractors per annum, is at the Canadian Memorial Chiropractic College (CMCC) in Toronto, Ontario, named in memory of the founder of chiropractic, Dr. David Daniel Palmer, who was born and spent his first 22 years in Port Perry, Ontario.

Canada is bilingual and a fusion of two cultures, British and French, and in recent years there have been extensive negotiations in Quebec for a French- speaking chiropractic college. In 1991 the Senate of the University of Quebec approved plans for a Faculty of Chiropractic at Trois Rivieres, commencing September 1993. The university is awaiting a final decision from the Quebec government due this month.

d) **Denmark.** In 1989 the Nordic Council, representing the governments of Denmark, Iceland, Norway and Sweden, resolved that there should be a publicly supported chiropractic college within a university in the region. A faculty of chiropractic has been approved and will open at the University of Odense, Denmark in September 1993. Enquiries should be directed to Arne Christensen, D.C., Managing Director, Nordic Institute of Chiropractic & Clinical Biomechanics, Klosterbakken 20, DK 5000, Odense C, Denmark, Fax: 45-65-91-7378.

Figure 1

WFC Member Associations

Australia	Hungary*	Russia*
Bahrain	Iceland	Singapore
Belgium	Iran	Spain
Belize	Ireland	South Africa
Bermuda*	Israel	South Korea
Brazil*	Italy	Switzerland
Canada	Japan	Taiwan
Colombia	Jordan	Trinidad &
Croatia*	Libya*	Tobago
Cyprus	Liechtenstein	United Arab
Denmark	Mexico	Emirates
Ecuador	Namibia	United
Egypt*	Netherlands	Kingdom
Finland	New Zealand	United States
France	Norway	of America
Germany	Panama	(ACA and
Greece	Peru	ICA)
Guam	Philippines	Venezuela
Hong Kong	Portugal*	Zimbabwe

* *Ratification pending*

Figure 2

Countries Where Practice of Chiropractic is Regulated by Legislation

Australia (all states)	Norway
Barbados	Panama
Canada (all	South Africa
provinces)	Sweden
Cyprus	Switzerland
Denmark	United States (all
Iceland	states)
Mexico	Zimbabwe
New Zealand	

e) **Japan.** Japan's chiropractic colleges have two models of education, both at variance with otherwise internationally accepted standards:

i) A three year undergraduate professional program for high school graduates, with some courses taught in Japan and/or the United States by faculty from U.S. accredited colleges (e.g. the Tokyo Chiropractic College and the Chukyo Chiropractic College, in Nagoya).

ii) Postgraduate courses of approximately one year for graduates of other health disciplines recognized in Japan, again with affiliations with U.S. colleges (e.g. the Universal Chiropractic College, Tokyo).

Currently there is a major effort in Japan, prompted by the government and assisted by the U.S. CCE and the World Federation of Chiropractic, to unify the profession and its educational standards. (For a full discussion see paras 10–14 below).

f) **Mexico.** In recent years the decline in value of the peso and the prohibitive cost of chiropractic education in the United States has

continued on page 3

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Figure 3

WFC Executive Council

Africa:	Gert van der Walt, DC (South Africa)
Asia:	Bruce Vaughan, DC (Hong Kong)
Eastern Mediterranean:	Efstathios Papadopoulos, DC (Cyprus)
Europe:	Christoph Diem, DC (Switzerland), *President*
Latin America:	Enrique Benet-Canut, DC (Mexico)
North America:	Gerard Clum, DC (ICA)
	John Cochrane, DC (Canada)
	Vince Lucido, DC (ACA)
	John Pammer, DC (ACA)
	Louis Sportelli DC (ACA), *Secretary-Treasurer*
Pacific:	John Sweaney, DC (Australia), *Vice-President*

arrested the development of chiropractic in Latin America. The answer to this problem must be a Spanish speaking school in Mexico. The Mexican Association, La Sociedad Cientifico Quiropractica de Mexico, in conjunction with a number of U.S. colleges and the World Federation of Chiropractic, is presently negotiating a university affiliated program in Mexico City.

g) **United Kingdom.** The Anglo-European College of Chiropractic (AECC) in Bournemouth has grown immensely in size and stature during the past 10 years. In 1990 its program was granted a university degree status equivalent to other primary health care professions in the U.K., and AECC is expected to enter formal affiliation with a major health science university during the next two years.

D. Practice Guidelines

5. On March 24, 1992 the state legislature in Florida, in a move that will soon be followed in other countries and U.S. states, passed the Health Care Reform Act. This requires that all health professions in Florida must, as a condition of continued licensure and reimbursement, prepare and file nationally based practice guidelines by January 1, 1993.

Thus in a few short years the requirement for comprehensive practice guidelines for health professionals has swept from theory to law, fuelled by compelling evidence of unacceptable variations, inefficiencies, ineffectiveness and cost in medical care.

If over 80% of all health care interventions and technologies have no scientific evidence of effectiveness,[1,2] and controlled trials are so time-consuming and expensive that the majority of health care will never be proven effective, regulators and third party payors are justifiably going to demand properly developed practice guidelines or parameters. The U.S. federal government said so when it established the new Agency for Health Care Policy and Research in December 1989.[3] Florida sees such urgency that it has given health professions a bare nine months to comply.

6. In the face of these developments the chiropractic profession in North America deserves plaudits for predicting this trend, appreciating that a legitimate consensus process to establish nationally based guidelines would take approximately three years, and unifying to support such a process – which culminated in the Mercy Center Conference in San Francisco in January 1992. Publication of the resulting guidelines has been frustratingly slow, delayed by editing of supporting text and agreements relating to publication, copyright and distribution. However, impressive arrangements for distribution have been made and:

• The final text of the guidelines is currently under print at Aspen Publishers.

• During the first week of October the guidelines will be mailed free of charge to every doctor of chiropractic in the United States. The World Federation of Chiropractic will distribute copies to every national association. Individual chiropractors outside the U.S. will be able to purchase copies at a cost of $24.95.

E. World Federation of Chiropractic

7. Over a period of five years the World Federation of Chiropractic (WFC), established in 1988 and now funded and supported by national chiropractic associations from every country worldwide with more than five chiropractors, has come of age. A review of its structure and current program follows.

Structure

8. a) Member associations are listed in Figure 1.

b) The Board of Directors, or Executive Council, has proportional representation from six world regions, and is elected by region. (Figure 3).

c) Current Executive Officers, elected in July for a three year term to 1995, are:

• *President:* Dr. Christoph Diem, Switzerland, also President, European Chiropractors' Union, the regional body which represents chiropractors throughout Europe.

• *Vice President:* Dr. John Sweaney, Australia, Executive Director and Past-President, Chiropractors' Association of Australia.

• *Secretary-Treasurer:* Dr. Louis Sportelli, former Chairman of the Board, American Chiropractic Association.

The Federation's secretariat, administered by Secretary-General Mr. David Chapman-Smith, is in Toronto, Canada. The Research Council is chaired by Dr. Scott Haldeman.

d) Pursuant to its written constitution most major decisions of the WFC are made by member national associations in Assembly. An Assembly is held every two years in conjunction with a major scientific symposium – both events being known as the "World Chiropractic Congress." The last Congress was in Toronto in May 1991, the next is in London in May 1993 (see notice page 4).

Current Programs

9. These reflect the goals set forth in the Constitution, which include:

Goal I: Working with the World Health Organization (WHO) and other international agencies in promoting chiropractic and world health.

Current collaborative projects with WHO include:

a) **1993 World Chiropractic Congress.** This meeting, which has a theme of occupational health, is the first chiropractic meeting sponsored by WHO. One of the opening speakers is Dr. Mikhail Mikheev, a Russian occupational health physician, who is Medical Director, Office of Occupational Health, WHO Geneva. His office in WHO has distributed notice of the Congress to all WHO world regional offices and WHO occupational health coordinating centres worldwide. WHO invited experts from several world regions will attend the meeting.

b) **Chiropractic in Occupational Health.** Last month the WHO and WFC signed a collaborative agreement to produce the WHO's first official publication on chiropractic, entitled "*Chiropractic in Occupational Health.*" Principal editor is John Triano, MA DC, Director, Ergonomic and Joint Research Laboratory, National College of Chiropractic, Chicago. The text will have approximately 12 chapters, half by doctors of chiropractic and half by occupational health experts from medicine and other disciplines.

The project will involve at least two scientific review meetings, bringing together world leaders in occupational health from Asia, Australia, Europe and North America, and will offer the chiropractic profession a new degree of exposure, acceptance and opportunity in this important branch of health care.

c) **Legislation Review.** In partnership with WHO's Division of Traditional Medicine, which has the responsibility of advising WHO member countries on legislation to recognize health disciplines, the WFC is collecting all chiropractic legislation and preparing background information and advice on model legislation. WHO will

continued on page 4

Main Article: *continued from page 3*

use this legislative package to answer enquiries from countries seeking to regulate the practice of chiropractic for the first time.

To illustrate the reach of WHO, following a meeting with WFC representatives in Geneva in May, Dr. Akerele, Director, WHO Division of Traditional Medicine, ordered and distributed to countries in all world regions a WFC pamphlet on chiropractic that has been produced in English, French and Spanish. WHO, which has least visibility in North America, is regarded by the great majority of countries worldwide as the primary source of information and policy on health.

Goal II: Assisting national associations of chiropractors to attain appropriate legislation and practice rights in their countries.

The WFC, as a matter of policy, only acts within a country at the request of the national association. It receives many such requests and significant assistance in the past year has included:

a) **Israel:** Correspondence with the Minister of Health successfully to reverse a policy that would have allowed immigrant Russian MDs practising manual medicine to practise using the title "*chiropractor.*"

b) **Hong Kong:** Advice to the Hong Kong Chiropractors' Association, representing 23 chiropractors in Hong Kong, on the draft Chiropractic Ordinance now before the legislature and, during the past month, meetings with the Secretary of Health and leading members of the government, legislature, media and medical profession. These meetings took place during the WFC's annual Council meeting, held in Hong Kong to assist a legislative campaign which is destined to make Hong Kong the first Asian country to pass chiropractic legislation.

c) **Japan:** In late 1990 the Miura Report, a report on chiropractic to the Japanese Minister of Health by a group of orthopedic surgeons, criticized both chiropractic and spinal manipulation as dangerous. It failed to reference recent research, and was reminiscent of western medical opinion in the 1960s. At the request of the Chiropractic Council of Japan, the national association representing Japanese chiropractors who have graduated from accredited colleges, the WFC prepared a detailed reply and position paper on chiropractic. On August 5 WFC and CCJ leaders met with the Japanese Vice-Minister of Health, Mr. Sonoda, at his Tokyo office to present this reply and lay the foundation for a reassessment of chiropractic in Japan. (For further details see paras 10–14 below).

d) **Trinidad & Tobago:** 18 months ago two chiropractors, U.S. college graduates who had recently established practices in Trinidad, were prosecuted for practising medicine without a licence. They turned to the ACA and ICA, who referred them to the WFC. Subsequent negotiations have led to withdrawal of the prosecutions, formation of an association which has applied to the WFC for membership, a request from the Minister of Health for a position paper on chiropractic, preparation and presentation of that paper by the new association and the WFC, and meetings of Association President Dr. Learie Graham and WFC representatives with the Minister of Health and his advisors.

e) **United Kingdom:** Legislation to regulate chiropractic in the United Kingdom, already discussed, has been identified by the WFC as a first priority. The Federation has assisted with advice on the contents of the legislation and strategy, and has been instrumental in raising funds from other national associations to support the major effort being mounted by the British Chiropractic Association.

Goal III: Encouraging research and an informed public opinion on chiropractic

As has been apparent in the U.S. following the initial RAND reports and in the U.K. following the Meade trial, effective public relations in health care in the 1990s relies upon the performance and report of credible research – basic science studies, clinical trials, and the interdisciplinary scientific meetings where this research is presented.

Accordingly the Federation, advised by its Research Council comprising Alan Breen, DC PhD – *England;* J. David Cassidy, DC PhD – *Canada;* Scott Haldeman, DC MD PhD – *U.S.A.;* Reed Phillips, DC PhD – *U.S.A.;* John Triano, MA DC – *U.S.A.;* Lynton Giles, DC PhD – *Australia;* holds a major international research competition and scientific symposium in a different world region every two years. The 1991 Congress in Toronto, published in a special issue of JMPT,[4] was of such a high calibre that the Centennial Foundation has invited the WFC to organize the complete academic and lecture program for the Centenary celebrations in the United States in September 1995.

F. Japan[5]

10. Japan, which is the sleeping giant of the chiropractic world, has a unique health care system. This, together with disunity in the chiropractic profession and language barriers, has meant that most of the chiropractic world has heard little of their colleagues in the east. However the Japanese chiropractic profession is stirring since its leaders were summoned to the Ministry of Health and Welfare in 1990 and asked to unify and organize their several thousand members.

11. Chiropractic was introduced to Japan in 1918 by Dr. Saburo Kawaguchi, a Palmer College graduate. Several American trained chiropractors returned to Japan within the next 10 years and chiropractic was well accepted because of traditional use of manipulation, acupressure and acupuncture. In various provinces chiropractic was licensed under the Ministry of Home Affairs.

However, hostilities between Japan and the United States meant that no American graduates returned after 1935, and chiropractic was absorbed by traditional schools of manipulative arts, which produced Japanese trained chiropractors. A new Ministry of Health formed in 1945 recognized various non-medical professions but not chiropractic.

Two Japanese trained chiropractors, Dr. Shigeru Matsumoto and Dr. Yoneo Takeyachi and their supporters formed the Japanese Chiropractic Association in 1961. The JCA, none of whose members had trained outside Japan, restored links with the American profession in 1965 by inviting Dr. Joseph Janse, President National College, to lecture. His meeting was attended by over 400 chiropractors. It resulted in Dr. Takeyachi's three sons attending and graduating from National College, and another 40 Japanese students attending American colleges in the 1970s and 1980s, principally Cleveland, LACC, National and Palmer.

However, there was an explosive growth of chiropractic inside Japan also, which has led to several colleges and professional associations, and a number of journals in Japanese that most chiropractors

continued on page 5

Main Article: *continued from page 4*

worldwide are unaware of. The publication "*Japanese Journal of Spinal Manipulation*" has a circulation of over 10,000. To understand the Japanese profession one must appreciate the unique divisions in the Japanese health care system.

12. There are three main categories of health providers in Japan:

a) *The medical profession and paramedical technologists and therapists.* They have no tradition of joint manipulation, and adopt the extreme stance against spinal manipulation seen in the western world in the 1960s.

b) *Regulated traditional health professionals separate from the medical profession.* The three main disciplines, all of which have a three year education (approximately 2500–2800 hours) are:

i) **Masseur/pressure therapists.** They number approximately 92,000. This profession was originally reserved for the blind, but today about 50% of practitioners are sighted.

ii) **Acupuncture/moxibustion therapists.** Approximately 60,000 in number.

iii) **Judo bonesetters.** Approximately 23,000. This profession, different from bonesetters elsewhere in the world, was originally established for retired judoists but is now open to all students. Scope of practice, which is in essence sports injuries other than bone fracture, used to include the setting of bone fractures until that was lost by recent amendment to medical orthopedists.

None of these three regulated traditional professions receives undergraduate training in spinal manipulation. However, they all have a major impact on the future of chiropractic because:

• They are well established and politically strong.

• They all oppose the development of a separate chiropractic profession, which is perceived as an economic threat.

• They have all, particularly the judo bonesetters, endeavoured to absorb chiropractic. They have established chiropractic colleges with 6–12 month postgraduate courses, the graduates of which practise their primary profession and chiropractic. Thus, for example, the Pacific-Asia Association of Chiropractic (PAAC) in Tokyo has over 2,000 judo bonesetter/chiropractors in its membership and has its own chiropractic college – the Universal Chiropractic College – and publications.

c) *Unregulated health professionals.* This is the status of Japan's 45 North American educated chiropractors. They can practise legally without legislative recognition or licence because of a 1960 Supreme Court decision interpreting the Japanese constitution to allow any drugless healing art that is not harmful or an infringement upon a regulated scope of practice.

However, this provision has also led to a proliferation of Japanese chiropractic college and seminar programs during the past 15 years run by unregulated Japanese trained chiropractors. One such college is the Tokyo Chiropractic College which has a 3-year program for high school graduates. A final complexity is that North American trained chiropractors have affiliated with some of these programs, and this has led to the formation of several chiropractic associations which have a great majority of locally trained chiropractors and a few North American graduates.

13. Thus in summary the Japanese profession, which now has approximately 9,000 practising chiropractors, includes:

a) Approximately 50 chiropractors trained in accredited colleges in North America.

b) Several thousand judo bonesetters and other regulated professionals who have taken postgraduate education in, and now practise, chiropractic.

c) Several thousand Japanese trained chiropractors, from colleges with greatly varying programs. Over 2,000 of these belong to the politically powerful association of unregulated therapists called the Zenkoku Ryojutsushi Kyokai (ZRK) led by the Japanese trained Dr. Shigeru Matsumoto, a leading educator in the chiropractic field. For some years the ZRK independently pursued chiropractic legislation for its members.

14. When the Ministry of Health summoned chiropractic leaders in 1990, two of the six were North American trained chiropractors, four leaders of the Japanese trained majority. Important developments since include:

a) Formation of the Chiropractic Council of Japan (CCJ) in April 1991, representing and finally bringing unity to all American trained chiropractors in Japan.

b) A new level of communication and cooperation between all chiropractic organizations in Japan, currently leading to the formation of a coalition under the leadership of neutral experts who carry weight with the Japanese government, such as Professor Oshima, Emeritus Professor of Ergonomics, University of Tokyo.

c) A new willingness, guided by a united leadership, CCE and the World Federation of Chiropractic, to set appropriate uniform minimum educational standards for chiropractic in Japan.

Joint Chairmen of the CCJ, leading Japan in these crucial years, are Dr. Mitsumasa Endo of Yokahama, a 1978 Palmer graduate, and Dr. Kazuyoshi Takeyachi of Tokyo, a 1968 National graduate.

References

1 Smith R (1991) "Where is the Wisdom: The Poverty of Medical Evidence," BMJ 303:798-799.

2 Rachlis M and Kushner C (1989) "Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It," Collins Publishers, Toronto, 10.

3 For further details see The Chiropractic Report (Vol. 5 No. 3) para 5.

4 J Manipulative Physiol Ther (January 1992) Vol 15 No. 1.

5 Information on Japan in this section comes from interviews between Mr. Chapman-Smith and a number of Japanese chiropractic leaders in Japan during August 1992.

Professional Notes: *continued from page 1*

$2,208), representing a saving of $10 million per annum to the state compensation fund with 40% of patients with back sprain/strain injuries managed by chiropractors.

2. A 75% reduction in compensation days.

3. A 6 times lower progression from acute to chronic injury (defined as incapacity due to work injury for more than 90 days).

The study, published in the June issue of the Chiropractic Journal of Australia, is by Dr. Phillip Ebrall, Director, Australian Centre for Chiropractic Research, a division of the School of Chiropractic at the Royal Melbourne Institute of Technology (RMIT). It is noted:

a) The database was all accepted compensable claims received by the State of Victoria Accident Compensation Commission, which covers all work-related compensable injury in the state, for the 12 month period April 1990 to March 1991.

b) The aim of the study was to compare the results of chiropractic and medical management of patients with mechanical low-back pain injuries excluding fracture.

c) Of 18,706 low-back sprain/strain claims during the year in question, 4,710 (25%) were handled by a sole provider – 998 by chiropractors and 3,712 by MDs. This study compared the 998 chiropractic cases with 998 medical cases drawn at random from the 3,712.

d) Chiropractic and medical patients were compared not only for type of injury but on demographic characteristics such as industry, age and sex and were clinically comparable.

Cost

e) The average claim under chiropractic management cost $963 (treatment cost and compensation) which was 58% less than the average medical case ($2,308). "*With respect to these 1,996 identified claims alone, medical management (of 998) cost the community an additional ... $1.3 million.*" If Victorian chiropractors had managed 40% of back sprain/strain patients (7,482 claims) "*then the direct savings within the Victorian work care scheme for this (1 year) period would have been $10 million.*"

Professional Notes: *continued from page 5*

f) Actual practitioner payments were higher in chiropractic cases – $369 vs $210. This reflected more treatment visits (an average of 14.25 per claim) under chiropractic management. The general scientific literature offers two reasons. Firstly chiropractors offer active treatment themselves rather than refer or prescribe medication. Secondly, in an approach now being increasingly adopted in medical practice, chiropractors favour an active rather than passive response to back pain – maintaining function and activities of daily living, and avoiding psychological overlay.

g) Total health care expense for chiropractic, however, was lower because of ancillary medical costs ($571 vs $738).

h) Compensation costs under chiropractic care were approximately 75% less ($392 per claim vs $1,570).

Time off work

i) With respect to time off work:

i) Chiropractic patients were only half as likely to take time off paid by compensation as those managed by medical practitioners (392 patients (39.3%) vs 774 patients (vs 77.6%)).

ii) Chiropractic patients who were forced to take time off averaged only half as many compensation days as medical patients (16 days vs 33 days).

iii) The cumulative effect was that the total number of compensation days taken by injured workers under chiropractic management was only about 25% that of comparable medical patients (6,243 days vs 25,513 compensation days).

Chronicity

j) This is a key indicator of the effectiveness of management of injuries. Progression to chronic injury, defined as incapacity due to work injury for more than 90 days, was 6 times lower for patients under chiropractic management than medical management (1.9% vs 11.6%).

Chiropractic Management

k) Chiropractic management is far more than spinal manipulation/adjustment, which is often the focus of attention.

What is it? The Victorian compensation records do not give this information since chiropractic management is paid for on the basis of flat rates for initial consultation and treatment, whatever the exact services provided. Chiropractors in Victoria have a standard scope of practice, including manual care, physical therapy modalities, and rehabilitation. Ebrall summarizes chiropractic management as including:

- Diagnosis, including manual palpatory procedures.
- Explanation, which serves to involve the patient in the individualized healing process.
- Recognition and treatment of illness behaviour, an essential component in the clinical management of low-back pain.
- Restoration of optimal spinal function, including an active after-care program.

He concludes that chiropractors have long been applying the components for early functional recovery from mechanical back pain that are now being recognized as important by medical leaders such as Waddell and Frymoyer.

Who should manipulate – $1.3 million award against MD

Saltzberg v Hawkins, Los Angeles County Superior Court, Case No. 697925. Kakita J and jury. Judgement dated 11/13/91.

Recently the citizens of Los Angeles read in their daily news that a "chiropractic error" had led to a damages award of $1.3 million. Not so. Here, from the court record now available, is what really happened – further proof of the inappropriateness of MDs and others practising spinal manipulation part-time on the basis of short postgraduate courses.

1. The plantiff, a 31 year old Los Angeles screenwriter, diagnosed with Epstein-Barr fatigue syndrome, consulted Dr. Hawkins, a Board-certified pediatrician in general medical practice.

2. During a course of treatments not involving spinal manipulation, the plantiff exhibited a classic transient ischemic attack or stroke – with slurred speech, unsteady walking, etc. Dr. Hawkins recognized the nature of the attack and referred his patient to a neurologist for a lumbar puncture.

3. However, through lack of training, he did not recognize this as a contraindication to cervical manipulation. A week later, as Dr. Hawkins related in his evidence, Ms. Saltzberg suggested she might be referred to a chiropractor for treatment but the defendant said that would be unnecessary because he had been trained in chiropractic manipulation. The evidence was he had taken one weekend seminar some years ago.

4. Accordingly Dr. Hawkins proceeded with a cervical manipulation which caused "*dissection of the left and right vertebral arteries leaving the right artery 100% blocked and the left artery 80% blocked resulting in an immediate stroke.*" At trial the plaintiff, once a gifted screenwriter, and now a file clerk, had made significant recovery but had residual permanent neurological deficit and impairment to higher level thinking.

5. Called as expert witness for the plaintiff, Stephen Foreman, DC DABCO chiropractor, testified as to the gross inadequacy of the defendant's education for the practice of spinal manipulation. The jury agreed and awarded damages of $1.3 million.