THE CHIROPRACTIC REPORT

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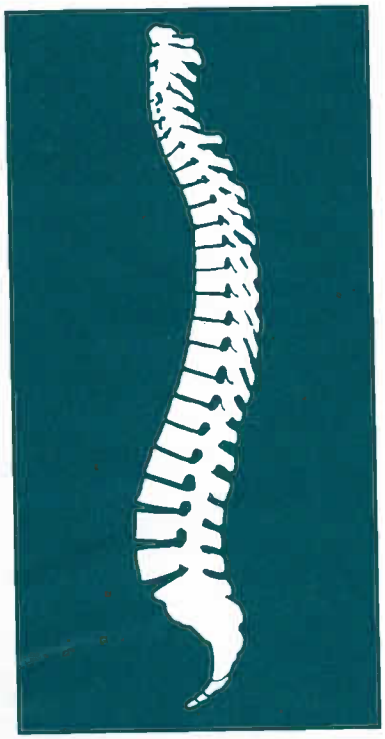

PROFESSIONAL NOTES

New International Consensus on Philosophy

Leaders from 34 chiropractic schools worldwide and many national chiropractic associations met November 10-13, 2000 in Fort Lauderdale, Florida, at the World Federation of Chiropractic's conference on *Philosophy in Chiropractic Education*. Impressively, they reached a consensus on major issues concerning philosophy in chiropractic education and practice.

As could be seen from this meeting, many new schools are opening throughout the world. Will they create a unified and stronger chiropractic profession or, like osteopathy, will they divide, fragment and weaken the profession? The first consensus statement agreed was: "A shared approach to health and healing, based upon a shared philosophy of chiropractic, is important for the identity and future of the chiropractic profession." Others appear below.

Delegations from all 17 North American colleges, from the oldest (Palmer) and the

continued on page 4

MEDICAL MANIPULATION SHOWN INEFFECTIVE

A New Trial, a New Spin, Games People Play

A. INTRODUCTION

NOW that national evidence-based clinical guidelines for the management of patients with low-back pain from many countries—including the UK,[1] the US,[2] Denmark[3] and New Zealand[4]—support the use of spinal manipulation as one of the few treatments proven effective, there has been a proliferation of weekend seminar courses for family physicians, teaching basic diagnostic and treatment techniques for use by them.

These are seen in Europe, especially the UK under the British Institute of Musculoskeletal Medicine, North America and Australia. Medical specialists familiar with the diagnostic and treatment challenges of manual therapy generally, and manipulation in particular, have long criticized such rudimentary courses as inappropriate and misguided, leaving physicians without necessary skills, confidence and—in the words of Lewit—"clinically blindfolded".[5] These courses obviously draw criticism from the chiropractic profession.

Previously there has been no study published assessing whether such courses give physicians any competence or effectiveness in treating patients. However now the long-awaited results of a study by prominent US researchers Curtis, Carey et al. have been published in *Spine*,[6] and:

a) In a study of 295 patients with acute low-back pain given either optimal physician care (for definition of this, see below) or such care plus manual therapy (muscle energy techniques and joint manipulation taught in 3-day courses), it is reported that there were no differences found in all the primary results or outcomes measured in the trial—which included levels of pain and disability, time to recovery, days absent from work, and patient satisfaction.

b) The prominent Dutch epidemiologist Maurits van Tulder, PhD, asked by *Spine* to contribute the Point of View published with the trial, confirms that this well-designed trial justifies the conclusion that "training primary care doctors in limited manual therapy is not useful".[7]

c) Interestingly, a survey of the physicians trained in manual therapy for the purposes of this trial has shown that within 2 years most had abandoned joint manipulation, were only using muscle energy techniques "2 or 3 times weekly", and had "changed their management by . . . reduced referrals to specialists and increased referrals to chiropractors."

d) There is irony in this because the trial was first devised because of the presumed reluctance of physicians to refer their patients to chiropractors. To quote the research grant application for this trial: "Even if immediate chiropractic referral (of patients by physicians) is an effective strategy in the treatment of acute low-back pain it is unlikely to become a dominant strategy to the public" because "primary care physicians may be reluctant to refer out to other providers such a common problem as acute low-back pain."[8]

2. However the tale of this trial is far from told. Curtis, Carey, et al. themselves:

- Make no criticism of their manual therapy workshops for physicians.
- Claim that the results of the 31 physicians used in the trial, who "by design . . . were not experts in manual therapy", were similar to those of chiropractors in an earlier trial comparing chiropractic management and the use of education materials by physicians.[9]
- Are of the view that a "specific mechanical diagnosis" is unimportant—it is sufficient for most patients to receive a stand-

ard set of manual maneuvers as in this trial, irrespective of diagnosis.

• Unbelievably, given all the evidence-based clinical guidelines supporting skilled manipulation for these patients, that spinal manipulation only has "modest benefit", is "not yet well validated", and remains "controversial".

All of this indicates that the spin doctors for medical associations will interpret this as a trial showing that manipulation and manual therapy in general are no more effective than good primary medical care. Because of this, and the prominence of Carey and Curtis as researchers in the field of back pain, this Report now looks at the new trial in detail, and then places it in historical and political context.

B. The New Trial

3. This study is from the University of North Carolina at Chapel Hill, and it was funded by the US Department of Health and Human Services—through the Agency for Healthcare Research and Quality (AHRQ), formerly and better known as the Agency for Health Care Policy and Research (AHCPR).

One of the principal investigators was Peter Curtis, MD from the Department of Family Practice. Dr. Curtis is originally from the UK and was trained there in medical manipulation. With Geoffrey Bove, DC PhD he was author of an article favorable to chiropractic published in the *Journal of Family Practice* in 1992.[10] He has practised manipulation for many years, and provided the treatment said to be similar to chiropractic manipulation in the foremost US trial of manipulation. This was by Hadler, Curtis et al.,[11] was also out of the University of North Carolina, and supported the effectiveness of manipulation for patients with acute low-back pain.

The other principal investigator was Timothy Carey, MD MPH, one of the most prominent US health services researchers in the field of back pain. Well-known studies from his North Carolina Back Pain Project include the comparison of cost and outcomes of care by chiropractors, orthopedic surgeons and primary care physicians published in the *New England Journal of Medicine* in 1995.[12]

Other investigators, presumably responsible for training the trial physicians in muscle energy techniques, included Paul Evans, DO and Michael Rowane, DO, doctors of osteopathy respectively from Madigan Army Medical Center and the School of Medicine at Case Western Reserve University in Cleveland, Ohio.

4. **Goal of the study**. The goal was "to determine whether training primary care physicians in techniques of limited manual therapy would result in improved outcomes for their patients with acute low-back pain." The specific hypothesis tested was "that limited manual therapy would improve the outcome of acute low-back pain (LBP) by at least 2 points on the Roland-Morris functional scale." On the 24 point Roland-Morris Scale, which is a patient questionnaire addressing levels of function in activities of daily living, a 2 point improvement—or advantage of one treatment over another—is generally regarded as clinically significant.

5. **Training in manual therapy**. The researchers explain that typical courses in manual therapy now given to physicians are "2-hour to 1-week workshops", and that these presume that "learning 'limited' manual therapy offers primary care physicians an additional strategy to improve the care of low-back pain." Against this background, internists and family practitioners interested in participating in this trial were given an 18 hour course developed by the researchers. It is described as "an intensive training course" and comprised:

a) Two single days of workshops, one month apart, then a third day with a "refresher session" later.

b) Essential elements included "an introduction to the paradigm of limited manual therapy", acquiring palpation and treatment skills, testing these on instructors and simulated patients, and—interestingly—"a patient-centered approach to management." In other words, responding to the research showing that the high satisfaction of chiropractic patients is linked not only to treatment but also inter- personal skills, this course emphasized caring as well as manual therapy techniques.

c) Physicians were trained in a set sequence of 8 standard maneuvers being 5 muscle energy techniques and 3 "high-velocity, low-amplitude thrusts." (The research grant proposal had proposed long-lever manipulation because that technique "is easier for physicians to learn", but something nearer to the chiropractic adjustment was finally chosen). These techniques were applied to the psoas and piriformis muscles and the sacroiliac and lumbosacral joints.

d) The physicians then practised these techniques on patients for 3 months before seeing patients in the trial.

It was acknowledged that "by design the physicians were not experts in manual therapy" and that the results should not therefore be extrapolated or applied to chiropractors and other "expert practitioners."

e) Chiropractors will be fascinated by the next assumption. This was that specific therapeutic maneuvers based on an accurate mechanical diagnosis, even though seen as "the key to success" in chiropractic and osteopathic education, are probably unnecessary. "A standard sequence of maneuvers . . . applied to more than one musculoskeletal region" will "adjust and stretch joints and soft tissues . . . (and)

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release local nerve compression" causing the necessary joint motion and reflex mechanisms, and will do this as well as anything more specific.

Accordingly, after exclusion of serious disease, physicians were to perform the full sequence of maneuvers the same way on every patient irrespective of diagnosis—though they were "given discretion to limit treatment if the patient was in severe pain or distress."

(It may be necessary at this point to pause and confirm that today is not April 1—all of this is actually true. "Intensive training" in "limited manual therapy" is of course an oxymoron, especially in a world where chiropractors have four full-time years of theoretical and clinical training).

6. **Patients**. Subjects in this trial were 295 adult patients aged 21 to 65 years presenting with "acute LBP of less than 2 months duration" and having no neurological deficits. Other standard exclusion criteria included no severe osteoarthritis, no prior spinal surgery or chymopapain therapy, and no prior manual therapy by the treating physician.

7. **Interventions**. Patients were randomly assigned to 1 of 2 treatment protocols, both given by the 31 primary care physicians—14 internists and 17 family practitioners—in the study. Protocols were:

a) **Control group**. These 143 patients received what was described as "enhanced" or "optimal" medical care in accordance with the US AHCPR back pain guidelines. [2] This emphasized early return to activities using "specifically designed patient handouts regarding exercises and activities of daily living". Treatment was for up to 5 visits as necessary, with not more than 2 visits per week.

Physicians could use normal options available to them including medication, brief bed rest and referral to "other professionals". In fact many patients in this group received muscle relaxants (76%) and narcotic analgesics (34%), undefined "LBP care from physical therapists" (14%) and "LBP care from other providers" including orthopedists and chiropractors (22%).

b) **Manual therapy group.** These 152 patients received the same care as the control group with the addition of manual therapy. Again there were up to 5 treatment visits with not more than 2 per week. In fact each physician treated between 4 and 5 patients with "limited manual therapy", with a frequency of "between 3 and 5 visits" (average 3.6).

Manual treatment was as already described, but few physicians used all 8 maneuvers. Therefore in the results the patients were categorized as having received *high-intensity* ("4 or more maneuvers to each side of the trunk per visit") or *low-intensity* (less than that) manual therapy.

In this group patients received a similar amount of other care—muscle relaxants (61%), narcotics (36%), and LBP care from physical therapists (13%) and other providers (22%).

(Readers familiar with the US AHCPR guidelines and following this closely will note that the level of prescription medication used is in fact inconsistent with the guidelines.)

8. **Outcome measures.** Results were measured in terms of:

a) *Functional disability*—the primary measure was the Roland-Morris Disability Scale or patient questionnaire, which measures levels of disability in performing daily activities of living. Functional status was also assessed by patient self-reports of function, pain and disability.

b) *Pain*—scores on a visual analog scale (VAS).

c) *Return to work*

d) *Patient satisfaction*—by means of a patient satisfaction questionnaire developed by Cherkin[13] that measured satisfaction with various aspects of care including the process of evaluation, diagnosis and history.

There was no economic analysis of direct or indirect costs.

9. **Results**. Patients gave a telephone interview within 7 days of the initial visit, and there were then further interviews and measurements of results 2, 4 and 8 weeks after the first treatment. Both groups of patients improved steadily and 265 (90%) reported that they had returned to their normal level of function and activities by the 8 week follow-up interview. With respect to the benefits of manual therapy in the test group:

a) Broadly speaking, there were none. On the primary outcome measure, the Roland-Morris Scale, there was no statistically or clinically significant difference. On other measures, "during the 8 week follow-up period there were no differences in levels of pain, days absent from work, and overall patient satisfaction between the two groups."

These main results held true after statistical analysis allowing for a number of variations—in the functional status of patients, length of time with pain before the first visit, and the competency of physicians in manual therapy as assessed by themselves or their instructors.

b) There was some evidence of difference related to intensity of manual therapy within the manual therapy group of patients. The 46 patients receiving 'high-intensity' therapy had an average time to functional recovery of 7.8 days which compares with the 10.4 days on average for the 106 receiving 'low-intensity' manual therapy. In addition, significantly more patients were completely recovered after the first treatment in the high-intensity subgroup—16 (19%) vs 7 (9%). However there were no differences in Roland-Morris scores, pain levels or time absent from work.

c) Fourteen of the physicians "used intensive manual therapy all the time" in the trial. However analysis of their results showed no patient differences that could be related to skill.

d) Accordingly Curtis et al. conclude that the use of limited manual therapy by physicians trained as described "offers little extra benefit" for patients over standard medical care according to current clinical guidelines.

As mentioned in the introduction van Tulder, internationally the most prominent epidemiologist providing systematic reviews for the Cochrane Collaboration in the field of low-back pain, is more frank. This trial, he says, justifies the conclusion "that training primary care doctors in limited manual therapy is not useful." And the fact that only 43% of the manual therapy patients actually received the complete intended treatment, he adds, "indicates that the limited training program may not have been successful in providing adequate skills and confidence to apply these skills."[7]

e) A survey of the physicians two years after the trial commenced, referred to in the report of the trial, apparently showed

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largest (Life) to the smallest and newest (Colorado), were joined by representatives from schools in 11 other countries — Australia, Brazil (2), Canada (2), Denmark, France, Italy, Japan (2), Korea, New Zealand, South Africa and the United Kingdom (4).

Others present represented proposed schools in Costa Rica and Mexico, accrediting agencies, examining boards and licensing authorities. Leaders of professional associations addressing the meeting included Dr Jim Mertz, ACA President, Dr Sid Williams, ICA Past President, Dr Tim St Denis, President, Canadian Chiropractic Association, Dr Laurie Tassell, President, Chiropractors' Association of Australia, and Dr Michael van den Bos, President, Chiropractors' Association of South Africa.

The World Federation of Chiropractic (WFC) called this meeting, co-sponsored by the Association of Chiropractic Colleges (ACC) and the US National Board of Chiropractic Examiners (NBCE), to seek consensus on the core beliefs and basic tenets of the philosophy of chiropractic, and how to teach them to chiropractic students. "Discord in our philosophical base," said WFC President, Dr Bruce Vaughan from Hong Kong as he opened the meeting, "underlies the discord in clinical approaches and political organisation in the profession and must be resolved."

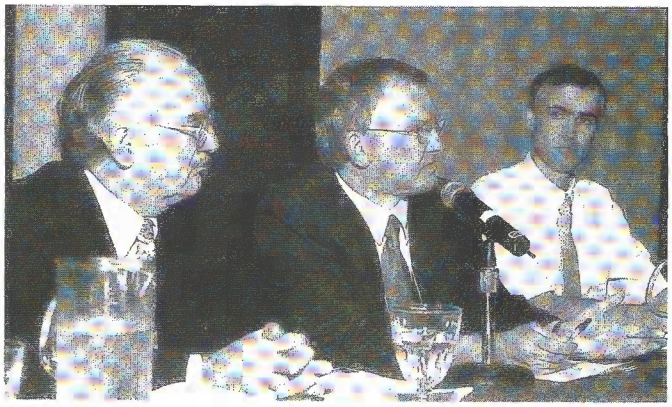
"If we can agree on the basic philosophy of chiropractic as it has evolved, then there will be less reason for division, discord and factionalism", said Vaughan. "On behalf of the WFC, I call for harmony in our profession." In other opening remarks, Dr Kenneth Padgett, ACC President, called for acceptance of the 1996 ACC Paradigm of Chiropractic, agreed to by all North American college presidents and illustrated in Figure 1.

Highlights of the program, co-chaired by Dr David Koch, Past President, Sherman College of Straight Chiropractic, and Dr Reed Phillips, President, Southern California University of Health Sciences (formerly LACC), were:

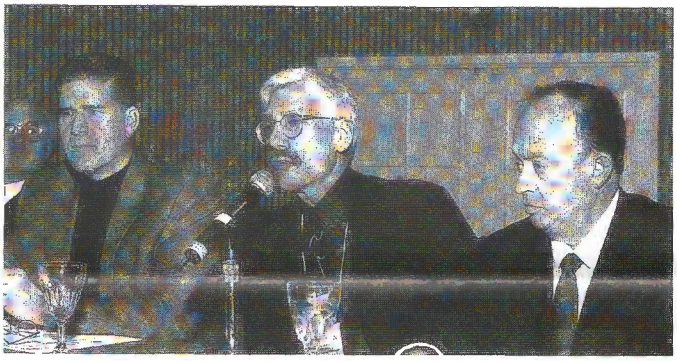
• Attendance by and consensus from all factions within the chiropractic profession.

• The presentation of impressive, formal lectures on philosophy not only in chiropractic but also in complementary and alternative medicine, medicine, and science generally. These are available without charge from the WFC's website - *www.wfc.org*. Keynote addresses were on the role of philosophy in the healing arts by Kenneth Schaffner MD PhD, George Washington University, and complementary health care by Ian Coulter PhD, RAND and UCLA.

• Other lectures explored vitalism (David Peters MD), the role of the nervous system in acupuncture, chiropractic and yoga (Howard Vernon DC), the therapeutic and non-therapeutic approaches to chiropractic (Joseph Keating PhD and Thom Gelardi DC, respectively), the importance of belief in health care (Michael Goldstein PhD), philosophical conflict between chiropractors and their patients (Jennifer Jamison MD) and the philosophical basis of condition-centered (Marion McGregor



Dr. Bruce Vaughan, WFC President, Hong Kong (*left*) and Dr. Philippe Richon, Institute Franco-Européen de Chiropratique, Paris, France (*right*), listen to Dr. Niels Grunnet-Nilsson, Director of Chiropractic Studies, University of Southern Denmark, Odense.



Dr. Guy Riekeman, President, Palmer College, Davenport, USA (*left*), here representing Palmer's affiliated chiropractic program at Feevale Central University, Novo Hamburgo, Brazil, and Dr. Enrique Benet Canut, Universidad Estatal de Ecatepec, Mexico (*right*) listen to Dr. Lester Lamm, describing the 5 year chiropractic program at Anhembi Morumbi University, São Paulo, Brazil.

Dr. Kenneth Schaffner, Professor of Medical Humanities, George Washington University, Washington, DC (*right*), a keynote speaker at the conference, answers a question from Dr. Simon Leyson, University of Glamorgan, Wales (*left*).

DC), vertebral subluxation-centered (David Koch DC) and patient-centered (Meridel Gatterman DC) care.

• Presentations by educational and professional leaders from all world regions on current content and methods of teaching philosophy in their chiropractic schools.

• A closing address by John Astin PhD, a health psychologist from the School of Medicine, University of Maryland, and a major figure in the US health care system's move toward integrated health care, confirming renewed philosophical and scientific interest in the concept of vitalism. Astin encouraged the chiropractic profession not to keep its valuable philosophical perspective to itself, but to engage the medical profession and others in a dialogue that would lead to a changed and improved philosophy of health care throughout the health care system.

• At this meeting speakers from several disciplines spoke of the new level of disenchantment with the limitations of the biomedical model, and the current move within health care to adopt the philosopher Engel's biopsychosocial model, which views health in physical, social, psychological and spiritual terms.

• A final day of workshops and discussion leading to the following new general consensus statements on philosophy in chiropractic education:

1. A shared approach to health and healing, based upon a shared philosophy of chiropractic, is important for the identity and future of the chiropractic profession.

2. Chiropractic is a unique discipline, but exists as part of a broader entity, the health care system. Accordingly, the discussion of philosophy as a discipline and the philosophy of health care, as well as specifically the philosophy of chiropractic, should be important components in every chiropractic curriculum.

3. The philosophy of chiropractic should be taught and developed in a manner that is intellectually defensible in the discipline of philosophy.

4. Principles from philosophical schools of thought that were discussed at some length at this meeting in the context of the philosophy of chiropractic included Conservatism; Holism; Humanism; Naturalism; Vitalism.

5. Other philosophical ideas that were presented at the meeting, but for which there was insufficient time for extended discussion included American pragmatism; Complexity theory; Critical rationalism; Ethics; Logic; Mechanism; Post modernism; Reductionism; Sociology of the professions; Systems theory;

6. Models of health care discussed at the meeting, and offered for consideration in chiropractic education, included the
- Biopsychosocial model;
- Condition-centered model;
- Evidence-based model;
- Patient-centered model;
- Vertebral subluxation-centered model.

7. With respect to the Association of Chiropractic Colleges' Paradigm of Chiropractic put before the meeting by the ACC, it is appropriate that the philosophy of chiropractic is presented as a core component of the foundation of the chiropractic paradigm of health. This philosophical foundation may be further understood in light of the above statements.

"It is timely and exciting that these statements support the ACC Paradigm of Chiropractic," says WFC Education Committee Chair and President of Life College West, Dr Gerry Clum, "because this ACC Paradigm forms the basis of a new common vision for the ICA, ACA and other chiropractic organizations in the United States, and has also been submitted to the World Federation of Chiropractic for approval as policy at its Assembly in Paris next May."

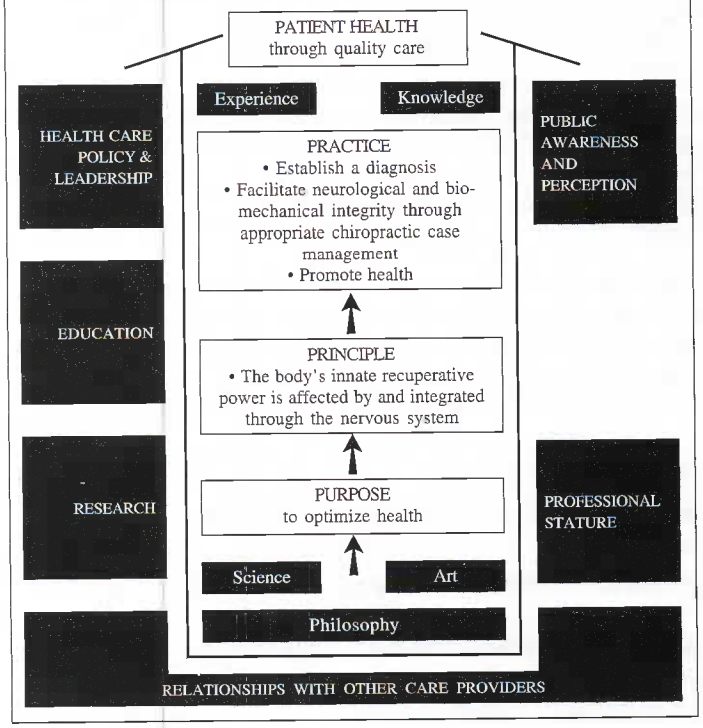
Contact for information and/or audiotapes of meeting: WFC, *www.wfc.org*, Tel. 416-484-9978, Fax. 416-484-9665, E-mail: info@wfc.org.

EUROPE

Germany—Medical Manipulation and Stroke. In 1995 Terrett documented widespread medical misrepresentation of the risks of chiropractic manipulation—cases of VAS and stroke caused by medical doctors and others were knowingly passed off as caused by chiropractors. (Terrett AGJ. *Misuse of the Literature by Medical Authors in Discussion of Spinal Manipulative Therapy Injury*, J Manip Physiol Ther 18(4):203-210). A recent paper from German neurologists provides the worst example yet. Titled *Stroke Following Chiropractic Manipulation of the Cervical Spine* it actually refers to 10 cases where treatment was by medical orthopedists (7 cases), a physiotherapist (1) and lay manipulators (2). None of Germany's 50 doctors of chiropractic was involved. (Hufnagel A, Hammers A et al. J Neurol 1999; 246:683-688.)

Figure 1

THE ACC CHIROPRACTIC PARADIGM



that most had given up spinal manipulation entirely—many were using no manual therapy, and "approximately half" were only using muscle-energy techniques 2 or 3 times per week. Exact figures on use of manipulation are not given.

C. Background and Conclusions

10. There is no doubt that this trial features much strong methodology and good science, and that we are dealing with gifted and experienced scientists. Equally there is no doubt that this project displays a pervasive bias against manual therapy, manipulation and referral of patients to chiropractors and other "expert practitioners of manual therapy" outside the medical fold. Whether this bias is conscious or unconscious is ultimately immaterial.

Past experience of the political spin put on the results of trials of manipulation, from Doran and Newell[14] published in the *British Medical Journal* in the 1970s to the trial by Cherkin, Deyo et al.[13] in the US published in the *New England Journal of Medicine* in 1998, makes it likely that this trial will be used by medical trade associations—including their research spokespersons—to dismiss all manual therapy as relatively costly and of little benefit. Patients should just continue seeing their family physician, whose "enhanced" modern care, employing better interpersonal skills and avoidance of bed rest, is equally effective and less costly for what is a self-limiting condition anyway.

What evidence is there for these rather sweeping allegations? In answer to that question, let's now review two things—firstly the wider context of medicine's attitude towards manipulation, and secondly some of the specific comments made by Curtis et al. in their report of this trial.

11. **The Historical context**. Until the early 1990s the medical profession was opposed to spinal manipulation. There was no training in manipulation in medical schools and there were few published clinical trials. Physicians were exposed only to their own colleagues who practised relatively crude techniques learnt informally and were thought of as mavericks. Medicine presumed that manipulation was potentially harmful, of little value —probably only the placebo effect of the laying on of hands—and therefore inappropriate. Mainstream medicine was equally critical of all who used spinal manipulation—chiropractors, osteopaths and "fringe" physicians using and advocating manipulation such as James Cyriax in the UK, John Mennell in the US, John Bourdillon in Canada and James Fisk in New Zealand.

Therefore, for example, the position of the New Zealand Medical Association's witnesses before a New Zealand Commission of Inquiry into Chiropractic into 1978/79 was that all manipulation was ineffective, dangerous and inappropriate.[15] Dr. Fisk, who had argued in favor of manipulation in the NZ Medical Journal in the early 1970s,[16] and had subsequently written a doctoral thesis on the subject, was not acknowledged or called as a witness.

When the American Medical Association published the *AMA Pocket Guide to Back Pain*,[17] as late as the 1990s, claiming in the introduction that it was "a reliable source of information" for the public, it made no mention at all of spinal manipulation, manual therapy or chiropractic treatment. These were not services that were acknowledged or provided by the AMA and its members.

12. However a scientific revolution was afoot, now documented by British orthopedic surgeon Waddell in his widely respected text *The Back Pain Revolution*.[18] Research in the 1980s and early 1990s had demonstrated two things—firstly that spinal manipulation was both safe and effective for most patients with back pain, and secondly that it was more effective and cost-effective than standard medical management based upon bed rest, medication and passive machine therapies.

These findings formed the basis for influential new evidence-based practice guidelines sponsored by the UK and US governments and published in 1994.[1,2] These called for early mobilization of the patient rather than bed rest, and dismissed the use of many prescription drugs and joint injections on the grounds of ineffectiveness and/or unacceptable side effects. They recommended keeping the patient positive and active, together with use of over-the-counter medications and/or skilled manipulation. The latter was widely seen as a reference to chiropractors and, especially in the UK, also osteopaths and physiotherapists who had completed postgraduate certificates in manual therapy. Still no medical schools provided education in manipulation.

Worse still from the perspective of medical self-interest, the large and influential Meade et al. trial published in the *British Medical Journal* in 1990,[19] and analysis of this and much other research and workers' compensation data by Canadian health economists Manga et al. in 1993,[20] reported that chiropractic was not only more effective than mainstream medical care for back pain patients—it was significantly more cost-effective and produced much higher rates of patient satisfaction.

13. All of this presented the medical profession with a quandary. On one hand science and the public, voting with their feet, were calling for services provided by other professionals. On the other hand the management of back pain was a multi-billion dollar marketplace that political medicine was reluctant to share or lose. The response, predictably enough, was two-fold. The first was to

start training physicians in manipulation as well as possible, trying to produce research showing that medical manipulation was as effective as any other. The second was to undermine the evidence for manipulation. The latter could be achieved by:

• reinterpretation of the evidence—and there are now actually more metanalyses and systematic reviews of spinal manipulation trials for back pain than trials (of which there are over 40). Somewhere you can find quite a good one saying anything you want;

• new trials showing that improved conservative management by physicians is about as effective and actually more cost-effective than referring patients for manipulation.

14. **Comments from the new trial**. To illustrate what is being said, look now at developments at the University of North Carolina and the trial now published. Just as the US government-sponsored AHCPR guideline on Acute Low-back Pain in Adults[2] was being drafted and published in 1993-1994, Dr. Timothy Carey and colleagues at the University, who were established LBP researchers with excellent access to government funding, began to plan the research on medical manipulation now published 6 years later. In their funding application dated May 3,1994 to the US Department of Health and Human Services they note:

a) Over a three and a half year period the university proposes to investigate "the training of primary care physicians in methods of manual therapy for acute LBP . . . including simple spinal manipulation". The investigation will include a clinical trial with these research questions:

• Can physicians reliably learn the approach to manual therapy, including spinal manipulation? (In other words, now that new evidence-based guidelines just being published are saying many patients should get manipulation, can we do it ourselves?)

• Can use of simple spinal manipulation therapy improve the clinical outcomes of patients with acute back pain? (Outside its political context a very fair research question.)

b) On the current evidence of effectiveness and patient satisfaction "immediate chiropractic referral is one strategy" for improved diagnosis and treatment, but "even if (it) is an effective strategy . . . it is unlikely to become a dominant strategy to the public." Why? The research proposal gives two reasons:

• "Primary care physicians may be reluctant to refer out to other provides such a common problem as acute low-back pain."

• "Managed care initiatives . . . encourage increased management of problems by primary care physicians without referral."

Thus, even if skilled manipulation services by chiropractors are best for many of these patients, and even if the preponderance of the evidence is that it is cost-effective,[19,20,21] physicians are unwilling to use a 'competitor' in the market.

15. Turning to the trial as published note the following:

a) In a manner that would be surprising, if the background context was not understood, the researchers label manipulation and manual therapy as "*controversial*", "*not yet well-validated*", and only having "*modest benefit*". As already noted this is completely inconsistent with systematic reviews and evidence-based guidelines. It is also inconsistent, rather interestingly, with what this research team said in its funding proposal to the U.S. government, namely that spinal manipulation "is one of the few treatments of acute low-back pain *with demonstrated efficacy*."

How can a treatment with 'demonstrated efficacy' suddenly become 'not yet well-validated' and 'controversial'? One is forced to the conclusion that Curtis et al., in now changing their tune, are simultaneously providing cover for their trial showing disappointing results of unskilled medical manipulation and shoring up the ground for medical management without manual therapy.

b) The next comment to spring off the page, as this trial reports no significant benefits from medical manual therapy, is the short, unsupported observation that "Cherkin et al. noted similar outcomes comparing manual therapy by chiropractors with an educational booklet". The clear implication is 'we didn't do well, but the experts don't either'. This *is* controversial.

That is certainly the way that organized medicine presented the Cherkin et al. trial in 1998, generating news media stories across the US with headlines such as '*Chiropractic Care Blasted*' and '*Studies Show Little Benefit to Chiropractic Treatment*'. However that trial, which compared chiropractic manipulation, McKenzie Methods physical therapy and a control group receiving an educational booklet for patients with chronic low-back pain, actually demonstrated that chiropractic patients had the best results, in terms of improvement, disability rates, time off work and patient satisfaction—*all for a total cost of $230 per patient.*

At the time this Report charged Cherkin and his colleagues with allowing science to become subservient to medical politics. Reasons included:

• The failure to provide any complete or expert analysis of cost. (If the reduced time off work for chiropractic patients was only one day per patient—it may have been far more, it wasn't reported—the chiropractic treatment was extremely cost-effective.)

• In these circumstances, this policy suggestion in their conclusion: "Given the limited benefits and high costs (*of chiropractic in the study we are now reporting*), it seems unwise to refer all patients with low-back pain for chiropractic . . .".

• The media fanfare—partly described above.

(For a comprehensive review of the Cherkin et al. study see the November 1998 issue of *The Chiropractic Report*).

c) Finally one might suppose that Curtis et al. would conclude from their trial that their model of short course training of physicians in manual therapy is not appropriate. It cannot be alleged that the limited manual therapy skills acquired are of value—they have just disproved that hypothesis. However, a little unbelievably from a chiropractic perspective, they argue that "hands-on training reported in this study may be an economic way to enhance patient satisfaction."

This seems to be the argument they present—the evidence shows that physicians are frustrated in managing patients with LBP and patients are dissatisfied with their care; extra didactic education for physicians has not proved helpful; meeting patient needs more effectively is required; the physicians in this trial felt more confident after their manual therapy training, albeit their limited skills provided little benefit; therefore this type of training should continue because the more caring attitude it engenders will likely enhance patient satisfaction in an economic way.

16. Plainly this complex analysis and solution—teaching MDs ineffective manual therapy to increase their sense of confidence—arise from professional rather than patient interests, from trying to keep low-back pain patients with their primary care physicians. From the point of view of the long suffering patient, why would you propose to train professional A to a level of admitted limited skill and competence when you know professional B has extensive formal training, superior skills, and superior results? The answer is plain—you should not.

The study provides clear evidence that physicians in the western world should adopt the approach of modern medicine in China. This is that physicians should receive relatively brief training in manual medicine—a mainstay of traditional Chinese medicine—not to practice in an unskilful and ineffective manner, but to understand when to refer for collaborative care in the best interests of the patient. Whatever spin the medical profession may want to put on the Curtis et al. trial in the months and years ahead, its actual scientific message has been nailed to the mast with clarity by the truly independent and expert hammer of van Tulder, who acknowledges that it is a well-designed trial justifying this conclusion:

"Training primary care doctors in limited manual therapy is not useful." TCR

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