The Chiropractic Report

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Professional Notes

Cervical Adjustment—What Risk?

Attacks against chiropractors concerning perceived risks of cervical manipulation are currently based on "coincidence, anecdotal reports and junk science" said the leading Canadian neurologist Dr. Adrian Upton, delivering a lecture titled *Chiropractic Therapy as Seen by a Neurologist* in Bournemouth, England on April 22.

Case reports and expert opinions represent a "very low level of evidence" and cannot establish a scientific or legal link between chiropractic treatment and vertebral artery injury or stroke. For causation to be proven there need to be large—and extremely complex and expensive—controlled trials.

If there is any risk it is extremely small, said Upton. People have vertebral artery injury and stroke after many activities or spontaneously—but very rarely. No one knows whether there is a higher incidence of injury and stroke after turning the head to sleep, visiting a chiropractor, or eating a hamburger—or whether the rate is the same as in the general population at large.

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Who and What is a Chiropractor?

Global Challenges—and Educational Standards from the Profession and the WHO

A. Introduction

OSTEOPATHS EVERYWHERE are challenged by their lack of agreed educational standards—internationally they have no identifiable profession.

In the US they are the equivalent of medical doctors with almost identical training and the same specialties—your cardiologist, anesthesiologist or surgeon may be an osteopath. In the UK there is a more traditional osteopathic education, similar in duration to chiropractic education. Elsewhere in Europe and in many other countries it is open season. Osteopaths are medical doctors, physical therapists or lay persons who have completed part-time weekend courses, typically of inadequate quality and given by entrepreneurs.

Chiropractic has taken a different path. It has developed one minimum standard of education worldwide that offers much greater protection to both the profession and the public it serves. This standard has been enforced by a network of affiliated accrediting agencies in various world regions, and by licensing laws worldwide that require licensed chiropractors to be graduates of accredited schools. Countries with laws recognizing and regulating chiropractic practice are given in Table 1. In many other countries the practice of chiropractic is legal—but not regulated.

2. Now that chiropractic has become established and well-known in all world regions, a strong new threat to the integrity of the profession is emerging in those countries where there is still no regulation of the profession, no law controlling who may use the titles 'doctor of chiropractic' and 'chiropractor', or claim to offer chiropractic services. This threat is principally from medical doctors, physiotherapists and lay manipulators claiming to provide chiropractic services—sometimes, regrettably, after inadequate and short-term courses given by qualified doctors of chiropractic in betrayal of their own profession. Therefore for example:

a) During the past year a US-educated chiropractor, Dr. Alain Dhers, originally from France and now living in Spain, has commenced weekend courses in chiropractic technique for other health professionals in Spain and Portugal, countries where the practice of chiropractic is nearing but has not yet achieved legal recognition. Notwithstanding pressure from the Spanish and Portuguese chiropractic associations and others, including his alma mater Sherman College, Dr. Dhers continues to advertise and give his courses. The opportunity for personal gain has triumphed over integrity.

b) This month, under the headline *American DC Angers Profession in Germany: Should DCs be Teaching Chiropractic to Non-DCs?*, the US newspaper *Dynamic Chiropractic* reports how "the chiropractic profession in Germany and throughout Europe is up in arms" over the actions of a young American chiropractor, Dr. Mark Styers, who has commenced a 432-hour, 26-weekend course of chiropractic technique seminars for lay manipulators.

Dynamic Chiropractic explains that, upon completion of courses at Dr. Styers' American Institute of Chiropractic (AIC) in Hamburg, graduates are encouraged to join a new association formed by him, the WCA-Germany, as chiropractors. These developments are bitterly opposed by the German Chiropractors' Association (GCA) representing most of Germany's 70 duly qualified doctors of chiropractic, but they have limited powers to act because Germany is a country where the chiropractic profession and its practice are not yet recognized and regulated by law. More on this below.

c) In Taiwan a Dr. Julian Wang, a medical doctor who re-qualified as a

Table 1: Countries with Legislation to Recognize and Regulate the Chiropractic Profession

African Region
Botswana
Lesotho
Namibia
Nigeria
South Africa
Swaziland
Zimbabwe

Asian Region
Hong Kong – SAR China

Eastern Mediterranean Region
Cyprus
Iran
Saudi Arabia
United Arab Emirates

European Region
Belgium*
Denmark
Finland
France*
Iceland
Liechtenstein
Norway
Portugal*
Sweden
Switzerland
United Kingdom

Latin American Region
Costa Rica*
Mexico*
Panama

North American Region/Caribbean
Bahamas
Barbados
Canada
Leeward Islands
Puerto Rico
United States
US Virgin Islands

Pacific Region
Australia
Guam
New Caledonia*
New Zealand

* = Legislation to recognize the profession, but legal framework for regulation not yet complete.

chiropractor in the US at the Southern California University of Health Sciences (formerly the Los Angeles College of Chiropractic), is providing short-term courses in chiropractic to medical doctors and physical therapists and asserting to government that legislation to recognize the chiropractic profession when enacted, should include those who have taken courses such as his.

d) In Brazil there are two new university-based chiropractic schools that have graduated their first classes this year, but there is still no legal regulation of chiropractic practice. In response the COFFITO, the national organization representing physiotherapists, is lobbying to have chiropractic recognized as a specialty of physiotherapy, and PTs are beginning to take postgraduate short-term part-time courses from informally trained Brazilian 'quiropatas' in Sao Paulo.

e) In Buenos Aires in Argentina a medical group led by Dr. Alberto Baigros has now provided a certificate in chiropractic to MDs who completed a 200-hour part-time course during May to December 2004. A second year of the course has now commenced.

3. What is the profession doing to prevent and respond to these problems? There are four major courses of action and the World Federation of Chiropractic, whose members are national associations in the above countries and throughout the world, has a significant role in all of them:

a) Maintenance of one minimum international standard for full qualification as a chiropractor, and ensuring that this is the standard incorporated in legislation in each country as licensing laws are passed.

b) For countries where persons with limited informal training are practicing as chiropractors, and can be expected to be grandfathered into the profession when licensing laws are passed, or where the first introduction of formal chiropractic education cannot realistically be at the international standard given social and legal conditions, establishment of clear guidelines for interim limited education in two ways:

• Through the profession's own agencies—including the Councils on Chiropractic Education International (CCEI) and the World Federation of Chiropractic (WFC).

• Through external agencies that have influence with governments – most importantly the World Health Organization.

c) Putting maximum pressure on chiropractors and chiropractic organizations that are dishonouring the profession and threatening its identity by offering their self-serving courses.

4. This issue of *The Chiropractic Report* reviews the above situation. If the right to practise chiropractic is regulated by law for you in your country, why should you be concerned? Because the continued existence of chiropractic everywhere as a separate and distinct profession, rather than a set of techniques used by various professionals, depends upon the defence of established educational standards. Educational and legal developments in one state or country can quickly influence developments in others in our small, interconnected modern world. All chiropractors should know of these wider international professional issues and be vocal in influencing colleagues not to embark on educational initiatives in other countries whatever their motives —unless the standards set by the profession and now WHO are honored.

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Table 2: A Sample Four-year, Full-time Accredited Chiropractic Curriculum

Subjects Taught in a Typical Semester-based Chiropractic Program, by Year and Number of Hours.

Division	First Year (Hrs)	Second Year (Hrs)	Third Year (Hrs)	Fourth Year (Hrs)
Biological Sciences	Human Anatomy (180) Microscopic Anatomy (140) Neuroanatomy (72) Neuroscience I (32) Biochemistry (112) Physiology (36)	Pathology (174) Lab Diagnosis (40) Microbiology & Infectious Disease (100) Neuroscience II (85) Nutrition (60) Immunology (15)	Lab Diagnosis (32) Toxicology (12)	Clinical Nutrition (26) Community Health (40)
Clinical Sciences	Normal Radiographic Anatomy (16) Radiation Biophysics and Protection (44)	Intro. Diagnosis (85) Intro Bone Pathology (48) Normal Roentgen, Variants & Roentgenometrics (40)	Orthopaedics & Rheumatology (90) Neuro diagnosis (40) Diagnosis & Symptomatology (120) Differential Diagnosis (30) Radiological Technology (40) Arthritis & Trauma (48)	Clinical Psychology (46) Emergency Care (50) Child Care (20) Female Care (30) Geriatrics (20) Abdomen, Chest & Special Radiographic Procedures (40)
Chiropractic Sciences	Chiropractic Principles I (56) Basic Body Mechanics (96) Chiropractic Skills I (100)	Chiropractic Principles II (60) Chiropractic Skills II (145) Spinal Mechanics (40)	Chiropractic Principles III (42) Clinical Biomechanics 100) Chiropractic Skills III (145) Auxiliary Chiropractic Therapy (60) Introduction to Jurisprudence & Practice Development (16)	Integrated Chiropractic Practice (90) Jurisprudence & Practical Development (50)
Clinical Practicum	Observation I (30)	Observation II (70)	Observation III (400)	Internship (750) Clerkships: Auxiliary Therapy (30) Clinical Lab (20) Clinical X-ray: Technology (70) Interpretation (70) Observer IV (30)
Research			Applied Research & Biometrics (32)	Research Investigative Project
TOTALS	914	962	1,207	1,382
TOTAL HOURS OVER FOUR YEARS: 4,465 plus research project				

B. Accredited Full Education.

5. This is familiar to all licensed chiropractors worldwide, except those grandfathered when laws were first introduced and does not therefore need detailed discussion here. A typical semester-based program (two terms per year) is given in Table 2.

This represents four years of fulltime study following entrance requirements, which are typically a bachelor's degree or three years colleges/university credits in North America. As chiropractic education has spread internationally there are various other models of full education, including the 5-year double bachelor degrees, or bachelor's plus master's degrees, found in Australia and South Africa.

In Europe, under the European Union's Bologna Directive, all professions including chiropractic are moving to the model of a 3-year bachelor's degree followed by a 2-year master's degree and one year in supervised professional practice. However, whatever the model, the content of the curriculum is substantially the same.

C. Interim Limited Education

6. No profession can control its world in countries where it is not recognized by law, and where social and legal conditions allow others to usurp its name and standards and develop their own economic and political power. As examples of this:

a) In Japan, where the practice of chiropractic is not regulated by law, there is recognition and government funding for a number of alternative health professions that have developed from traditional Japanese healing methods, known as 'ryoujytsu'. These include judo bone-setting, moxibustion therapy, Japanese massage (anma)/shiatsu and acupuncture. Education comprises three years of fulltime or part-time education. Many of these professionals have completed post-graduate local courses in chiropractic, practise as chiropractors, and belong to large and influential associations.

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Cervical Adjustment—What Risk?

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Professor Upton, Head, Division of Neurology, McMaster University School of Medicine, Hamilton, Ontario, was speaking at the 80th Annual Spring Convention of the British Chiropractic Association (BCA) held jointly with the 40th anniversary celebration of the Anglo-European College of Chiropractic. Other noteworthy contributions on the topic included:

• Dr. Paul Carey, familiar with malpractice claims history in Canada as President of the Canadian Chiropractic Protective Association (CCPA), which has data confirming a risk of stroke following cervical adjustment (following—not caused by) of less than 1 in 1 million treatments, spoke of the surprising level of medical bias in claims handled by the CCPA. If an individual suffered stroke within a week or two of chiropractic treatment, almost invariably causation was assumed by medical specialists—without any contact with the chiropractor or proper investigation. The absurdity of this was demonstrated by a recent incident in which a patient suffered a stroke following chiropractic treatment—and, since this treatment was suggested as a probable cause, commenced a claim for damages. This was easily resisted since the patient had only received chiropractic treatment of the ankle.

• Dr. Haymo Thiel, providing an interim report on a major UK prospective study of the safety of chiropractic neck manipulation, commenced in June 2004 and involving 420 BCA members, explained that to date there were data on 50,214 consecutive neck manipulations without a single serious incident of harm. (NSAIDs and even aspirin cannot manage that level of safety).

BCA/AECC Conference—Other Items.

1. *Waddell – Principles of Rehabilitation*. The prominent Scottish orthopaedic surgeon Professor Gordon Waddell, who has been reviewing the whole field of rehabilitation for the UK Department for Work and Pensions during the past three years, reviewed concepts of rehabilitation for common health problems. Traditionally rehabilitation has been seen as a secondary intervention after primary health care for the obviously disabled—such as those who are blind or confined to wheelchairs.

In fact in the UK 80% of persons requiring rehabilitation and on long-term incapacity benefits have the common health problems (CHPs) of mental health concerns (44%), back and other musculoskeletal disability (26%) and cardiovascular problems (10%). Their problems are biopsychosocial. Their long-term incapacity is not inevitable, and is often the result of poor rehabilitation.

Rehabilitation for CHP should address not only obstacles to recovery (the focus of health care), but also barriers to return to work. Key new principles and attitudes in the world of rehabilitation are:

• Principles of rehabilitation must be incorporated in primary care—not secondary care.

• Care should be directed not only at symptomatic relief but also restoration of function.

• Appropriate health care only addresses 50% of the problem—the other half is occupational management of return to work. Primary health care professionals must communicate with employers on this.

• A key shift in attitude must be from the 'work is harmful' to 'work is healthy'—physically, mentally and emotionally.

2. *Nilsson—Why Trials are Disappointing.* Professor Niels Grunnet-Nilsson, DC MD PhD from the University of Southern Denmark, with a background of 12 years in practice and then 18 years in education and research, asked why the excellent results he experienced with patients in practice are so hard to duplicate in clinical trials/research. He is partway through a major analysis of this, and suggested that the answer may lie in problems in research design of trials in these areas:

• Choice of patient population. With respect to headache trials, for example, it is known that 20% of those with headaches are seen in primary care, only 0.1% in headache centres—yet it is in these centres that the trials are done. A further point relates to pain levels. With respect to a back pain trial in which chiropractic management is being compared with another treatment and/or a placebo, the powerful factor of regression to the mean—which means that all subjects will be presenting for care at a more serious stage in their pain cycle and will tend to improve anyway whatever treatment or lack of treatment they are getting—means that you have to have subjects with a significant average level of pain if the trial is going to be able to demonstrate treatment effects over and beyond regression to the mean. Many trials do not—the chiropractic treatment has no chance of demonstrating significant benefit.

• Choice of outcome variables to measure results. In practice clinicians tend to use a retrospective global assessment by the patient ("how are you doing"?) as well as disability questionnaires and other measures. New research is showing that such a global assessment is actually more sensitive to change than questionnaires—but it has not often been used in trials.

• Choice of treatment protocols. When drug trials are done the best dosage has already been established—how much to take and how often—before the trial of effectiveness is begun. That is not the case for chiropractic and other physical treatments. This means there is danger in adopting standardized treatment protocols in chiropractic research at this point in time. That should not be done until best frequency of treatment—or dosage—has been established.

Grunnet-Nilsson illustrated this with two chiropractic randomized controlled trials in the field of infantile colic/irritable baby syndrome. A Norwegian trial (Olafsdottir et al. 2001) provided a standardized treatment protocol—3 treatments over 2 weeks—and did not report benefit from chiropractic management. A Danish trial (Wiberg et al. 1999) adopted a pragmatic design of as many treatments as were felt necessary over a 2 week period. Under this design different infants received between 1 and 7 treatment visits, and 64% had 4 or more treatments—more than the other trial allowed. The Danish trial did report significant benefit from chiropractic management as compared with standard medical management. Different dosage may have been the deciding factor.

Research Highlights

1. **Australia—Long-Term Benefit of Chiropractic Manipulation for Chronic Mechanical Back and Neck Pain**. An important randomized controlled trial from Muller and Giles at Townsville Hospital published in *Spine* in 2003 [28(14):1490-1503] reported that chronic back and neck patients receiving chiropractic manipulation (twice weekly for a maximum of 9 weeks) had significantly better results than patients receiving acupuncture or medication (Celebrex, Vioxx and paracetemol). At 9 weeks the highest proportion of patients with complete early recovery (asymptomatic status) was found for patients receiving chiropractic manipulation (27.3%), in comparison with acupuncture (9.4%) and medication (5%).

An important follow-up paper has just published long-term results—at 12 months after treatment. Those receiving spinal manipulation "gained significant broad-based beneficial . . . long-term outcomes" compared with those receiving acupuncture or medication. As Muller and Giles relate, these results are important—firstly because chronic spinal pain is such a huge problem in terms of suffering and cost, and secondly because there are very few RCTs for chronic spinal problems with long-term follow-up.

(Muller R, Giles LGH (2005) *Long-term Follow-up of a Randomized Clinical Trial Assessing the Efficacy of Medication, Acupuncture, and Spinal Manipulation for Chronic Mechanical Spinal Pain Syndromes,* J Manipulative Physiol Ther 28:3-11.

2. **US—Chiropractors See Little Occupational LBP.** The Arizona State University Healthy Back Study, funded by NCMIC and with principal investigators that include prominent economists Marjorie Baldwin and William Johnson and Pierre Côté, DC PhD from the Institute for Work and Health in Toronto, has the goal of discovering who injured workers with back pain consult, why, and with what results—in terms of effectiveness and cost-effectiveness. It is the most comprehensive study ever in this field and includes 200,000 workers from 37 states and five major US employers—America West Airlines, American Medical Response, The Earthgrains Company, Maricopa County and Marriott International Inc.

Over a three year period from July 1999 to July 2002 all workers with back injuries entered the study and completed pain, disability and quality of life questionnaires at baseline then 1, 6 and 12 months. Major findings from the first paper from the study, reporting professionals workers consult and why, are:

• Workers with back injuries in the US are most commonly treated by an MD and PT (44.7%) or MD alone (29.7%), and relatively few are seen by an MD and DC (5.3%) or a DC alone (only 4.1%).

• The major reason for this pattern of care, which is markedly different from that of the general public with back pain—approximately 33% of them seeking care consult a chiropractor—is that the choice of health professional is not primarily a matter of personal choice or dictated by level of pain or dysfunction - it is chosen by the employer. Another factor in choice of provider is the type of job held—unskilled workers, as for example in the transportation/moving sector, are much more likely to see a medical doctor only than more skilled workers.

Overall, then, there is large potential for growth in chiropractic practice in the occupational back pain field. The evidence of cost-effectiveness and patient satisfaction is there – what is now needed is the trust and support of employers.

(Côté P, Baldwin ML, Johnson WG (2005). *Early Patterns of Care for Occupational Back Pain.* Spine 30 (5) 581-587).

3. **Canada—Management of Paediatric Health Conditions**. It is noteworthy that *Paediatric Child Health*, the official journal of the Canadian Paediatric Society, has just published a systematic review by chiropractic researchers Gotlib and Rupert to determine the evidence supporting the benefits of chiropractic management for paediatric health conditions.

Results are bittersweet. On one hand claims for chiropractic management and manipulation are "for the most part supported by low levels of scientific evidence" and more rigorous study is needed. On the other hand the chiropractic profession is the only one using spinal manipulation with children that has conducted significant research and, although the evidence is patchy, there are randomized controlled trials suggesting effectiveness for paediatric patients (those 18 years of age or younger) for asthma, enuresis, infantile colic and chronic otitis media. This paper also gives you a good set of references for the research to date.

(Gotlib A, Rupert R (2005) *Assessing the Evidence for the Use of Chiropractic Manipulation in Paediatric Health Conditions: A Systematic Review*. Paediatric Child Health 10(3):157-161).

4. **Denmark—LBP and Degenerative Changes in Children.** Paediatric low-back pain is common, is associated with spinal degenerative changes visible on MRI, and is a significant area of health care practice. These are messages from a large study of 13-year-old children from Kjaer, Leboeuf-Yde et al. at the University of Southern Denmark just published in *Spine*.

Very little is known about lumbar MRI findings in youngsters and how they are associated with LBP, which was the subject of this study, the largest single-age study of children yet performed in this field. Findings were:

• Almost 1 in 4 (22%) had experienced back pain within the past month—a one month prevalence rate supported by three other recent studies—and 8% sought care.

• This was in a population of students which had a 4% one month prevalence rate at the age of 9.

• MRI signs of degenerative disc changes were present in approximately one-third of the subjects, and there was association between LBP and degeneration—"strong statistically significant associations" for boys in the upper lumbar discs and for girls in the lower segments of the spine.

• Endplate changes, especially in relation to the L-3 disc, were strongly associated with LBP.

(Kjaer P, Leboeuf-Yde C, et al. (2005) *An Epidemiologic Study of MRI and Low Back Pain in 13-Year Old Children,* Spine 30(7):798-806).

What can the Japanese Association of Chiropractors (JAC), representing the relatively small number of duly qualified doctors of chiropractic in Japan who have studied in North America and Australia, do when faced with this situation? How can the JAC start a five-year fulltime course in a society that gives greater recognition to 'chiropractors' who can qualify with much less time and cost through other recognized natural healing arts?

b) In Argentina and Chile, for example, where there are large groups of kinesiologists practising as 'chiropractors' in the absence of any regulatory laws, what can a few local DCs and the international profession do to achieve full educational standards?

7. The profession has addressed these issues principally through the World Federation of Chiropractic (www.wfc.org), formed in 1988 and now representing national associations in 80 countries, and in official relations with the World Health Organization since 1997. In dealing with these matters the WFC works closely with the profession's specialized organizations for accreditation (the CCEI and its members), accredited colleges (the Association of Chiropractic Colleges) and examining authorities (the US National Board of Chiropractic Examiners and the recently formed affiliate, the International Board of Chiropractic Examiners).

There are two major initiatives to be aware of:

a) The WFC's International Charter for the Introduction of Chiropractic Education (the Tokyo Charter—see paragraph 8 below).

b) WHO's Guidelines on Basic Training and Safety in Chiropractic (the WHO Guidelines—see paragraph 11 below).

8. **The WFC's Tokyo Charter.** The full text of the Charter, with explanatory notes, may be found at www.wfc.org under Policy Statements. It was agreed unanimously by WFC member associations at their Tokyo Assembly in 1997 following wide consultation and debate over a four year period. The key principles of the Charter are:

a) When chiropractic undergraduate education is first introduced in a country there should be a plan for reaching the recognized international standard, but local conditions may require transitional staged development.

b) Partners should include a university or similar institution in the country where education is being introduced, and an accredited chiropractic college from another country.

c) There must be approval by and support from the national association representing chiropractors in the country where education is being introduced. Ideally the national association should be leading the project.

d) Any part of chiropractic undergraduate education is subject to the above principles. Therefore for example an accredited US chiropractic college should not provide human dissection or other anatomy courses offshore to students from, say, an Asian country unless this is part of a complete undergraduate program in that country that satisfies the principles of the Charter.

9. As an example of how these principles should work, when the Japanese Association of Chiropractors proposed a first official chiropractic course in Japan in the early 1990s it partnered with RMIT University of Melbourne, Australia. Initially the JAC and RMIT established a three-year fulltime program. This was the most that students could be expected to attend in the first instance, for reasons already given. Three years later, having established a reputation and financial base, they were able to commence a five-year program at the international level at RMIT Japan in Tokyo. This is currently on the point of receiving full accreditation from the Australasian Council of Chiropractic Education.

As a second example, when chiropractic education was introduced in Brazil in the mid-1990s this involved a partnership between the Brazilian Chiropractors' Association, Palmer College in the US and FEEVALE University in Brazil. Initially there was a two-year part-time course for health professionals (medical doctors, physical therapists and nurses), followed by a one-year internship at Palmer for leading students who would fill some future faculty positions in Brazil. What followed was a five-year program for high-school graduates, which graduated its first class last September.

10. These planned and orderly developments may be compared with what is happening at the American Institute of Chiropractic (AIC) in Germany. Dr. Styers, a young American chiropractor who is a 1999 graduate of Life University, acting alone and with no expertise in curriculum design and no teaching experience, has commenced a private course. There are neither the appropriate partners nor the plan for development of a curriculum, faculty and school at the international level.

This is the 432-hour, 26-weekend web-advertised course he started:

- Upper Cervical Specific Techniques I, II, III, and IV
- Pediatrics I, II, and III
- Instrument Adjusting (Activator) I & II
- Chiropractic Biophysics Technique I & II
- Thompson Drop Technique I & II
- SOT Basic and Advanced
- Extremities Techniques
- Sports Rehabilitation I & II
- Neurological Re-Balancing Technique I & II
- Nutrition
- Basic and Advanced Cranial Techniques
- CMRT (Chiropractic Manipulative Reflex Technique)
- Chiropractic Practice and Case Management
- Network Technique I & II

There are no basic sciences, no clinical sciences such as biomechanics, applied neurology and radiology, and nothing on the history and philosophy of chiropractic. However, quite apart from its individual areas of deficiency, the course presents chiropractic as a set of techniques rather than a separate and distinct profession. It can be expected that graduates from such a program, as in Asian countries such as Japan and Korea in the past, will turn around and develop their own weekend courses in chiropractic. The Japan problem has arrived in Europe.

This entrepreneurial initiative is naturally opposed by each of the German Chiropractors' Association (GCA), representing Germany's duly qualified chiropractors, and the European Chiropractors' Union (ECU), neither of which was consulted in advance. Dr. Styers, when contacted, alleges his initiative is justified because of the number of heilpraktikers and medical doctors in Germany claiming to be chiropractors. He claims to be motivated by the need to upgrade their standards. The GCA completely disagrees with his actions and, understandably, sees this as "selling out chiropractic" and quite possibly "the begin-

Table 3: Sample Limited Interim Program

An example of the type of program contemplated under the impending WHO Guidelines for persons with limited educational background practising as chiropractors in countries where the profession is unregulated by law. Such a program is design to enable graduates to attain a minimal and safe standard of practice and be suitable for grandfathering and registration when law is passed. This program was provided by Murdoch University, Perth, Australia, which has a chiropractic program at the international level, for graduates of a three-year part-time program at the Kansai Chiropractic School in Kurashiki, Japan.

Division	First Year	DL	IR	CP	Second Year	DL	IR	CP	Third Year	DL	IR	CP
Biological Sciences	Anatomy Biochemistry Physiology Pathology Public Health Clinical Nutrition	56 56 56 70 56 56	24 4 4 12 4 4		Laboratory Diagnosis	42	8					
Clinical Sciences					Physical Diagnosis Orthopaedics/ Neurology Radiology Clinical Diagnosis	56 56 56 56	14 14 16 9		Head/Cervical spine care Thoracic/Lumbar Spine & Pelvis care Hip/Knee/Ankle/ Foot care Shoulder/Elbow/ Wrist/Hand care Special Population Care	70 70 70 70 56	20 20 20 20 24	
Chiropractic Sciences	Biomechanics Principles of Chiropractic	56 42	16 3		Patient Management Procedures	42	18		Record keeping, Documentation & Quality Assurance	42	16	
Clinical Practicum				400				400				400
Research	Computer Skills Workshop			6	Research Methodology First Aid/ Emergency Care	50 28	24					
TOTALS		448	71	406		486	103	400		378	100	400
TOTAL HOURS of Part time study over three years: 2,790												

DL = Distance Learning (Self-Directed Learning) ***IR = In Residence (Lectures & Workshops)*** ***CP = Clinical Practicum (Supervised)***

ning of the end for our profession in Germany", to quote GCA member and Palmer graduate, Dr. Gordon Janssen.

Under the new WHO Guidelines, which we now turn to consider, the type of students being accepted by the AIC would require a far more comprehensive course of study over a minimum of 2,500 hours. Under the WFC's Tokyo Charter, this course should be sponsored by the GCA and an accredited chiropractic college.

11. **WHO Guidelines.** As discussed at some length in the July 2004 issue of *The Chiropractic Report*, the World Health Organization (WHO) has been developing guidelines on chiropractic education for its 192 member nations during the past three years. This is through its normal broad consultation process and in partnership with the WFC. WHO's principal consultant for the project has been WFC Past-President Dr. John Sweaney of Australia.

This project is part of WHO's Traditional Medicine/Complementary and Alternative Medicine Strategy 2002-2005, which may be found at http://www.who.int/medicines/library/trm/strategytrm.shtml. This strategy promotes the rational use of chiropractic and other forms of CAM in national health systems and offers advice to governments on how to regulate education and practice. The strategy document opens with these words:

"Traditional, complementary and alternative medicine attract the full spectrum of reactions—from uncritical enthusiasm to uninformed skepticism. Yet use of traditional medicine (TM) remains widespread in developing countries, while use of complementary and alternative medicine (CAM) is increasing rapidly in developed countries. In many parts of the world, policy-makers, health professionals and the public are wrestling with questions about the safety, efficacy, quality, availability, preservation and further development of this type of health care.

It is therefore timely for WHO to define its role in TM/CAM by developing a strategy to address issues of policy, safety, efficacy, quality, access and rational use of traditional, complementary and alternative medicine."

The final text of the WHO Guidelines was discussed and agreed at a consultation meeting in Milan, Italy on December

2-4, 2004 and is currently undergoing editing and printing and will be available shortly. These WHO Guidelines will confirm:

• that chiropractic is a distinct profession

• that one must be a duly qualified chiropractor to offer chiropractic services, rather than for example a medical doctor or other type of professional who claims to use chiropractic methods as part of medical or other practice, and

• that a comprehensive course of study is essential.

There will be provision for two levels of education:

a) **Full education**.

i) *General students. A*fter entrance requirements, not less than 4,200 hours in four years of fulltime education, including a minimum of 1,000 hours of supervised clinical training. (This represents the current international standard within the profession already discussed, and shown in Table 1). Detailed course requirements are given by WHO.

ii) *Students with prior medical/health sciences professional qualifications*. Not less than 2,100 hours in two to three years of fulltime or part-time education, including a minimum of 1,000 hours of supervised clinical training.

b) **Limited education**. (Transitional time-limited programs in circumstances contemplated by the WFC's Tokyo Charter, and in countries where the profession is not regulated by law and there is no history of chiropractic education. This transitional education would not apply in a world region such as Europe, where countries belong to the European Union in which many nations have already established accredited education at the full international level.)

i) *Students with prior medical/health sciences professional qualification.* Not less than 1,800 hours in two to three years fulltime or part-time education, including a minimum of 1,000 hours supervised clinical training.

ii) *Unregulated persons already practicing as chiropractors but with little or no formal training.* Not less than 2,500 hours in a fulltime or part-time program designed to address the deficiencies in their theoretical and clinical education. Table 3 provides an example of this type of program as given in Japan to students already practicing as chiropractors after two-year and three-year part-time programs. There is a significant focus on the biological and clinical sciences, areas in which these students have weak background. These students are similar to the heilpraktikers in Germany offered the 432-hour program at the American Institute of Chiropractic.

E. Conclusion

12. Chiropractic, unlike osteopathy, has a distinct and identifiable profession worldwide because of its insistence on agreed, high, minimum standards of education. Very importantly, at a policy level those standards are now being reinforced not only by the profession but also by the UN agency responsible for policy on health and healthcare professions, the World Health Organization. It is clearly important that individual chiropractors understand and support this position, bringing maximum pressure to bear on those that would undermine the profession's integrity.

This Report has focused on the situation in Germany. What will happen there, you may ask, given that under 100 duly qualified doctors of chiropractic are faced with thousands of medical doctors and heilpraktikers who have graduated from short-term programs and are claiming to offer chiropractic services? Germany may well follow the example of France, where chiropractors not only faced a similar position but were also being prosecuted for the illegal practice of medicine until five years ago.

France and Germany are both leading nations in the European Union (EU). In March 1997 the EU Parliament adopted the Lannoye Report on The Status on Non-conventional Medicine, a committee report which in essence called for the uniform recognition and regulation of major complementary health disciplines such as chiropractic throughout the EU. As a result various countries which had indicated that they would never recognize an independent profession of chiropractic, including France and also Belgium and Portugal, reversed this decision. Legislation was passed to recognize the profession, and full regulatory frameworks are currently being put in place.

Germany is likely to follow this path in the near future—but only if as in France and the other countries mentioned, duly qualified chiropractors maintain their distinct educational standards and professional identity.

If you are ever offered the opportunity of teaching seminars in chiropractic diagnostic and treatment methods to anyone but duly qualified chiropractors, please reflect on the matters discussed in this Report, the oath of allegiance to the profession you took upon graduation, and then decline unless the context is consistent with the principles and standards laid down by your profession and WHO.

Persuade others to do the same—nothing less than the international identity of the profession is at issue. This is not about brands of chiropractic, though some may try to portray it as such. It is about maintaining educational standards that justify and support an independent chiropractic profession. TCR