# The Chiropractic Report

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## An Identity Battle in Latin America

**Explaining the Differences Between Chiropractic and Physiotherapy**

### A. Introduction

THE CHIROPRACTIC PROFESSION has its own distinct history, educational process and professional organization. Like the medical profession, nursing, dentistry, and optometry it is recognized by law as an independent profession in every country in which it is established.

The World Health Organization has recently published Guidelines on Basic Training and Safety in Chiropractic which confirm that chiropractic is an independent profession to be practised by duly qualified chiropractors, rather than a set of techniques that can be taught to and practised by other health professionals after short postgraduate courses. WHO's definition of chiropractic is:

"A health care profession concerned with the diagnosis, treatment and prevention of disorders of the neuromusculoskeletal system and the effects of these disorders on general health. There is an emphasis on manual techniques, including joint adjustment and/or manipulation, with a particular focus on the subluxation."[1]

2. However in February the physiotherapy/physical therapy profession in Brazil launched a public relations and legislative campaign to have chiropractic recognized as a specialty of physiotherapy in that country, as seen in the advertisement placed in *The Globe*, a national newspaper in Brazil, and shown in Figure 1. Brazil has two new university-based chiropractic educational programs, approximately 200 doctors of chiropractic, and the Brazilian Chiropractic Association is promoting legislation to recognize and regulate the profession. The response of the COFFITO, the regulatory board representing Brazil's 95,000 physical therapists, has been to claim that chiropractic is part of its profession. See more on this below.

In Peru, there is a legally recognized group of health professionals called medical technologists, which includes x-ray technicians, nurse assistants and rehabilitation technologists. Last December the rehabilitation technologists obstructed draft legislation to recognize chiropractic, again on the grounds that chiropractic was part of what they do. Peru has 25 duly qualified doctors of chiropractic educated in North America, but no chiropractic school or legislation.

3. These claims will seem strange to chiropractors in the many countries where the chiropractic profession and its education and practice are regulated by law – and such claims would of course be illegal in these countries. However parallel problems exist in many countries where the profession is long established. In the US for example, physical therapists, medical doctors and osteopathic doctors have claimed to be able to provide the chiropractic service of 'manual manipulation of the spine to remove subluxation' under the Federal Government's Medicare plan for seniors. In an ongoing lawsuit filed by the American Chiropractic Association it has now been ruled that physical therapists cannot provide this service, but the dispute with MDs and DOs and the managed care organizations that use their services continues.

In the marketplace for insured services, physical therapists with specialized training in orthopedics, manual therapy and rehabilitation sometimes assert that they offer similar and competing services with those available from doctors of chiropractic.

4. So why are some physical therapists claiming that chiropractic is part of their profession or that they provide equivalent services? And how should chiropractors best explain to others the difference between their profession and its

## Professional Notes

**Chiropractic at Harvard**

A new trial from Eisenberg, Post et al. at the Harvard Medical School reports that patients with acute back pain receiving best medical care have better results and higher satisfaction if they can add their choice of chiropractic, acupuncture or massage therapy – and this has led to the introduction of chiropractic services within the Harvard University health care system:

a) Subjects/patients were 444 adults with mechanical acute low-back pain (21 days maximum) who had had no prior treatment before visiting 1 of 4 clinical practice sites of the Harvard Vanguard Medical Associates (HVMA). On average they had "moderate to high" levels of pain (bothersomeness almost 8 on the 10-point scale) and dysfunction (over 16 out of 23 on the Roland Morris Questionnaire).

b) They were randomized into two groups:

- *Usual care.* Subjects received treatment on the HVMA standard treatment algorithm – NSAIDs, muscle relaxants,

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**Main Article** *continued from page 1*

**Figure 1. Advertisement from Brazil**

services and the physical therapy (as it is known in the US) or physiotherapy (as it is known in most other countries) profession? The answer to the first question lies in the history of the management of spinal problems, the research discoveries of the past generation and the response to this research by that branch of the physiotherapy profession that specializes in the management of patients with spinal and other musculoskeletal pain. In summary:

a) The chiropractic profession has always focused on the assessment and management of function in the neuromusculoskeletal system. Its signature treatment approach and art has always been skilled joint manipulation or adjustment. This represents a central part of clinical training in chiropractic education. Surveys confirm that virtually all chiropractic patients receive manual treatments, most commonly spinal joint adjustment.

b) Until the 1980s the medical and physiotherapy (PT) professions had no formal training in joint manipulation – either at undergraduate professional level or in their specialties concerned with spinal care and physical rehabilitation. This was because these professions viewed all joint manipulation, and especially spinal manipulation, as potentially dangerous and inappropriate. For treatment of patients with spinal pain and disability the medical profession relied upon rest, medication, referral to physical therapists for modalities and exercise or, where determined necessary, surgery. There was not the remotest chance in this era that any medical doctor (MD) or physical therapist (PT) anywhere in the world would claim that chiropractic was part of medicine or physical therapy.

c) In the 1980s and 1990s research into the most effective management of acute and chronic spinal pain led to evidence-based, national, interdisciplinary, clinical guidelines that sparked what medical experts have described as a "revolution" in the management of patients with the most prevalent forms of back and neck pain and referred pain to the head, shoulders, arms and legs:

- First, the chiropractic approach, and specifically spinal manipulation and promotion of early activity rather than rest, were declared safe and effective and a preferred first line of management for most patients.
- Second, the traditional methods of medical and PT assessment and management – for MDs reliance on rest and medication, for PTs reliance on electrotherapies and exercise for acute pain patients – were found ineffective and inappropriate.[2]

d) Faced with this situation the PT profession has had to adapt its education and practice during the last generation. Spinal manipulative therapy is now approved. Unlike former times, most students receive some introduction to manual therapy in their undergraduate program. There are then postgraduate programs for those PTs interested in practising manual therapy. These have been of variable quality and most remain as part-time courses for PTs already in practice. The emerging gold standard internationally, first achieved in Australia, is a fulltime university-based master's program of two to three years duration.

e) In medical education, which features a very crowded curriculum, there is no training in manipulation or manual therapy. There are postgraduate part-time courses in manual therapy in some countries, but efforts by leading proponents have been largely unsuccessful in establishing a new specialty of musculoskeletal or manual medicine.

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5. The great majority of MDs and PTs practise in areas other than manual therapy, and would be astounded by the claim that chiropractic was a specialty of their profession. This issue of *The Chiropractic Report* now looks at the differences between the chiropractic and physiotherapy professions, how these differences can best be explained to other stakeholders, and what the international chiropractic profession, led by the World Federation of Chiropractic, is doing to help the Brazilian Chiropractic Association protect the profession and the patients it serves in Brazil and Latin America.

## B. The Professions of Chiropractic and Physiotherapy

6. For PTs to claim that chiropractic is a specialty of their profession is exactly the same in principle as medical doctors claiming that physiotherapy is a spe-

cialty of medicine. These are three distinct and separate professions, with their differences and identities founded upon distinct and separate education and clinical training. The best way to illustrate their differences is by looking at their educational programs – both the content and the goals.

7. Chiropractic education has internationally agreed minimum standards, goals and content. Standards have been set by the profession through a network of national and regional accrediting agencies that belong to the Councils on Chiropractic Education International. These standards have been adopted in legislation wherever the profession has been recognized by law, and are now recommended by the World Health Organization. WHO's recent Guidelines on Basic Training and Safety in Chiropractic are a good reference to use because they not only summarize the goals and content of chiropractic education but also do this in the context of recommendations to national governments on minimum standards for the regulation of chiropractic practice and patient safety. Further the WHO Guidelines provide examples of:

a) A standard fulltime accredited program for students after fulfillment of entrance requirements. This gives an overview of subjects taught. See Figure 2.

b) A conversion program for other health professionals, including MDs and PTs, wishing to requalify as doctors of chiropractic (DCs). This allows credits for previous education. WHO recommendations are that such a program should be a minimum of 2,200 hours, including 1,000 hours of supervised clinical training.[3] The value of this conversion program, in the present context, is that it illustrates the subject areas in which chiropractic education and skills development are significantly different from physiotherapy. See Figure 3.

To read and download the full WHO Guidelines go to www.who.int and enter 'Guidelines on Chiropractic' in the website search box.

8. Much detailed comment could be made about the differences from PT education shown by these programs, but to highlight some key points:

a) **Principles of chiropractic.** First and foremost, chiropractic has a significantly different philosophy of health care to the PT and medical professions, which includes a biopsychosocial approach rather than a biomedical one. As the WHO Guidelines point out, principles of holism, vitalism, conservatism and naturalism are basic to chiropractic theory and practice. A unique and special attention is given to the functional relationship between the spine and the nervous system, and the results of this relationship on general health and wellness, and "the concepts and principles that distinguish and differentiate the philosophy of chiropractic from other health care professions are of major significance to most chiropractors and strongly influence their attitude and approach towards health care."[4]

The four year program contains 158 hours of this philosophy and theory (Chiropractic Principles I, II and III), the conversion program for MDs/PTs 90 hours (History, Principles and Philosophy). PT principles and theory are markedly different.

b) **Radiology.** Patients have always consulted chiropractors directly without the requirement of medical referral. Unlike physiotherapy the chiropractic scope of practice includes the duty and right to perform a diagnosis. The taking and interpreting of plain film x-rays, and in recent decades more sophisticated skeletal imaging, is a major element of chiropractic education and practice. This is not found in PT education – PTs rely upon medical radiologists for diagnostic imaging and differential diagnosis.

The sample four year program in Figure 2, under Clinical Sciences, has extensive courses in radiological and radiographic subjects. The conversion course for MD/PTs includes 180 hours of radiology.

c) **Biomechanics.** One of the core objectives in all chiropractic educational programs, identified in the WHO Guidelines and again markedly different from PT education, is to "achieve a comprehensive theoretical understanding of the biomechanics of the human locomotor

**Figure 2. WHO Guidelines – Sample four-year, accredited chiropractic education**

*Category I (A) Subjects taught in a typical semester-based chiropractic program, by year and number of hours*

| *Division* | *First year (hours)* | *Second year (hours)* | *Third year (hours)* | *Fourth year (hours)* |
|---|---|---|---|---|
| *Biological Sciences* | Human Anatomy (180)<br>Microscopic Anatomy (140)<br>Neuroanatomy (72)<br>Neuroscience I (32)<br>Biochemistry (112)<br>Physiology (36) | Pathology (174)<br>Lab Diagnosis (40)<br>Microbiology & Infectious Disease (100)<br>Neuroscience II (85)<br>Nutrition (60)<br>Immunology (15) | Lab Diagnosis (32)<br>Toxicology (12) | Clinical Nutrition (26)<br>Community Health (40) |
| *Clinical Sciences* | Normal Radiographic Anatomy (16)<br>Radiation Biophysics and Protection (44) | Intro. Diagnosis (85)<br>Intro Bone Pathology (48)<br>Normal Roentgen, Variants & Roentgenometrics (40) | Orthopaedics & Rheumatology (90)<br>Neuro. Diagnosis (40)<br>Diagnosis & Symptomatology (120)<br>Differential Diagnosis (30)<br>Radiological Technology (40)<br>Arthritis & Trauma (48) | Clinical Psychology (46)<br>Emergency Care (50)<br>Child Care (20)<br>Female Care (30)<br>Geriatrics (20)<br>Abdomen, Chest & Special Radiographic Procedures (40) |
| *Chiropractic Sciences* | Chiropractic Principles I (56)<br>Basic Body Mechanics (96)<br>Chiropractic Skills I (100) | Chiropractic Principles II (60)<br>Chiropractic Skills II (145)<br>Spinal Mechanics (40) | Chiropractic Principles III (42)<br>Clinical Biomechanics (100)<br>Chiropractic Skills III (145)<br>Auxiliary Chiropractic Therapy (60)<br>Introduction to Jurisprudence & Practice Development (16) | Integrated Chiropractic Practice (90)<br>Jurisprudence & Practical Development (50) |
| *Clinical Practicum* | Observation I (30) | Observation II (70) | Observation III (400) | Internship (750)<br>Clerkships: Auxiliary Therapy (30);<br>Clinical Lab (20)<br>Clinical X-ray: Technology (70);<br>Interpretation (70)<br>Observer IV (30) |
| *Research* | | | Applied Research & Biometrics (32) | Research Investigative Project |
| *Totals* | 914 | 962 | 1207 | 1382 |

***Total hours of full-time study over four years:* 4465 plus research project**

*continued on page 6*

**Chiropractic at Harvard**

*continued from page 1*

limited bedrest, education, activity alterations, no referral for physical therapy during the acute 3-4 week initial period.

• *Choice of care.* Subjects continued to receive usual care but could also select acupuncture, chiropractic or massage therapy – one of these only. Such complementary treatment included up to 10 sessions at no charge over 5 weeks and up to 5 additional sessions at 50% co-pay.

c) Primary outcome measures were changes over the first 5 weeks in each of:

• Symptoms. 'Bothersomeness over the last 24 hours measured on a 0-10 scale.'

• Function. As assessed by a modified Roland Morris Questionnaire.

• Satisfaction. A 5-point scale – excellent, very good, good, fair or poor.

• Cost. Insurance claims data

Secondary outcomes measured included difficulty performing important self-identified activities, worry about the back problem and overall mental and physical health. Subjects were followed up at 5 weeks, 12 weeks, 26 weeks and 52 weeks.

d) Results included:

• There was a statistically significant reduction in pain at 5 weeks for those in the choice of care group, but otherwise no statistically significant advantage in pain reduction or function. (No breakdown in results is given for each of acupuncture, chiropractic and massage therapy).

• On satisfaction "choice participants were significantly more likely to rate their back pain care at HVMA as excellent compared with usual care participants at each time point throughout the trial."

• With respect to the secondary outcome measure of worry, there was a significant reduction in worry in the choice of care group.

Eisenberg, Post et al. acknowledge the difficulty of showing that one treatment method is better than another for patients with acute uncomplicated low-back pain, because they all tend to improve significantly anyway because of the effects of natural history, placebo and regression to the mean. One should not expect dramatically better results from limited treatment over 5 weeks when doing follow-ups after 3 months, 6 months and one year. However it is worth noting the better early results in the choice of care group – which is consistent with a number of earlier trials of chiropractic care. Good early results, combined with patient satisfaction and less worry, translate into major benefits and less chronicity.

(Eisenberg M, Post DE et al. (2007) *Addition of Choice of Complementary Therapies to Usual Care for Acute Low Back Pain: A Randomized Controlled Trial,* Spine 32(2)151-158.)

## Other Research

1. **Canada – Is Multidisciplinary Rehab Effective for Whiplash?**

A new study of strong practical interest by an interdisciplinary team led by prominent Canadian chiropractic researcher David Cassidy, DC PhD, DrMedSci, addresses the question of whether multidisciplinary rehabilitation programs help recovery from whiplash. In their population-based study of all road traffic injuries in the Canadian province of Saskatchewan for two years from December 1997 they report 'no' – it actually delays recovery. Details are:

a) In 1995 Saskatchewan Government Insurance (SGI) introduced a no fault insurance policy that increased medical and rehabilitation benefits for all claimants with traffic injuries.

b) This study included the 6,021 claimants over two years who were adults, filed a claim within 42 days of injury, were not hospitalized for more than two days and had whiplash identified by answering yes to the question "did the accident cause neck or shoulder pain?"

c) Claimants, who were followed by telephone interview six weeks and then 3, 6, 9 and 12 months after the injury date, received either the usual care provided by individual physicians, chiropractors, massage therapists and physical therapists, or three levels of rehabilitation now funded by SGI namely:

• Group fitness training at a local health club (fitness training)

• Multidisciplinary outpatient rehabilitation at private clinics (outpatient rehab).

• Multidisciplinary hospital inpatient rehabilitation (inpatient rehab)

d) Recovery was measured by asking "how well do you feel you are recovering from your injuries", with the claimant selecting one of the following six replies – "all better" (cured); "feeling quite a bit improved"; "feeling some improvement"; "feeling no improvement"; "getting a little worse"; "getting much worse".

"Recovered" was defined as choosing either of the first two answers, above, with no recurring symptoms at the subsequent follow-up date.

e) For acute care 50% of claimants attended an MD only, 50% "various combinations of physicians, physical therapists, chiropractors and massage therapists"

f) 14% (833 claimants) attended fitness training for a median time of 64 days; 8% (468) attended outpatient rehab for a median of 59 days; and 2% (135) attended inpatient rehab for a median of 85 days. The fitness training, outpatient rehab and inpatient rehab did not commence, respectively, for an average of 63 days, 143 days and 171 days following the accident.

g) Those attending the fitness/rehab programs were more likely to have various characteristics relevant to delayed recovery – e.g. a history of headaches, prior injury claim, greater pain intensity, less optimism about future recovery – but "all important differences were statistically adjusted in the multivariable analyses" that were made. It was found that the policy of providing fitness training/rehab did not improve whiplash recovery

– but prolonged it. Group fitness training slowed recovery by 19-32% depending upon when it was started, community-based multidisciplinary rehabilitation by 50%. Chronic whiplash patients receiving hospital-based multidisciplinary rehabilitation did not recover any faster than those receiving the usual individual primary care.

(Cassidy JD, Carroll LJ et al. (2007), *Does Multidisciplinary Rehabilitation Benefit Whiplash Recovery? Results of a Population-Based Incidence Cohort Study,* Spine, 21(1):126-131).

## Focus on Latin America

The Federación Latinoamericana de Quiropráctica (FLAQ) represents national associations of chiropractors throughout the Latin American Region, a region in which chiropractic is experiencing exciting growth but facing challenges. Ten countries were represented at the recent FLAQ meeting in Panama on February 22 at which new officers were elected – Argentina, Bolivia, Brazil, Chile, Costa Rica, Honduras, Mexico, Panama, Peru and Venezuela.

The meeting was chaired by FLAQ founder and Past-President, Dr. Enrique Benet Canut of Mexico. New FLAQ President is Dr. Carlos Ayres (a graduate of New York Chiropractic College) of Peru, Vice- President is Dr. Alfredo Orillac (Palmer) of Panama, First Secretary Dr. Raúl Cadagan (SCUHS) of Argentina, Second Secretary Dr. Raúl Guiñez Martinez (AECC) of Chile and Treasurer Dr. Alejandra Rodriguez (Life) of Costa Rica. Executive Director is Dr. Sira Borges (Palmer) of Brazil.

Chiropractic is finally growing rapidly in the region because of the introduction of educational programs in the late 1990s – two university-based programs in Brazil (which now has approximately 200 DCs and 500 students); a university-based and state-funded program in Mexico City, Mexico (which has approximately 75 DCs and 250 students); and postgraduate conversion programs in Argentina and Chile supported by the Southern California University of Health Sciences, Los Angeles, California and the Anglo-European College of Chiropractic, Bournemouth, England. New colleges are planned for a number of countries including Argentina, Chile and Costa Rica.

However only three countries in the region – Costa Rica, Mexico and Panama – have laws to regulate the practice of chiropractic and protect title. One of the main challenges facing the region is achieving recognition and regulation of the profession in more countries to prevent unqualified persons practising as 'quiropracticos'. In the absence of legislation to protect the public and the profession various informal short-term courses teaching chiropractic technique are flourishing.

The main article in this Report refers to the situation in Brazil, where unofficial chiropractic courses exist for physical therapists and lay persons. There are similar courses in Argentina and Bolivia (part-time postgraduate courses of some 300 hours for medical doctors) and Guatemala (courses of 100-200 hours for naturopaths, MDs and other health professionals).

"This is a time of both excitement and challenge for the profession" says Dr. Ricardo Fujikawa, a Palmer College graduate who is President of the Brazilian Chiropractors' Association, Course Director of the School of Chiropractic, Feevale Central University, Novo Hamburgo, and the representative for the Latin American Region on the Council of the World Federation of Chiropractic. It is imperative, he says, that there be legislative recognition of chiropractic in Brazil without delay, and that Brazilian physiotherapists are blocked in their efforts to have chiropractic declared a specialty of their profession.

"We are most grateful to the WFC and the international chiropractic profession for the financial and other support they are giving us for this historic battle for chiropractic in Brazil and Latin America."

*For more information on how you can help please see the main article, and also go to the Newsroom at www.wfc.org which provides you with a donation form.*

(l to r) *Dr. Raúl Cadagan, Argentina, FLAQ First Secretary, Dr. Carlos Ayres, Peru (FLAQ President), Dr. Sira Borges, Brazil (FLAQ Executive Director) and Mr. David Chapman-Smith, Canada, WFC Secretary-General.*

(l to r) *FLAQ founder and Immediate Past-President Dr. Enrique Benet Canut, Mexico and FLAQ Vice-President, Dr. Alfredo Orillac of Panama.*

*Dr. Yolanda Camacho Kortman* (left), *President, College of Chiropractors of Costa-Rica, the regulatory board in Costa Rica established last year under legislation to regulate chiropractic education and practice, and Dr. Alejandra Rodriguez, Costa Rica, FLAQ Treasurer.*

*Dr. Ricardo Fujikawa, President, Brazilian Chiropractors' Association.*

**Main Article** *continued from page 3*

system in normal and abnormal function and, in particular, possess the clinical ability needed for an expert assessment of spinal biomechanics."[5]

The WHO sample four year program has 236 hours of basic body mechanics (96), spinal mechanics (40), and clinical biomechanics (100), supplemented by much other biomechanics in other skills courses. The conversion course has 60 hours of spinal biomechanics and 90 hours of static and dynamic palpation.

d) **Anatomy and Neurosciences.** Various aspects of anatomy are studied in greater depth in medical education than chiropractic or PT education. Likewise, various aspects of anatomy relevant to chiropractic practice are taught in a specialized and more detailed manner in chiropractic education than in medical or PT education. Spinal anatomy and neuroanatomy are examples. Therefore:

- With respect to specialization, chiropractic students study not only static but also functional anatomy and neurology – understanding the body in terms of movement, upright posture and load bearing.
- With respect to detail, medical and PT students are not taught the different angles and morphology of the facet joints at each vertebral level of the spine, and the different planes and ranges of movement of these joints. All chiropractic students, whose careers will involve assessing the movement and integrity of those joints and adjusting or manipulating them, do have this level of detail in their training.

The conversion course in Figure 3 for MDs/PTs requalifying as chiropractors contains extensive additional education in spinal anatomy (45 hours).

e) **Chiropractic Skills and Clinical Training.** The central focus of skills and clinical training in chiropractic education is the assessment of abnormal tone and function in joints and soft tissue, and the correction of this through a range of manual treatments including the signature spinal adjustment. Extensive training is required to achieve the necessary psychomotor skills. Even then, as studies show, skills steadily improve over the first five years of practice.[5]

This focus on function and skills level for all students in chiropractic education is unique to the profession. The WHO sample conversion program prescribes 450 hours of spinal palpation (90) and other manual assessment and treatment skills (360), and then 845 hours of supervised clinical practice, as a minimum for MDs/PTs and other requalifying as DCs.

f) **Scope of Practice – Chiropractic Healthcare**. Finally and most importantly, the overall scope of chiropractic, a profession with its own philosophy of healthcare, is different from PT, a technical and specialized profession that throughout its history has been practised on referral and supplemental to the medical profession. DCs promote a 'chiropractic lifestyle' with good health founded upon spinal health, exercise, good nutrition, a healthy lifestyle and the natural healing powers of the body.

Therefore for example, there is a strong component of nutrition in chiropractic education and practice. The WHO Guidelines, when they list the patient management interventions taught in chiropractic education, list "patient education on spinal health, posture, nutrition and other lifestyle modifications" The WHO four year sample program in Figure 2, under Biological Sciences, lists 86 hours of nutrition (60) and clinical nutrition (26), and studies in North America and Australasia show that the great majority of doctors of chiropractic (78-90%) use nutritional supplements and/or counseling with over one third of their patients.[6]

9. Do the differences between the two professions – in education, philosophy, knowledge base and set of clinical skills – lead to significant differences for patients? In numerous ways they do, and illustrations are:

a) **Headache Patient.** For someone medically diagnosed as having migraine or tension headaches a neurologist will look for an intracranial cause to be managed principally with medication. A PT specializing in manual therapy is now trained to look for a possible cause in the cervical spine – the neck joints and muscles – which may have restricted movement and then be a target for manual treatment.

The DC,, with a more holistic education and trained to understand the interaction of biomechanics through the body, will consider functional short-leg, pelvic balance, compensating restricted movement in the low-back and cervical spine, and lifestyle. S(he) may then treat chronic and persistent headaches with a heel lift to balance the pelvis; sacroiliac joint manipulation to increase movement in that joint and therefore to remove compensating subluxations in the low-back and cervical spine, and also make recommendations on diet and posture. If there is manual treatment directly to the cervical spine there will be use of a different level and range of techniques – most PTs limit their manual treatments to joint mobilization and soft tissue techniques, DCs also have a range of joint manipulation techniques.

b) **Infant with Colic and Adult with Asthma.** Such patients are not usually

**Figure 3. WHO Guidelines – Sample acceptable conversion programme for medical doctors and other health professionals requalifying as doctors of chiropractic**

*Category II (A) Suitable for persons with a solid medical education to attain minimal registerable requirements to practise safely and relatively effectively as chiropractors*

| *Division* | *First year (hours)* | *Second year (hours)* | *Third year (hours)* |
|---|---|---|---|
| *Biological Sciences* | Spinal Anatomy (45)<br>Pathology (60)<br>Physiology (45) | Pathology (60) | Clinical Nutrition (30) |
| *Clinical Sciences* | Diagnostic Imaging (45)<br>Neurology (45)<br>Neuromusculoskeletal Diagnosis (30) | Diagnostic Imaging (45)<br>Neurology (45)<br>Physical Diagnosis (30)<br>Neuromusculoskeletal Diagnosis (30) | Paediatrics (45)<br>Geriatrics (30) |
| *Chiropractic Sciences* | Chiropractic History (30)<br>Principles & Philosophy of Chiropractic (20)<br>Spinal Biomechanics (60)<br>Static & Dynamic Spinal Palpation (30)<br>Chiropractic Skills (90) | Principles & Philosophy of Chiropractic (20)<br>Static & Dynamic Spinal Palpation (60)<br>Chiropractic Skills (90) | Principles & Philosophy of Chiropractic (20)<br>Chiropractic Skills (60) |
| *Clinical Practicum* | Supervised Clinical Practicum (100) | Supervised Clinical Practicum (220) | Supervised Clinical Practicum (420) |
| *Total* | 600 | 600 | 605 |

***Total hours of part-time study over three years:*** **1805**

referred by MDs for physical therapy and are seldom seen in PT practice. According to chiropractic education, principles and practice, a main or important contributing cause of symptoms may be referred pain and dysfunction from the neuromusculoskeletal system. For such patients there are frequently good clinical results from chiropractic diagnosis and treatment. There is now controlled trial evidence that selected infants with constant crying and colic, but also evidence of spinal restriction and pain, get better results from standard chiropractic care for their infantile colic/irritable baby syndrome than standard medical care.[7]

c) **Wellness Care.** Unlike PT, many patients choose chiropractic care to improve overall function and well being – not because of pain or disability. This may be illustrated by elite athletes, many of whom have discovered that pre-performance chiropractic care to improve biomechanical and neurological function has a highly significant impact on performance and results. The Canadian Donovan Bailey publicly thanked his chiropractor for his success in a television interview immediately after winning the 100 meters gold medal in world record time at the Atlanta Olympics. Current European 100 meter record holder and 2006 European Male Athlete of the Year, Francis Obikwelu of Portugal formerly of Nigeria, also set his record (9.86 seconds) immediately following pre-performance assessment and adjustment by his sports chiropractic specialist.

d) **Manipulation vs Mobilization.** Given their more limited training, skills and confidence, most PTs using manual therapy limit their joint treatments to mobilization – slower techniques that move a joint through a smaller range of motion and produce less reflex activity in the nervous system. The faster techniques of manipulation create more space between the joint surfaces and appear to have a greater impact on function.[8] However, they require much greater understanding and psychomotor skill. Studies report that most PTs avoid joint manipulation because of lack of confidence in their training and ability. For example:

• A 1992 survey of South African PTs reported that their training in manual therapy was a one year part-time postgraduate course of 75 hours, that most had decided to use only mobilization, and that "the most frequent reasons given for not using manipulation were lack of skill, lack of confidence and reasons related to the teaching of the manipulation."[9]

• A large and comprehensive surveys of PTs in Britain and Ireland published in 1999 reported that the majority (59%) used mobilization but that "little evidence was demonstrated of the use of manipulation" – almost 8 in 10 (77%) did not use manipulation at all, only 2.8% of PTs ranked manipulation as frequently used, and "of those therapists who had received training in manipulative techniques, some reported not having sufficient confidence with the approach to use it as much as they wished."[10]

## C. Fight for Chiropractic in Brazil

10. Let us now turn to examine the rather brazen new claim by Brazilian PTs that chiropractic is a specialty of PT – and to examine the educational basis for that. Those most strongly promoting this claim clearly hope to make very substantial income from short, part-time courses of study, have no formal chiropractic education themselves, and have complete disregard for minimum standards as recommended by WHO and patient safety and welfare.

A major purpose of WHO's Guidelines, as stated in the introduction, was to "deter commercial exploitation of chiropractic education and practice" which was seen as "a significant and growing problem in some countries" because of the spreading awareness and popularity of chiropractic health care worldwide. Brazil now becomes the worst case example.

At the request of the Brazilian Chiropractors' Association (ABQ), representing approximately 200 members and facing the combined strength of 95,000 PTs and their national regulatory body the Council of Physiotherapists and Occupational Therapists (COFFITO), the World Federation of Chiropractic (WFC) has just launched an international fundraising appeal to help the ABQ challenge COFFITO and have chiropractic recognized as an independent profession as elsewhere in the world. First contributions in late February have been $20,000 from the British Chiropractic Association and $10,000 from the Danish Chiropractors' Association, together with smaller but generous donations from many individual chiropractors in Europe and North America.

You are encouraged to read the following summary then go to the Newsroom at www.wfc.org to see more information and make your donation to protect chiropractic in Brazil and Latin America:

a) Until the 1990s there were few DCs in Brazil, a country of 150 million people. In the 1990s the ABQ was formed and two university-based chiropractic schools were established in partnership with US chiropractic colleges – at Feevale Central University in Novo Hamburgo (with Palmer College) and at University Anhembi Morumbi in Sao Paulo (with Western States Chiropractic College). These schools have education in accordance with internationally accepted standards and have received full recognition from the Brazilian Ministry of Health.

b) The practice of chiropractic is not yet regulated by law. The ABQ has been promoting draft legislation since 2001. This has received first reading in the legislature or Camara, has now received three necessary committee approvals and has been returned to the Camara for final vote where it is being blocked by COFFITO.

c) The practice of physiotherapy is regulated by law in Brazil and COFFITO, as the national regulatory body for PTs, has the right to develop and create specialties for physiotherapy. To support its claim that chiropractic is a specialty of PT, COFFITO is endorsing part-time weekend certificate courses in chiropractic for practising PTs. Teachers have no formal chiropractic qualifications, and courses are typically 144 to 200 hours over a series of weekends during a 12 month period. This can be compared with the minimum of 2,200 hours recommended by WHO. Graduates are forming a Brazilian Physical Therapist Chiropractic Association (ABRAFIQ) to try to formalize chiropractic as a specialty of PT before separate chiropractic legislation can be passed.

d) COFFITO is mounting an aggressive campaign. That much is plain from its new advertising campaign led by its regional division in Rio de Janeiro, CREFITO-2. This openly adopts chiropractic terminology – see Figure 1. Under the heading 'Chiropractic: A Specialization of Physiotherapy' the second paragraph reads in English translation:

*"The aim of the physiotherapist who specializes in chiroprac-*

*tic, through vertebral adjustments, is to eliminate friction that provokes degeneration in the articulations, thus promoting the maintenance of a healthy functioning nervous system and a satisfactory neurological flow, taking an active approach to the prevention (of ill health) and the promotion of health."*

e) Should COFFITO succeed in Brazil the problem is likely to spread to other Latin American countries. Peru has already been mentioned, and at least one PT leader in Chile is known to be planning a chiropractic course. There is then potential for this problem in other world regions such as Europe (e.g. Spain) and the Middle East (e.g. Egypt). This is a new challenge to chiropractic, which the international profession must come together to defeat.

## D. Conclusion

11. The above discussion has explained the difference between chiropractic and physiotherapy in terms of their different education. Various other objective facts, of course, confirm that these are separate professions, including:

- **History**. The chiropractic profession was established by DD Palmer and its other early leaders in the US Midwest in the 1890s, some 25 years before the PT profession was developed out of the experiences of World War I, and the education, professional organization and legal rights of both professions have been separate worldwide ever since.
- **Professional organization.** Both professions have completely separate structures – in local and regional societies, national associations, and the international bodies representing them in official relations at the World Health Organization – the World Federation of Chiropractic and the World Confederation of Physical Therapy.

Other approaches to distinguishing the two professions that may be thought useful at first, but that are not in fact helpful include:

a) Different patient management skills. Those trained in the field of spinal manipulation understand important differences of where, how and why treatment is given – but lay persons have difficulty in understanding these. They assume that all professionals using manual therapies have a variety of skill levels but are basically applying similar treatments in a similar way.

b) Unique language and philosophy. Important as this is to be chiropractic profession, it is not helpful in distinguishing the profession for others. First, see for example how PTs in Brazil have co-opted chiropractic language to claim they are doing the same thing. Second, if the uniqueness of chiropractic is said to be linked to the vertebral subluxation complex and the adjustment, others will simply claim they address the same lesion with similar treatments but use different language – the joint dysfunction of PT, the spinal blockage of manual medicine, the osteopathic lesion of osteopathy. Lay persons will be unable to understand any major difference.

The best way to differentiate all profession – including chiropractic and physiotherapy – is to focus on their education, which is the foundation of their principles, knowledge, practice and professional identity. TCR


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