The Chiropractic Report

www.chiropracticreport.com Editor: David Chapman-Smith LL.B. (Hons.) March 2003 Vol. 17 No. 2

Professional Notes

The Case for Cervical Adjustment

The superb cervical spine program, at a time when the safety of chiropractic adjustment is under unprecedented attack, is being credited for heavy early registrations for the World Federation of Chiropractic's International Congress to be held at the Hilton Hotel, Disney World, Orlando, May 1-3, 2003.

There are many leading experts providing lectures and technique workshops but particular highlights will be:

• A 2½-hour plenary session sponsored by NCMIC Insurance and reporting on the Lewis Inquest, the Toronto Coroner's court case still in progress after 11 months and producing international media debate on the safety of chiropractic neck manipulation. A number of attorneys and expert witnesses associated with the inquest will be present for this session.

These include the Coroner's principal expert witness Dr. Scott Haldeman and the biomechanics expert Prof. Walter Herzog – whose recently published research reports that no form of adjust-

continued on page 4

The Three Paths to Growth and Success - Research, Politics and Professional Standards

RESEARCHERS AT THE DEPARTment of Health Care Policy, Harvard Medical School, have just reported striking new data on the success of chiropractic management of patients with neck and back pain in the United States.[1]

This is a further subset of information from Eisenberg et al.'s comprehensive national survey of the use of complementary health care (CHC) in the US in 1997.[2] With respect to adults reporting back and neck pain problems over the past 12 months, the new study provides these dramatic findings:

a) Just 12% of these adults consulted a medical doctor ("conventional provider") alone. Another 25% consulted an MD but also a CHC provider. Sometimes this will have been on referral from the family physician, sometimes because of dissatisfaction with medical care given other findings mentioned below. The figures for those alternatives are not given.

b) 54% consulted a CHC provider, either alone (29%) or together with a medical doctor (25%). The most commonly chosen CHC provider was a chiropractor (20%), with next most popular choices being massage therapy (14%) and relaxation techniques (12%).

c) 34% consulted no one – many, presumably, because their complaint was of a minor nature. The 2055 participants in this random survey were not asked about the duration of pain.

d) The above figures mean that, despite widespread problems of access to chiropractic services under managed care, 33% (1 in 3) of patients with neck and/or back pain who sought professional help chose or were referred for chiropractic care. Why?

e) Consistent with past studies, because there was a much higher satisfaction rate with chiropractic care – 61% of patients (approximately 2 in 3) rated chiropractic treatment "very helpful", whereas only 27% (approximately 1 in 4) gave this rating for medical care.

Wolsko, Eisenberg et al., senior researchers from one of the most respected policy research centers in the US, make these pointed observations:

• Back pain is experienced by 15-30% of adults annually and is "the second leading symptomatic cause of physician visits in the United States." Neck pain affects up to two-thirds of adults at some point in their lives, and together these pain syndromes have "great impact on society." Nothing new there. It is well-established that back pain is the leading cause of disability of work-aged adults.

• "We found that back pain and neck pain were most commonly treated with complementary therapies alone or a combination of complementary and conventional medicine, *whereas use of conventional medicine alone was an infrequent mode of care*". (Emphasis added)

• "Our data on helpfulness (of CHC) support the need for randomized trials of promising complementary therapies."

In other words, there is such widespread patient use of chiropractic services and other CHC for these highly prevalent and disabling conditions, and such patient satisfaction, that there is now a public policy requirement that governments and their research agencies fund and support chiropractic research. Frankly, in a dispassionate and fair world, Wolsko, Eisenberg et al. should have gone much further and, certainly with respect to chiropractic, acknowledged substantial existing research supporting its effectiveness for back and neck pain. They should have openly recommended much greater integration and use of chiropractic services now.

2. That observation leads to the core topic of this issue of the Report, which

is an analysis of how to promote greater acceptance and utilization of chiropractic services, of how individual chiropractors and the profession as a whole must act if there is to be an appropriate increase in patient access to and use of chiropractic services in the months and years that lie ahead.

The sad, repeatedly demonstrated and inescapable fact is that health care systems are multibillion dollar enterprises governed primarily by interest groups seeking financial control, not by structures promoting the best interests of patients. Most researchers are influenced by that reality, some consciously and some not. All of this certainly applies to the field of back and neck pain.

Here is one example. In 1994 the US Agency for Health Care Policy and Research published government-sponsored, evidence-based multidisciplinary guidelines for the management of adults with acute low-back pain.[3] These acknowledged that there was good scientific evidence supporting the effectiveness of skilled spinal manipulation for most patients with back pain, and on grounds of safety and effectiveness recommended early activity, spinal manipulation and over-the-counter medications as first line treatment options. Many individual physicians listened and commenced referral of patients to chiropractors.

However, in a major publication on back pain for the public the following year the American Medical Association made no mention of chiropractic or spinal manipulation and simply recommended standard medical treatments.[4] Medical opinion leaders such as Curtis and Carey have continued, plainly inappropriately, to describe spinal manpulation for back pain as "controversial".[5] In their new study, and notwithstanding the findings in favor of manipulation by 35 leading experts on the AHCPR panel, Wolsko, Eisenberg et al. make the scientifically unsupportable statement that "investigators agree that most episodes of back or neck pain are best treated with analgesics and self-care."[1]

There is little point in trying to change human nature and the competitive realities and excesses of the health care marketplace. If this is so, what are the most effective and professional steps that individual chiropractors and the profession can take to advance their case and the interests of their patients. There must be action on three major fronts – research, corporate politics and individual professional standards – and each of these is now discussed.

B. Research

2. There is broad agreement amongst analysts and stakeholders in national health care systems globally that future health policy and funding decisions will be governed by data, much more so than in the past. Funding will increasingly be "evidence-based".

As explained in the 1998 Institute for Alternative Futures expert report in the US, commissioned by NCMIC Insurance and titled *The Future of Chiropractic: Optimizing Health Gains,*[6] traditional research performed from a professional perspective with a dominant spirit of scientific inquiry is being replaced by scientific research from a perspective of public policy and interest. This new research evaluates health care as services in a marketplace. Future success for all health professionals will be ruled by quality data on results of care, key results being *effectiveness, cost-effectiveness* and *patient satisfaction*

To illustrate this point, take the field of exercises to prevent or manage back pain. Until recent years research simply reported effectiveness, and if high-tech, intensive, rehab programs demonstrated reasonable effectiveness they were implemented and funded even if expensive. Current research focuses on comparative effectiveness and cost. Therefore Larsen, Weidick and Leboeuf-Yde's new Danish study involving 240 young military conscripts:[7]

a) Assesses the effectiveness of a simple low-cost protocol for the prevention of back pain – a 40-minute back school class to educate and motivate, and then twice daily passive, prone extension exercises.

b) Reports not only that this exercise regime is effective, but that:

- The cost to prevent one conscript getting back pain during 8-10 months of military duty was $7.00.
- The cost of prevention of one medical consultation was $8.00.

As can be seen this research is driven by economics as well as science.

4. How well is the chiropractic profession doing in this new era of pragmatic research for evidence-based practice?

The Chiropractic Report is an international review of professional and research issues published six times annually. You are welcome to use extracts from this Report. Kindly acknowledge the source. Subscribers may photocopy the Report or order additional copies (.75 cents each – minimum of 20 copies plus shipping) for personal, non-commercial use in association with their practices. However, neither the complete Report nor the majority or whole of the leading article may be reproduced in any other form without written permission.
Subscription: for rates and order form, see page 8. For information or orders visit www.chiropracticreport.com or telephone 416-484-9601, fax 416-484-9665.

Changes of mailing instructions should be sent to The Chiropractic Report, 3080 Yonge Street, Suite 5065, Toronto, Ontario M4N 3N1, telephone 416-484-9601, fax 416-484-9665. Printed by Harmony Printing Limited, 123 Eastside Drive, Toronto, Ontario, Canada M8Z 5S5. **ISBN 0836-144**

Generally very well, because it has a much stronger evidence base of cost-effectiveness and patient satisfaction for prevalent conditions commonly seen in chiropractic practice – common or mechanical musculoskeletal pain and headache – than the medical profession does. However the score card is mixed and there is a constant need for new and better data. This need will be greatly helped, of course, by the final arrival of significant public funds for chiropractic research. But the profession itself must make an even stronger commitment to research, and must remain vigilant to root out bias and misrepresentation. In summary:

a) **Back pain**. Since the mid-1990s there has been strong evidence supporting the effectiveness, cost-effectiveness and high patient satisfaction rates of chiropractic management of the most common forms of acute and chronic back pain.[3,8,9] The profession owes a huge debt of gratitude to Dr. Alan Breen and the British Chiropractic Association in their roles in the

historic trial by Meade et al.[8] which was published in the *British Medical Journal* in 1990 and laid the foundation for this evidence.

b) **Neck Pain**. The evidence is not as strong as for back pain, but is growing and is as sound as the evidence of safety and effectiveness for any other treatment approach.[10-12] The new data from Wolsko, Eisenberg et al. reinforces the evidence of patient satisfaction. For US patients who had neck pain as well as back pain the gap between the satisfaction levels of chiropractic and medical patients was even higher than for back pain – 65% (2 in 3) of chiropractic patients found their treatment "very helpful", only 19% (1 in 5) of medical patients.

c) **Headache.** This field has produced the most compelling new evidence in the past 10 years – both as why chiropractic manipulation is effective (the anatomical basis and mechanisms of action) and to what degree. It is now appreciated that cervicogenic headache (CGH – headache arising from the cervical spine) is far more common than previously understood – as common as migraine. There are randomized controlled trials supporting the safety and effectiveness of chiropractic management of patients with CGH, migraine and tension-type headaches,[14] and much of this has now been further documented in a recent systematic review by medical specialists at the Evidence-based Practice Center at Duke University.[14]

d) **Other Conditions**. For many other conditions that may be managed successfully under chiropractic care, according to the more anecdotal evidence found in case reports and preliminary case series, stronger evidence is required. New levels of public funding and interprofessional cooperation now make this possible. This research will require careful design and selection of patients, given the chiropractic paradigm of care which focuses on the presence or absence of underlying neuromusculoskeletal functional lesions (subluxation) rather than the condition itself. A patient with asthma and subluxation is materially different from one with asthma with no subluxation.

Chiropractors have often been criticized for the management of patients with conditions apparently unrelated to the neuromusculoskeletal system. On one hand the profession has deserved some of this criticism because of enthusiastic overclaim by some chiropractors. On the other hand many clinicians and researchers have made best efforts with the resources at hand and if the data from future research supports clinical experience the scope of chiropractic will increase significantly with much benefit to patients. Example areas are asthma and infantile colic, which is better described as irritable infant syndrome from a chiropractic perspective. First controlled trials have produced mixed results but indicate that subsets of patients have symptoms that are linked to spinal problems which may be corrected safely and effectively under chiropractic care.

As a further example take the condition of Meniere's Disease, which is hearing loss, tinnitus and vertigo resulting from disease and distension of the labyrinth in the inner ear. Currently few family doctors would refer a patient with Meniere's Disease for chiropractic care. This is a disorder that seems to be remote from the neuromusculoskeletal system. However Australian chiropractors Corwin and Bryner have just produced a well-documented case study of successful long-term chiropractic management that changed the life of a schoolteacher severely disabled by Meniere's Disease following an automobile accident.[15]

When Mrs. AB consulted a chiropractor, having been diagnosed medically as suffering from Meniere's Disease and having had medical and other specialist care from 10 health professionals over approximately three years, her severe symptoms of otalgia (earache), tinnitus and dizziness were dominating her life. She was unable to perform many household chores, to participate in sports and social life, and was retraining in sign language to teach hearing-impaired students because she couldn't handle the noise of regular teaching.

On a chiropractic diagnosis of "right anterior 'into the angles' upper cervical subluxation" she was treated with a modified Pettibon adjusting device to align the atlas vertebra to surrounding tissues, and given advice and a neck support. After her first adjustment she experienced no tinnitus or earache for four days. Over the ensuing 7 years she had remissions, but they were progressively less severe and responded rapidly to chiropractic treatment. Throughout she continued teaching. She also discontinued her diuretic medication, resumed her household chores and social life, and studied successfully for a master's degree in education.

Until now there has not been the capacity to perform controlled trials with respect to patients such as this. In future they must be undertaken.

e) **Childhood Disorders**. From some quarters there are criticisms of chiropractic management of infants and children. Some of this is uninformed, some justified because of overclaim by some members of the profession. The only compelling answer to criticism will be research data. In this connection Hayden, Mior and Verhoef have just produced the first prospective cohort study of chiropractic management of children and adolescents (ages 4 to 18) with low-back pain.[16] Almost 90% of the 54 cases involved acute, mechanical low-back pain, and there were favorable results ("clinically important" improvement for most patients on a pediatric visual analogue scale (62%) and subjective patient assessment (87%) with no side effects or complications. For an authoritative recent overview of chiropractic research relating to various childhood disorders, including asthma and otitis media, see the Foundation for Chiropractic Education and Research's recent publication *Infant and Child Chiropractic Care: An Assessment of the Research*, authored by FCER's Director of Education and Research, Anthony Rosner, PhD (www.FCER.org)

f) **Prevention**. The Institute for Alternative Futures' report already mentioned notes that an estimated 14-35% of chiropractic visits in the US are for wellness/preventive care, but that there is as yet no good data on effectiveness. The IHF warns that, even there is more public demand for preventive care, the role of chiropractors will be decreased unless they have the right supportive data. In the future the public will be faced with many more physicians and nurses, nutritionists, homeopaths, massage therapists, etc. offering preventive care and it is the professions who develop good outcomes data who will prosper.

C. Politics

5. Politics here means formation of an effective political voice by means of professional associations that can advance the interests of members through collective strength, negotiating with third

continued on page 6

The Case for Cervical Adjustment

continued from page 1

ment can generate sufficient force to damage a vertebral artery under normal circumstances.

• Lectures and then a joint workshop by Dr. Heiner Biedemann, a Belgian manual medicine specialist, and Dr. Joan Fallon, a US chiropractor, on upper cervical manipulation for infants and children.

• Lectures and workshops on state-of-the-art chiropractic management of acute and chronic neck pain by Dr. Arthur Croft and Dr. Craig Liebenson.

• Dr. Haldeman's review of the comparative safety and effectiveness of various chiropractic and medical treatments for the cervical spine.

Sports chiropractic is the second major theme for the WFC's Orlando meeting, the first WFC Congress held in the US since Washington, DC in 1995.

The Congress has been approved for 20 CE credits in all US states except Oklahoma and Ohio. For all details concerning the program and registration visit www.chiroweb.com/wforlando2003 or contact the WFC at 416-484-9978, fax 416-484-9665.

Research Highlights

UK – Skill Levels in Manipulation. A new study from McCarthy, Prudden and Byfield at the Welsh Institute of Chiropractic, University of Glamorgan, UK, published in the *European Journal of Chiropractic*, is of scientific, clinical and policy importance. It finds significant differences in skill levels in chiropractors who have been practising for 6-10 years as opposed to those who have been practising for only 2-5 years. This strongly suggests that other practitioners with much more limited education in manipulation then only part-time practice, cannot provide satisfactory skill and care. Relevant details are:

a) At British Chiropractic Association conferences in October 1999 and April 2000, 24 chiropractors with differing levels of experience in full-time practice were tested – groups in practice for 2-5 years (Number=6), 6-10 years (N=13), 11-14 years (N=5) and 22-24 years (N=4). Each practitioner performed three vertical thrusts to an isolated lumbar spinous process mounted on top of a push rod system in a mechanical device described and illustrated in the paper. The two most similar thrusts were taken as representative of that individual's thrust profile and averaged. The following parameters were recorded on a force-time trace and analyzed by computer:

i) *Rise time*. The time taken to achieve peak force.

ii) *Fall time*. The time taken for the force reading to fall from peak to a minimum. (Addition of the rise and fall times gives the *duration time* of the procedure.)

iii) *Rise rate*. The rate of change of force application, corresponding to the gradient of the trace representing force application.

There is no absolute definition of what represents skill in adjustment or manipulation generally, but this and other chiropractic studies cited below, identify rise time, fall time and rise rate of the thrust as valid key components.

b) Results were that, after statistical analysis, there was "a significant difference for all parameters analyzed between the least experienced and medium experienced groups" – i.e. those with 2-5 years experience and those with 6-10 years.

c) McCarthy et al. then review the results of these earlier studies:

• Triano et al. have found significant differences between a novice chiropractor and an expert chiropractor performing in vivo lumbosacral manipulation. Biomechanical parameters measured there were peak loads, duration of impulse, loading and rise rate.

• Schultheir et al. also found significant differences in skill levels between novice and experienced toggle recoil practitioners measuring force time variables equivalent to those in the present study.

• Cohen et al. did not find significant differences. There was a trend towards increased speed and decreased time parameters for experienced chiropractors, but this did not reach statistical significance. However their "experienced" chiropractors had only three or more years experience and were not actually using the technique assessed in that study.

Accordingly, McCarthy et al.'s new study fleshes out a body of evidence confirming that even after extended psychomotor training for manipulation, as in a chiropractic education, extensive fulltime clinical experience is necessary to attain high levels of skill. (McCarthy PW, Prudden M, Byfield D (2002) *An Investigation of the Manipulative Parameters of Postgraduate Chiropractors*, Europ J Chiro 50:15-25.)

2. **UK – Cervical Spine Degeneration not Linked to Pain and Disability**. A new study of 180 consecutive neck pain patients who attended the Anglo-European College of Chiropractic (AECC) outpatient clinic in Bournemouth, England and were referred for cervical spine radiographs has considerable medico-legal importance in reporting is for patients with neck pain that:

a) There is no difference in reported pain and disability levels between those with and without evidence of cervical spine degeneration, indicating that the presence of degenerative changes shouldn't be blamed for symptoms in litigation involving auto accident victims.

b) "Impending litigation is not the reason that these trauma patients reported significantly more pain and disability . . . the symptoms were real and most likely related to the soft-tissue holding elements of the cervical spine."

Peterson, Bolton et al. reference and discuss the quite substantial previous body of research in this area. It is often conflicting but, overall, "the link between spinal degeneration and patient symptoms remains controversial". It is even more controversial after this impressive study.

(Peterson C, Bolton J et al. (2003) *A Cross-Sectional Study Correlating Degeneration of the Cervical Spine with Disability and Pain in United Kingdom Patients*, Spine 28(2):129-133.).

3. **US – LBP Manipulation and Factors Predicting Success**. A recently published Texas study of physical therapy manipulation for a population of 71 patients with low-back pain is of interest in two respects:

a) There is a comprehensive list and assessment of diagnostic tests for sacroiliac dysfunction – position tests (assessing structural symmetry), provocation tests (to reproduce symptoms) and mobility tests (assessing symmetry of pelvic motion). Gillet's Test was the only mobility test that demonstrated acceptable reliability in this study. Overall, provocation tests were more reliable than symmetry and motion tests.

b) Efforts were made to find clinical predictors of success – helping to identify subgroups of patients with back pain more likely to respond to manipulation. The five reported were duration of symptoms less than 16 days; at least one hip with more than 35° of internal rotation; lumbar hypomobility; no symptoms below the knee; and a low rating on the work subscale of the Fear Avoidance Beliefs Questionnaire (FABQ). The FABQ assesses a patient's beliefs about the influence of activity on low-back pain. It has one subscale related to general physical activity and a second related to work. A low score denotes low fear. (Flynn T, Fritz J et al. (2002) *A Clinical Prediction Rule for Classifying Patients with Low Back Pain Who Demonstrate Short-Term Improvement with Spinal Manipulation*, Spine, 17(24):2835-2843.)

World Notes – Latin America

1. **Chile.** Since 1998 a group of approximately 150 Chilean kinesiologists, who have a five year undergraduate university degree and were subsequently introduced to chiropractic by visiting lecturers, have practised as chiropractors. Chile has no law regulating the practice of chiropractic, and such practice is legal. For the past three years, in a partnership brokered by the World Federation of Chiropractic, the Southern California University of Health Sciences (formerly Los Angeles College of Chiropractic), has worked with these kinesiologists/ chiropractors to provide a conversion degree course of chiropractic education, similar to those originally developed for Japan.

The professional group representing these Chilean professionals, the Chilean Corporation for the Study and Development of Chiropractic (CCHQ) has now been officially recognized by the Chilean government and it is anticipated by the CCHQ, SCUHS, and a Chilean university will be developing chiropractic education at an international level in Chile within the next few years.

Three other university programs of chiropractic education at the international level have been established in the Latin American region during the past five years - two in Brazil and one in Mexico. Latin American countries with legislation regulating the practice of chiropractic are Bolivia, Costa Rica, Mexico, Panama and Venezuela.

2. **Costa Rica**. This, with Panama, is one of the two countries in Central America with legislation to regulate the practice of chiropractic. To obtain a licence a chiropractor must be a member of the Colegio, the regulatory body, and this requires a degree from a CCE accredited college and validation of this by the University of Costa Rica. Presently there are approximately 30 US-educated chiropractors practising in the country.

3. **Cuba**. The UK-based organization Chiropractic Overseas Relief (CORe) reports a successful sixth year at the only established chiropractic clinic in Cuba – on the Isle of Youth. Services are provided by volunteers, and during 2002 15 volunteers came from Australia, Canada, France, Holland, New Zealand and the UK, typically for between 2-4 weeks each.

The first goal of the CORe project has been to provide chiropractic care for the local population, and its clinic is now an established part of the local health care community. The long-term goal is to provide a basis for the development of a chiropractic profession in Cuba. Many chiropractic volunteers return for further service, but new volunteers are also required. For information visit www.chiropracticoverseas.org.

WORLD FEDERATION OF CHIROPRACTIC | LA FÉDÉRATION MONDIALE DE CHIROPRATIQUE | LA FEDERACIÓN MUNDIAL DE QUIROPRÁCTICA

WFC's 7th Biennial Congress

Co-sponsors:

American Chiropractic Association

Canadian Chiropractic Association

International Chiropractors' Association

Foundation for Chiropractic Education and Research

Fédération Internationale de Chiropratique du Sportive (FICS)

Approved for 20 hours of CE credits in all US states except Oklahoma and Ohio

Major Theme:
Management of the Cervical Spine

Secondary Theme:
Sports Chiropractic

Place:
Hilton Hotel at Disney World, Orlando, Florida,

Dates:
May 1-3, 2003

All information: For program, registrations and all other information:

- Visit www.chiroweb.com/wforlando2003 or
- Contact the WFC at info@wfc.org. Tel. 416-484-9978, Fax. 416-484-9665 (*Attention:* Gillian Sloane-Seale)

Opening Disney Show, and Convention Discounts for Disney Theme Parks

parties, lobbying for legislation and resorting to litigation where necessary. It is only through mature and effective political structures that patient access can be enhanced and protected in contemporary health care systems. Whatever individual practitioners may be able to do in their own practices, their future ultimately rests in the hands of higher forces.

Despite some notable exceptions, chiropractic organizations have generally had limited impact and success until recent years. Difficulties have included divisions in the profession but also overall lack of numbers, corporate partners and resources. During the past decade organizations have grown larger and more ready to pool resources and influence, and this has led to significant breakthroughs into mainstream health care, thereby offering major new potential for growth of individual practices and the profession.

6. To illustrate these matters let us explore the major and unfolding impact of two developments in the US only made possible by the strength of the American Chiropractic Association, the largest national chiropractic association in the world, and its strategic partnerships with the Association of Chiropractic Colleges (ACC), the International Chiropractors' Association (ICA – a second national association in the US), the National Board of Chiropractic Examiners (NBCE) and the major corporate supporters that now exist. These include for example the NCMIC Insurance Company which, with 33,000 malpractice insurance policyholders, has serious assets with which to assist the profession. The two developments are:

a) **Chiropractic Services in the Military Health Care System**. Until the fall of 1995 no chiropractic services were funded or available within the vast US military health care system administered by the Department of Defense (DOD). That year, after a major lobbying effort led by the ACA and ACC, Congress approved a three year demonstration project that placed chiropractors in 13 major army, navy and air force base medical centers throughout the US. This pilot project produced data confirming the cost-effectiveness of chiropractic services and their successful integration with medical services, and led to the decision of Congress in 2000 to provide chiropractic services for the military on a comprehensive and permanent basis. What is important to understand is the magnitude of the benefits that flow from this beachhead. Accordingly:

i) Chiropractic services are now in the process of being established in all communities in the US and worldwide where there are active US military personnel.

ii) The chiropractic clinics and units established are often the focus for clinical training for both medical and chiropractic students, and offer broad new opportunities and resources for research.

Therefore, for example, the two chiropractors stationed at the chiropractic clinic at the navy's flagship hospital, the National Naval Medical Center (NNMC) at Bethesda, Maryland, are Palmer West graduates Dr. William Morgan (ex-navy) and Dr. Terry Kearney (ex-air force). Dr. Kearney also treats patients at each of the Navy Yard, Washington DC and Andrews Air Force Base, Maryland. Dr. Morgan, because of his affiliation with NNMC, the hospital that traditionally provides care for the President and many of the nation's leaders, now also treats congressmen two days weekly at a chiropractic clinic located within the Capitol. Drs. Morgan and Kearney have a constant stream of medical residents visiting their chiropractic unit on rotation in their medical training on the same basis as all other departments in the hospital.

Like colleagues at other military medical centers they are also now accompanied by chiropractic students completing their clinical training. At NNMC the students are from the New York Chiropractic College and have 4-5 months during which they do hospital rotations from 7.00 am to 12 noon (e.g. neurology, neurosurgery, orafacial pain, orthopedics, physical medicine and rehabilitation, rheumatology) and then provide supervised treatment to patients during the afternoon. They see a wide range of pre and post-surgical patients with neuromusculoskeletal disorders, and there is access to sophisticated imaging and referral for specialist opinions.

iii) The legislative decision to mandate chiropractic services within the military health care system was the platform for the ACA's next successful lobby, resulting in last year's decision by Congress to provide chiropractic services to veterans under the VA health care system. During the years that lie immediately ahead millions of patients will have first access and exposure to chiropractic services because of the DOD and VA legislation, and indirect effects of this integration of chiropractic into mainstream federal health care services will be even more extensive.

a) **HHS and Blue Cross/Blue Shield Lawsuits.** These huge and complex lawsuits provide a second example of why the profession can only reach its true potential, and patients have appropriate access to chiropractic services, through collective action. In the past year alone legal costs have exceeded $2 million.

The litigation against the US federal government's Department of Health and Human Services (HHS) relates to chiropractic services under Medicare, the government-funded program for seniors. It alleges that health maintenance organizations (HMOs) with seniors enrolled in their plans have been using physical therapists, medical doctors and others to provide the chiropractic service "manual manipulation of the spine to correct a subluxation", and have actively restricted access to chiropractic doctors. HHS has approved these illegalities, colluded in the denial of chiropractic services, and contravened the intent of Congress and the law.

The preliminary stages of the lawsuit have already brought substantial victories, including a ruling by HHS that physical therapists cannot deliver the chiropractic service, and evidence on discovery from HMOs that access to chiropractors by seniors enrolled in their plans is minimal and very significantly below the national average. The remaining fight, a large one, is about whether medical and osteopathic doctors can deliver this Medicare service.

The lawsuit against Blue Cross/Blue Shield, the behemoth of private health insurance in the US, is about alleged anti-trust violations through the systematic restriction of access to chiropractic services and unfair levels of reimbursement. The suit was filed initially against Trigon in Virginia, the second largest Blues' affiliate in the US, which boasted deep enough pockets to bankrupt and stop any legal action by the chiropractic profession.

If the Blues had been at the ACA's National Chiropractic Legislative Conference in Washington DC at the beginning of this month, they would have seen that they now have a tiger by the tail, as the American Medical Association did in the famous Wilk Case in the 1970s-1980s. The lead attorney is once more

ACA's general counsel Mr. George McAndrews from Chicago, and following his address at the Conference a further $410,000 was raised inside one hour, including $210,000 from NCMIC Insurance, $100,000 from the practice management firm Breakthrough Coaching, and further contributions of $70,000 from state associations and $27,000 from Foot Levelers. Over 1000 individuals are now on monthly givings averaging $100 per month each, and that number is expected to double during this year. Over $500,000 has been raised from individuals and organizations through the Parker Seminars during the past 12 months and the profession is unifying as never before.

Will David beat Goliath? First skirmishes are already won. In Oklahoma, for example, the Blues' affiliate quietly increased its reimbursement for a chiropractic treatment visit from $25 to $36 within 24 hours of the lawsuit against Trigon being filed.

7. There are similar stories of chiropractic corporate action in other countries. It was strong and consistent leadership in the Danish Chiropractors' Association from the early 1980s that led to government-supported chiropractic education at the University of Southern Denmark, Odense in the 1990s and the now well-advanced integration of chiropractic services into the Danish health care system.

The simple point of these stories is that health care systems in developed countries are now subject to extremely strong and complex competitive forces, and chiropractors must create and support effective political structures if they are to protect and promote the ability of patients to choose and receive chiropractic care.

D. Professional Standards

8. Any new enterprise must go the extra mile to win acceptance and, within health care, chiropractic remains a new enterprise. As such it continues to suffer disproportionate harm from the unprofessional acts of a few, much more for example than the professions of dentistry or medicine or engineering or law.

Leading accountants assisted gross fraud at Enron without a backlash against the profession as a whole. Insurance companies report a similar percentage of health care fraud by the members of each health profession – 2-3% of providers – but the most prominent media story always seems to be about the chiropractic profession. Recently the Institute of Medicine reported 98,000 deaths from medical errors in US hospitals in one year with little public reaction, but one case of suspected stroke following chiropractic treatment provokes national headlines warning of danger.

9. There is no quick fix to this situation. Chiropractic, like other professions before it, must simply keep developing its standards of education and practice consistently until it achieves the critical level of acceptance, or "cultural authority" to use the technical term from sociology, at which the actions of a minority of chiropractors are not identified with the profession as a whole. And, in the meantime, regulatory boards must be willing to suspend and cancel licences for those guilty of serious professional misconduct. Few things are more important.

10. The profession has taken major strides during the past generation. In many countries there is rapidly increasing integration of chiropractic and medical education and practice. At the ACA's Legislative Conference this month Dr. William Dallas, President of Western States Chiropractic College (WSCC) in Portland, Oregon, explained that 10 years ago there was no communication between WSCC and the University of Oregon Medical School. Now they are working on collaborative research, funded by the US National Institutes of Health, to test and develop the most effective methods to provide medical students with an introduction to chiropractic services during their training. The goal is to develop a curriculum on chiropractic and other complementary health care services that will then be implemented at all 126 US medical schools.

11. What must chiropractors do in their daily lives to prepare for and assist this integration and acceptance of chiropractic services, and the access to care that it will give to many more patients than currently receive chiropractic treatment? Key summary points seem to be:

a) **Maintain Clinical Success**. High levels of patient satisfaction have been the foundation for the success of the profession, and chiropractors must continue to assure that the average patient visit leaves the patient well satisfied. All the data collection and political action in the world will be of no avail if patient satisfaction and support is lost.

b) **Maintain a Consistent Brand**. Chiropractors must remain faithful to the essence of their profession, providing a consistent brand and quality of chiropractic care wherever it is delivered. The road map for this has been provided by the Association of Chiropractic Colleges' Paradigm of Chiropractic, adopted by the profession internationally at the World Federation of Chiropractic's Paris Congress in 2001, together with WFC/ACC consensus statements on the philosophy of chiropractic (Fort Lauderdale, Florida 2000) and clinical practice (Sao Paulo, 2002). Essential clinical elements include:

- Maintaining the distinctive chiropractic approach to diagnosis of neuromusculoskeletal dysfunction, including joint dysfunction or subluxation – featuring manual and visual assessment of ranges of motion throughout the full spine and skeletal system because of its interrelated function.
- In the words of the ACC Paradigm, treatment "to restore biomechanical and neurological integrity," with an emphasis on joint adjustment, other manual methods, exercise and advice. The personal, holistic and integrated nature of the chiropractic approach to patient management must not be lost as new methods of diagnosis and treatment and measurement of outcomes emerge.

c) **Focus on time-limited outcomes-based care**. As in dentistry there will always be a place for ongoing preventive care in chiropractic practice. However for the great majority of chiropractic patients, those seeking relief from musculoskeletal pain and headache, the course of chiropractic treatment must seem reasonable and necessary – to them, to their third party payers, and to medical doctors and others who have referred them or are jointly participating in their care. This means time-limited care with results or outcomes properly measured with validated and accepted outcome measures.

There is a public and medical perception that chiropractic treatment is endless. That is inconsistent with formal clinical guidelines adopted by the profession and the now substantial body of evidence of cost-effectiveness. It is inconsistent with the new national survey figures from Wolsko, Eisenberg et al.[1] which report an annual average for back and neck pain patients of 8.5 visits, which for example compares with 5.6 visits for massage therapy, 13.6 visits for energy healing and 17.4 visits for relaxation techniques. However, the perception is fueled by

and is consistent with some practices and practice management schemes that boast lifetime care, promote unreasonable frequency of care, and press patients for large advance payments for future treatments. As has been the case in Australia recently, licensing boards need to deal aggressively with unprofessional behavior in these areas.

d) **Improve communication skills**. This is arguably the single greatest field in which chiropractors must make a quantum change. Educated in private colleges and practising in isolation from mainstream medical services, chiropractors have always communicated well with patients with their hands but poorly with the public in explanation of their profession. Many have made sweeping statements on scope of practice and effectiveness that are not supported by evidence, and criticisms from the medical profession and others – unjust as these may often have been – have been answered with attitudes of defensiveness and aggression.

The chiropractic profession now finds itself in an era of acceptance increasingly dominated by public rather than professional interests. Patients want care, cooperation and mutual respect from their medical and chiropractic doctors. This demands significant changes in attitude and communication skills. Other health professionals must now be treated as colleagues rather than opponents, and communication must feature common terminology and attitudes that promote mutual respect and cooperation.

As delegates to the ACA's Legislative Conference were told this month by Dr. Dallas, a former ACA President, reviewing his career and the dramatic changes of recent years, "we're on an entirely new page". Chiropractors must understand this deeply and be willing and available partners in the health care team if they and their profession are to prosper as they might in the health care system of tomorrow. TCR

References

1. Wolsko PM, Eisenberg DM et al. (2003) *Patterns and Perceptions of Care for Treatment of Back and Neck Pain. Results of a National Survey*, Spine 28(3):292-298.

2. Eisenberg DM, Davis RB et al. (1998) *Trends in Alternative Medicine Use in the United* States, *1990-1997: Results of a Follow-up National Survey*, JAMA 280:1569-1575.

3. Bigos S, Bowyer O, Braen G et al (1994) *Acute Low Back Problems in Adults. Clinical Practice Guideline No.14. AHCPR Publication No. 95-0642. Rockville, MD; Agency for Health Care Policy and* Research, Public Health Service, U.S. Department of Health and Human Services.

4. American Medical Association (1995) *AMA Pocket Guide to Back Pain*, Random House, New York.

5. Curtis P, Carey TS et al. (2000) *Training Primary Care Physicians to Give Limited Manual Therapy for Low Back Pain*, Spine; 25(22):2954-2960.

6. The Future of Chiropractic: Optimizing Health Gains (1998), Institute for Alternative Futures, Alexandria, VA.

7. Larsen K, Weidick F et al. (2002) *Can Passive Prone Extensions of the Back Prevent Back Problems? A Randomized, Controlled Intervention Trial of 314 Military Conscripts*, Spine 27(24):2747-2752.

8. Meade TW, Dyer S et al. (1990) *Low-back Pain of Mechanical Origin: Randomised Comparison of Chiropractic and Hospital Outpatient Treatment*. Br Med J 300:1431-7.

9. Waddell G, Feder G et al. (1996) *Low-Back Pain Evidence Review*, London: Royal College of General Practitioners.

10. Spitzer WO, Skovron ML, et al. (1995) *Scientific Monograph of the Quebec Task Force on Whiplash-associated Disorders: Redefining Whiplash and its Management*. Spine 20:8S.

11. Coulter ID, Hurwitz EL et al. (1996) *The Appropriateness of Manipulation and Mobilization of the Cervical Spine.* Santa Monica, California: RAND, Document No. MR-781-CR.

12. Hurwitz EL, Aker PD et al. (1996), *Manipulation And Mobilization Of The Cervical Spine: A Systematic Review Of The Literature*. Spine 21:1746-60.

13. For references and fuller discussions see *The Chiropractic Report* (2001) Vol 15 No. 3 titled *Safety and Effectiveness of Cervical Manipulation.*

14. McCrory DC, Penzien DB et al. (2001) *Evidence Report: Behavioral and Physical Treatments for Tension-Type and Cervicogenic Headache*, Des Moines, Iowa, Foundation for Chiropractic Education and Research. Product No. 2085.

15. Cowin R, Bryner P (2002) *Hearing Loss, Otalgia and Neck Pain: A Case Report on Long-Term Chiropractic Care that Helped to Improve Quality of Life*, Chiro J Aust, 32(4):119-130

16. Hayden JA, Mior SA et al. (2003) *Evaluation of Chiropractic Management of Pediatric Patients with Low-Back Pain: A Prospective Cohort Study*, J Manipulative Physiol Ther 26(1): 1-8.