The Chiropractic Report

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Professional Notes

A New Primary Spine Care Specialty

In the July issue this Report drew attention to an important article in the British Medical Journal by Hartvigsen et al. – who called for the transfer of primary musculoskeletal care in Europe from general medical practitioners to those with more specialized training and skills for the work – chiropractors, osteopaths and physiotherapists.

The open access online journal Chiropractic and Manual Therapies has just published a similar call from the United States. However this is much more comprehensive, and presents a clear, informed and persuasive argument for establishing a new category of primary spine care specialist in the US as part of current reforms to the health care system.

It may be read and downloaded free at the journal's website at http://chiromt.com/content/19/1/17 where it is already marked "highly accessed". It should be considered required reading for all chiropractors.

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The Philosophy of Chiropractic

What is it and is it important?

A. Introduction

PALMER COLLEGE OF CHIROpractic in Davenport, Iowa, the birthplace of the chiropractic profession, held its Homecoming last month. The theme was *Vision 2020: Planning for the Future.*

The Fountainhead, where DD Palmer first proclaimed the science, art, and philosophy of chiropractic, was focused on the future.

Chancellor Dennis Marchiori DC, PhD, moderated the Saturday keynote panel discussion titled The Changing Worlds of Health Care and Education. Given his extensive administrative , academic and research credentials, which include a major text on imaging, he was well-qualified on this subject and so were the panelists.

They included Christine Goertz DC, PhD, Palmer's Vice-Chancellor for Research and Health Policy, formerly of the National Institutes of Health and one of the principal investigators for a new $7.4 million four year multi-center research study of chiropractic treatment for active duty personal in the U.S. military. Another was Kurt Wood DC, Palmer's Vice-Chancellor for Clinic Affairs and Director of Palmer's most impressive new clinic or academic health center.

Those who visited that health center found a new generation of Palmer students, such as Hamisi Kote Ali, a physical therapist from the Nairobi Hospital, Kenya. Hamisi first met chiropractors and chiropractic at the Beijing Olympics where he was a member of the Kenyan Sports Medicine Team. His plans are to develop and lead the foremost musculoskeletal rehabilitation clinic in his home country.

In another room Bill Moreau DC, Director of Sports Medicine Clinics for the US Olympic Committee, addressed a well-attended breakout session titled Multidisciplinary Integrated Health Care – Structure and Case Studies from the USOC's Sports Medicine Model.

In contrast, appropriately and as one would expect at a Palmer Homecoming, Joseph Ferezy DC spoke on The Neurology of the Chiropractic Subluxation Complex and Laura Tanis DC on The Chiropractic Adjustment: Optimizing Neuroplastic Development in the Pediatric Patient.

All of this provokes the following questions:

- In this changing world of health care, education and chiropractic, very different from that experienced by Palmer and the other founders of the profession, how much of the original science, art and philosophy of chiropractic inform the practice of chiropractic today, will inform it in 2020?
- Specifically with respect to the philosophy of chiropractic, what is it and to what degree is it different from other philosophies of health care? How important is a shared philosophy and a common conceptual framework to the future of chiropractic as a distinct and successful profession within health care?
- Should and will a shared philosophy be of fundamental importance in influencing decisions on major issues being debated in the profession today, such as relationships with other health professions, the appropriate balance between art and science in chiropractic health care, research methods and priorities, and the controversial question of whether or not there should be any use of medication in chiropractic practice.

This issue reviews the current state of the philosophy of chiropractic, including significant developments since the year 2000.

Main Article *continued from page 1*

B. Philosophy – Definitions

2. The word philosophy has a number of different meanings. Kenneth Schaffner MD, PhD, Professor of Philosophy, George Washington University, Washington, DC, USA, delivering the opening lecture titled What is Philosophy and it's Role in Science and the Healing Arts at a conference titled Philosophy in Chiropractic Education in November 2000, began his presentation with four definitions from Encata: (1)

- Examination of basic concepts ("the branch of knowledge or academic study devoted to the systematic examination of basic concepts such as truth, existence, reality, causality, and freedom").
- System of thought ("a particular system of thought or doctrine").

These two definitions focus on philosophy as an activity – philosophizing.

In these meanings philosophy has no body of knowledge or subject matter of its own, but is rather thought and reflection on different subjects. Therefore one should not speak of chiropractic philosophy, or scientific or legal philosophy, but the philosophy **of** chiropractic and the philosophy **of** science or law.

- Guiding or underlying principles ("a set of basic principles or concepts underlying a particular sphere of knowledge").
- Set of beliefs or aims ("a precept or set of precepts, beliefs, principles, or aims, underlying somebody's practice or conduct").

These are more populist meanings of the term philosophy as used in general speech. More strictly these meanings should be conveyed by the words "principles" and "beliefs". They describe subject matter so it is appropriate to use the terms chiropractic principles, or chiropractic beliefs, and this is what many in the profession are describing when they talk of philosophy.

In professional discussion, education and practice it is more correct, and helpful in keeping meaning clear, not to use the term chiropractic philosophy but refer to the philosophy of chiropractic, encompassing all four meanings, and chiropractic principles and beliefs. That is the approach used here.

C. Traditional Philosophy of Chiropractic

3. The main elements of the traditional philosophy of chiropractic, in the sense of principles, can be simply stated:

a. The body has its own innate intelligence and healing powers. Health comes from within.

b. The principal regulatory system for the body is the nervous system.

c. Spinal joint disorders, termed subluxation and later vertebral subluxation complex, can interfere with the body's ability to regulate and maintain health.

d. The core purpose of chiropractic care is to relieve that inference through skilled manual assessment and correction, termed spinal adjustment.

e. As chiropractic is a natural healing art, respecting the inherent healing powers of the body, there is no use of drugs or surgery in chiropractic practice.

4. All the main elements of this traditional set of chiropractic principles were affirmed in 1996 by the Association of Chiropractic Colleges (ACC), representing all seventeen chiropractic educational institutions in North America. This was in an ACC Paradigm of Chiropractic unanimously agreed and subsequently endorsed by the American Chiropractic Association (ACA), the International Chiropractors' Association (ICA), and the World Federation of Chiropractic (WFC). That paradigm was summarized by the ACC in Figure 1. The ACC described chiropractic as follows:

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs and surgery.

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, doctors of chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

The ACC's goal in developing and publishing its paradigm was to influence and provide direction for chiropractic education, practice and research. It was recognized, however, that chiropractors were increasingly working within and with changing health care systems. Therefore the ACC, with the WFC, planned a major conference on philosophy titled *Philosophy in Chiropractic Education*. This, by far the most comprehensive international philosophy meeting ever staged by the profession, was held in Fort Lauderdale, Florida, in November 2000.

D. Fort Lauderdale Conference

5. If new levels of understanding and consensus on the philosophy of chiropractic were going to be achieved at the Fort Lauderdale conference, the right people were present to achieve this and make the consensus authoritative. Dr. David Koch, then President of Sherman College of Chiropractic, and Dr. Reed Philips, then President of the Southern California University of Health Sciences, presidents representing insti-

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tutions at both ends of the philosophical spectrum, were Program Directors.

There were delegations from 36 of the world's 38 recognized chiropractic educational institutions, representing 12 countries.

Other organizations represented included national associations of chiropractors, accrediting agencies, and examining and licensing authorities. Importantly, the full spectrum of the philosophy of chiropractic was represented.

6. **Goals.** Goals of the conference were:

- To review the roles of philosophy and belief systems in the healing arts generally and in chiropractic education specifically.
- To seek a consensus on whether the chiropractic profession needs a common conceptual framework and, if so, on what that conceptual framework is.
- To review current course content on philosophy at chiropractic colleges.
- To produce draft consensus guidelines on the role and methods of teaching philosophy in chiropractic education.

7. **Keynote Presentations.** These were on the role of philosophy in the healing arts by Kenneth Schaffner MD PhD, Professor of Philosophy and Medical Humanities, George Washington University, Washington DC, and the role of philosophy in complementary health care by Ian Coulter PhD, a sociologist, former President of the Canadian Memorial College of Chiropractic in Toronto, and author of the respected text Chiropractic: A Philosophy for Alternative Care.[2]

Schaffner acknowledged the limitations of the reductionist biomedical model of medicine dominant since the early twentieth century, and described the biopsychosocial model advanced by medical philosopher, Dr. George Engel, since 1977.[3]

He supported Engel's claim that, despite the enormous contribution of the biomedical approach, "better health care would be delivered by healers mindful of the psychosocial as well as the biological dimensions of illness. The appreciation of the complexity of a human being's reality and a joint analysis of the interactions among various levels of causation, from the molecular through the organ-level to the intellectual, emotional, familial, and ecologic will both permit a better understanding of how illness arises, as well as provide a richer armamentarium for the physician and the health care provider."[1]

Coulter, speaking on philosophy in complementary and alternative medicine (CAM), explained that the biomedical model of medicine, with it's whole hearted embrace of science as the foundation for medical practice, "is itself the endorsement of a philosophical system, that of critical rationalism."[4] CAM had kept alive a different philosophy of health, and as a result philosophy of health care, that increasingly matched contemporary thought about health and wellness. Those seen as CAM providers in Western society, such as homeopaths, naturopaths and chiropractors, although a very diverse group, were "surprisingly similar" on philosophy of health. Health comes from within, germs may initiate diseases but they are not the root cause - lowered resistance is the predisposing factor.

This leads, Coulter explained, to a fundamental difference in logic with respect to treatment. Under a biomedical model "the intent of the provider is to cure the patient, in CAM the intent is to assist the patient to heal himself/herself". Coulter then listed the five following metaphysical principles embraced by CAM providers:

a. **Vitalism**

Vitlaism accepts that all living organisms are sustained by a vital force that is both different from, and greater than, physical and chemical forces. In extreme form, the vital force is supernatural. In a less extreme form it is simply *vis medicatrix naturae* (the healing power of nature).

b. **Holism**

Holism postulates that health is related to the balanced integration of the individual in all aspects and levels of being: body, mind and spirit, including interpersonal relationships and our relationships to the whole of nature and our physical environment. Holism therefore is contradictory to the notion of reductionism since it holds that the whole is different from, and greater than, the sum of the parts.

c. **Naturalism**

There is a preference for natural remedies. This is bound up with a set of philosophical principles which may be expressed as the body is built on nature's order, it has natural ability to heal itself, that this is reinforced by the use of natural remedies, that it should not be tampered with unnecessarily through the use of drugs or surgery, and that we should look to nature for the cure.

d. **Humanism**

Humanism is based on the postulate that individuals have immutable rights, for example the right to dignity. In CAM there is extensive concern about dehumanizing procedures and the dehumanizing institutions that have been created for the ill. Partly it is recognition of the personal, social and spiritual aspects of health and a move away from simply the biology of health.

e. **Therapeutic Conservatism**

Most of CAM is therapeutically conservative. That is, it uses therapies that have a low level of side effects and it tends to

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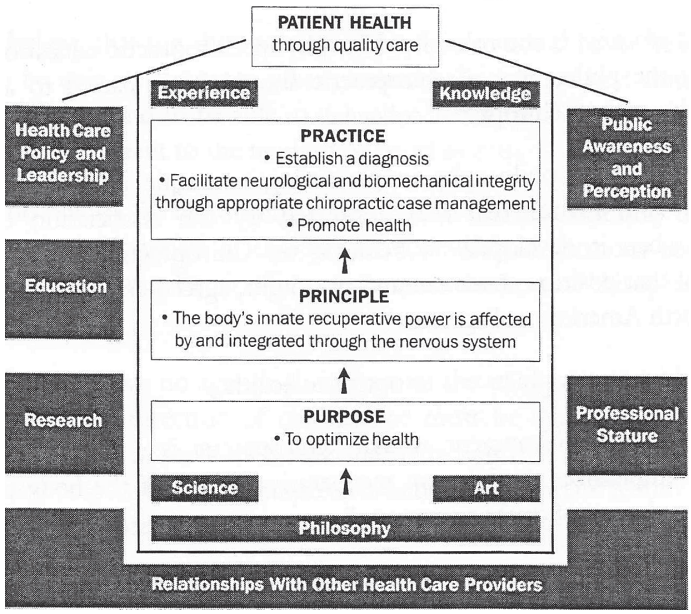
Figure 1. The ACC Chiropractic Paradigm



A New Primary Spine Care Specialty

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The case made applies equally to health care systems and chiropractors in all countries. The authors suggest that the chiropractic profession is well-placed to fulfill this new role, though identify obstacles – and how to overcome them. The essence of their case, found in the abstract, is:

"It is widely recognized that the dramatic increase in healthcare costs in the United States has not led to a corresponding improvement in the healthcare experience of patients or the clinical outcomes of medical care. In no area of medicine is this more true than in the area of spine-related disorders (SRDs)."

"Costs of medical care for SRDs have skyrocketed in recent years. Despite this, there is no evidence of improvement in the quality of this care. In fact, disability related to SRDs is on the rise. We argue that one of the key solutions to this is for the healthcare system to have a group of practitioners who are trained to function as primary care practitioners for the spine".

This article has scholarship and clinical and market common sense. The authors are all well-established clinician scientists in the chiropractic profession. First author Dr. Donald Murphy, is in private practice as Clinical Director of the Rhode Island Spine Center, and is also on faculty at the Brown University School of Medicine. He is editor of the major text *Conservative Management of Cervical Spine Syndromes* (McGraw Hill, 1999).

Dr. Brian Justice is in private practice with the Rochester Chiropractic Group in New York, Dr. Ian Paskowski is now Medical Director of the Back Pain Program at Jordan Hospital. Dr. Stephen Perle is Professor of Clinical Sciences at the University of Bridgeport College of Chiropractic in Connecticut, and Dr. Michael Schneider is Assistant Professor, School of Health and Rehabilitative Sciences, University of Pittsburgh.

To summarize the case they present:

The problem. This is:

i. SRDs – defined as "the group of conditions that include back pain, neck pain, many types of headache, radiculopathy and other symptoms directly related to the spine" – affect virtually 100% of the population during life and "are among the most common, costly and disabling problems in Western society".

ii. The burden of SRDs on individuals and societies is huge. Direct costs in the US are over $102 billion annually. Fifteen years ago in 1996 total costs for neck pain only in the Netherlands were US$686 million.

iii. Between 1997 and 2005 expenditures for back and neck pain in the US rose by 65% (the real increase – after adjustment for inflation) but measures of physical functioning, mental health and work, school and social activity among patients with SRDs declined.

Between 1994 and 2004 LBP-related Medicare expenditures in the US increased 629% for epidural steroid injections, 423% for opioid medications, 307% for magnetic resonance imaging (MRI) and 220% for lumbar fusion surgeries, but "despite the tremendous amount of time and money spent on the diagnosis and treatment of patients with SRDs chronicity and disability related to these disorders appears to be steadily on the rise".

"We are not aware of any other health condition in which a similar level of worsening has occurred despite significant increase in healthcare expenditures".

Problems with current general and specialist medical care. These include:

i. There is a supermarket approach with the patient left to sort out which of many different approaches and practitioners to use.

ii. Traditional medical primary care physicians (PCPs) are not well trained in the differential diagnosis and management of musculoskeletal disorders. Medical specialists are no better trained than traditional PCPs in the management of common SRDs seen in primary care.

iii. There is a general problem of under-availability or shortage of traditional PCPs – this can be helped if patients with SRDs see a new primary spine care specialist.

iv. "Treatment for SRDs has become increasingly specialist-focused, imaging-oriented, invasive and expensive."

Definition and role of a primary spine care practitioner. Paraphrasing the definition of primary care by the American Academy of Family Physicians, the authors define primary spine care as "that care provided by practitioners specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioural, or social), involving the spine".

The roles of a new primary spine care practitioner include being first contact for patients with SRDs and a source to which patients with SRDs can be referred by traditional PCPs (family practice physicians, internists, primary care nurse practitioners etc.)

"This model is analogous to the general dentist who provides 'primary care' for oral health."

Necessary skill set. See the article for comments on skills in differential diagnosis; skills in the management of most patients with spine pain; a wide range in understanding of spinal pain – which combines biological and physiological processes, is multi-factorial and often has no well-defined lesion that can be clearly detected by imaging or other tests; the ability to detect and manage psychological factors; an appreciation of minimalism in spine care; an understanding of intensive rehabilitation, interventional treatments and surgical procedures; an understanding of unique features of work-related and motor vehicle-related SRDs; etc.

Benefits for patients. Issues discussed include faster recovery, cost savings, avoiding iatrogenic disability, reduced chronic pain, higher patient satisfaction, focus on prevention.

Benefits to society and the healthcare system. See a useful analysis with many valuable ideas and references. The Spine Care Program at Jordan Hospital, discussed in the January 2011

issue of The Chiropractic Report, is given as a concrete example of these benefits.

Obstacles to implementation. The first given is the need for educational changes in the relevant professions. In chiropractic many of the skills required are already taught. Osteopathic medicine and physical therapy "include some level of spine care training within their respective curricula." However expansion of and amendment to curricula will be necessary.

Other obstacles discussed include providing financial incentive for care based on value rather than volume of procedures, overcoming medical prejudice, overcoming resistance from those doing well under the supermarket approach, and administrative issues in implementation.

While this new role of primary spine care specialist will be "actively resisted" by many in all relevant professions, including chiropractic because of "significant disruption to the traditional practice patterns or self image," any profession that accepts the role of primary spine care practitioner "will likely dramatically increase the volume of patients that seeks its services".

In summary, this commentary by Murphy et al. updates, expands upon and provides extensive references for the spine care specialist role that Dr. Scott Haldeman, neurologist, chiropractor and and pre-eminent spine care authority, has argued for in recent years. Whether or not you accept that argument, here is a commentary that lays out all the issues and evidence in an informed and clear manner - it becomes the best publication available in its field.

(Murphy et al. Chiropractic and Manual Therapies 2011, 19:17 http://chiromt.com/content/19/1/17)

Chiropractic at Pan American Sports Medicine Congress

The Pan American Games, like the Olympics, are held every 4 years. They feature national teams from 41 nations from throughout the Americas and the Caribbean. This year they are to be held in Guadalajara, Mexico from October 14-30 and COPAG, the organizing committee, has made arrangements for a team of 36 sports chiropractors to be part of the host sports medicine team available for all athletes.

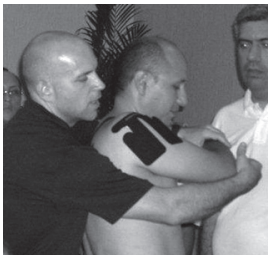
COPAG Chief of Chiropractic Services is Dr. Saul Luengas of Queretaro, Mexico, a 1994 graduate of Palmer College West Campus, San Jose, California, and the sports chiropractic team has been appointed following a selection process administered by the Fédération Internationale de Chiropratique du Sport (FICS). Those selected come from 9 countries.

As part of the Pan American Games, but prior to them, there is a major scientific and clinical meeting titled The Pan American Sports Medicine Congress. This was held in Guadalajara, from July 27-30, attended by 650 delegates from 26 countries and featured an impressive number of chiropractic presentations – possible because of generous sponsorship from Logan College of Chiropractic, the Northwestern Health Sciences University and other sponsors. The Congress comprised plenary sessions with 29 keynote speakers, and 17 breakout symposia and workshops. Chiropractic presentations included:

- Keynote presentations from William J. Moreau DC, Director of Sports Medicine Clinics for the US Olympic Committee (*Chiropractic Science Applied in The Multidisciplinary Management of Sports Medicine*) and Jonathan Mulholland DC, Northwestern Health Sciences University and a member of the US Sports Medicine Team for the Vancouver Paralympic Games in 2010 (*The Challenges and Concerns of Working with Paralympic Athletes'*).
- Other sports chiropractors giving lectures were Dr. Raul Carrillo, Mexico, Dr. Francisco Diaz, Mexico, Dr. Kevin Jardine, Canada, Dr. Saul Luengas, Dr. Laney Nelson, USA, and Dr. Ramiro Ramirez, Mexico.
- Technique workshops, presented to a multi-disciplinary audience of chiropractors, medical doctors and physical therapists, many of whom will be working at the Pan American Games, were on *Kinesiotaping* by Dr. Kevin Jardine, sponsored by Spidertech, and *Graston Technique* by Dr. Tim Stark, USA.

"This was the first time that chiropractic speakers have been invited to a Pan American Sports Medicine Congress," reports Dr. Luengas, "and they were an important part of a very successful event attended by many Pan American and Mexican sports medicine and political leaders."

*Dr. Saul Luengas (*left*) with Dr. Bill Moreau.*



Dr. Kevin Jardine at the kinesiotaping workshop.

Some of the chiropractic speakers and delegates.

*(*From left*) Dr. Luengas, COPAG Chief of Chiropractic Services, with Dr. Antonio Lopez, Executive Director of the Pan American Sports Medicine Congress and Director, Guadalajara Sports Medicine Institute, and Dr. Raul Carrillo, who lectured on chiropractic management of acute cervical pain syndromes during competition.*

accept that the least care is the best care. This in some ways is derived from earlier principles. If the body is capable of healing itself, the role of the therapy is simply to initiate the process. This is not to suggest that CAM treatment may not be extensive but only that philosophically it tends to be conservative.

This philosophy of health goes beyond a biopsychosocial model because it focuses on the innate tendency of the body to restore health. From this comes a philosophy of health care that make a distinction between treatment and care. The objective of CAM is to *care* for the whole person and not simply *treat* the symptom. The health provider is merely a facilitator and an educator and therefore not strictly a *provider* of health. Health is not something given by the provider – it comes from within or not at all.

8. **Vitalism.** When seen as an eighteenth century philosophy rejected by science, vitalism is truly controversial. However David Peters MB ChB, the British physician and homeopath invited to speak to the Fort Lauderdale Conference on vitalism, announced "let there be no doubt – vitalism is alive and well."

He drew attention to:

• The highly evolved philosophies of Eastern systems of traditional medicine, interweaving mind, body and spirit and based on generations of accumulated observation and knowledge about the process of becoming ill and getting well, "knowledge Western medicine lost as it focused on biology at the expense of lived experience."

• The growth of information medicine, energy medicine, and mind-body medicine in the West. Workers in psycho-neuro-imminology (PNI) were discovering "how biochemical messengers communicate information intelligently, orchestrating an organism-wide information flow. He observed:

"Neuro-chemical information flow may well inform and shape structure and if so, the emergent properties of these incalculably complex processes is indeed a kind of intelligence permeating the entire organism. And it has been suggested that this flow must itself be organized by a system of communication flow far more rapid than the neuropeptide-receptor system.

Just such a living matrix of organismic information is described by James Oschman. Biologists now recognize that cell nuclei, cyto-skeletons and extra-cellular matrices form a continuous and interconnected system, since each cyto-skeleton sends fibrils into surrounding cells through the extra-cellular matrix. According to Oschman's theory this could be a vehicle for a system of *structural* communications and he makes the point that as these systems of information flow integrate and shape the organism, they have similar properties to what Vitalists have called vital energy."[5]

9. **Other Speakers.** Many other invited lectures included:

• A comparison of the therapeutic and non-theraputic approaches to chiropractic practice (Joseph Keating PhD and Thom Gelardi DC, respectively).

• A comparison of the philosophical bases of condition-centered (Marion McGregor DC, PhD), vertebral subluxation-centered (David Koch DC, PhD) and patient-centered (Meridel Gatterman DC) chiropractic care.

• A comparison of the concept of interference with the nervous system as a source of ill health in chiropractic theories with very similar theories in acupuncture and yoga (Howard Vernon DC, PhD).

• The importance of belief by clinicians and patients in the effectivness of health care (Michael Goldstein PhD).

• A closing address by John Astin PhD, Assistant Professor, Complementary Medicine Program, University of Maryland School of Medicine, and a major figure in the US health system's move toward integrated health care. Asked to speak on whether the chiropractic profession needed a common conceptual framework, he explained not only that it did but also that the approach to philosophy and the philosophy of chiropractic he had heard at this convention was truly needed in a "re-envisioned health care system" in the US. He was currently working with a consortium of major academic medical centers on underlying values for a new vision of health. Key components included:

a. A recognition of the crucial importance of non-physical factors in health.

b. An appreciation of the fundamental importance of the *relationship* between patients and their health care providers (e.g. the quality of listening, attention and communication, expression of empathy, compassion).

c. The facilitation of patients becoming less reliant on the health care system by educating them about appropriate self-care measures. Health care providers should first and foremost be teachers.

d. A recognition that effective health care must be patient-centered. Decisions about treatment options need to be made collaboratively, and the experience, perceptions, and ideas of the patients need to always be valued and respected and never diminished, discounted, or overlooked.

e. An acknowledgment of the crucial importance of the environment in which healing takes place.

f. The development of evidence-based "best practices" that effectively integrated conventional and complementary approaches to the treatment and prevention of illness.

10. **Consensus Statements.** Following all lectures and debate at the conference there was unanimous support for the consensus statements shown in Table 1. These conclude that study of the philosophy of chiropractic, in the wider context of the philosophy of health care, should be an important component of all chiropractic educational programs. Important concepts underlying the consensus statements, and identified in the introduction to the published proceedings are :

a. To retain its distinct identity, especially as chiropractic education and practice go truly international and many others enter the field of manual health care, the profession "needs a common conceptual framework based on shared philosophy."

b. The prime responsibility for establishing a shared philosophy rests with chiropractic educational institutions.

c. Philosophy is an activity which "necessarily involves critical analysis and evolution of thought."

d. Principles traditionally emphasized in the philosophy of chiropractic, including holism , vitalism, and the subluxation-centered model of care, have continuing validity and importance. Equally, so do new principles and ways of expressing principles, as for example the biopsychosocial and patient-centered models of care.

E. Orlando Congress 2003

11. The keynote Saturday morning session at the World Federation of Chiropractic's Congress in Orlando, Florida in 2003 was devoted to putting these consensus statements and a further discussion of vitalism before a large international chiropractic audience.

Dr. Peters, now Professor of Integrated Medicine at the University of Westminster, was back confirming that medical science had succeeded brilliantly with explanation of the structures of the cell, DNA and gene, but not with explanation of the consciousness that provides the operating environment for the gene – the biomechanical, structural and electrical information flows predicted by vitalists in the past and now addressed in psycho-neuro-immunology and the burgeoning science of consciousness.

After Peters came four presentations from doctors of chiropractic with diverse backgrounds. Dr. Ashley Cleveland and Dr. Gerard Clum, chiropractic educators, Dr. Cheryl Hawk, a clinical research scientist and Dr. Charles Masarsky, a clinician from private practice, all agreed on the position of the chiropractic profession with respect to vitalism. Chiropractic principles and care should not be based either on extreme vitalism or a strictly mechanist approach. With its respect for both structure and function, chiropractic stood at the intersection of intelligence and matter, both mechanist and vitalist principles are important, and chiropractors should operate comfortably within what is now known as the biopsychosocial model of health.

When the session was thrown open for comment and questions it was apparent that in this representative international chiropractic audience there was no significant dispute on philosophy or principles. The only concern was with the most effective language to describe the philosophy of chiropractic care to external audiences. "Vitalism" was a label with much baggage in a world dominated by a mechanist view, and where that view has produced phenomenal technological advances and was still equated by many to be synonymous with science and even reality. Chiropractors should therefore be able to discuss vitalistic elements of their philosophy in terms of the contemporary concepts of the science of consciousness and flow of information, and the holistic biopsychosocial model of health.

Table 1

Conference Consensus Statements from WFC/ACC Conference on Philosophy in Chiropractic Education

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

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

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

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

5. Other philosophical ideas that were presented at the meeting, but for which there was insufficient time for extended discussion included American pragmatism, complexity theory, critical rationalism, ethics, logic, mechanism, post modernism, reductionism, sociology of the professions, and systems theory.

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

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

F. McDonald Survey

12. In 2003 McDonald, Durkin et al. reported the first structured opinion survey in North America on the attitudes of practicing chiropractors on the more contentious aspects of philosophy and practice.[6] Their hypothesis was that most chiropractors display considerable unity on how they think and practice, and that differences have been exaggerated. The survey confirmed that this was true. They found "surprising unity" when you went to practicing chiropractors as opposed to leaders and special interest groups and concluded that "the profession needs to review and modify century-old stereotypes".

The written survey was sent to a systematic random sample of 1102 chiropractors in the United States, Canada and Mexico. There was a response rate of 63.3%. It is noted:

a. Respondents were asked to rate themselves as one of the following:

- **Broad scope**: allows a wide array of manual and other clinical procedures for diagnosing and treating both symptoms and neuromusculoskeletal conditions. Some in this camp would include minor surgery, obstetrics and prescribing medications.
- **Middle scope**: tends to combine subluxation adjusting with other conservative treatment and diagnostic procedures.
- **Focused scope**: emphasizes the detection and adjustment of verterbral subluxations to restore normal nerve activity to musculoskeletal and visceral tissues. Some in this camp oppose therapeutic modalities, extremity adjusting, and diagnostic procedures.

b. Approximately half (46.4%) rated themselves middle scope chiropractors, between broad scope (34.3%) and focused scope (19.3%). Interestingly, the majority of graduates from colleges with a reputation for promoting a traditional philosophy of chiropractic and focused scope did not rate themselves as focused scope practitioners. For example, approximately 2 in 3 of Life College graduates (68.1%) described themselves as broad scope (23.2%) or middle scope (44.9%) practitioners.

c. The overwhelming majority of respondents agreed with

continued clinical use of the term verterbral subluxation complex (88.1%) and that the adjustment should not be limited to musculoskeletal conditions (89.8%) and for North America McDonald et al. concluded that overall "the profession presents a united front regarding the subluxation and the adjustment".

d. There was a "united front" concerning differential diagnosis at new patient exams (93.4%) and the appropriateness of offering patients a broad spectrum of clinical services. "Orthotics (97.7%), clinic-based exercise (96.9%), vitamins (96.7%), acupressure (94%), therapeutic modalities (93.5%), and herbs (91.1%) are just a few of the many services recognized by a super-majority of chiropractors."

e. McDonald et al. report that "on most issues, broad scope and focused scope chiropractors differ more in degree than in kind." For example:

- Asked "In what percentage of visceral ailments is the vertebral subluxation a significant contributing factor" responses were 55.8% (broad scope respondents), 61% (middle scope), and 81.5% (focused scope).
- Asked "of all pharmaceutical prescriptions filled annually, what percentage is clinically beneficial" responses were 48.4%, 39.4 and 27.9% respectively for broad, middle and focused scope practitioners.

f. In this opinion survey there was largest disagreement on the issue on which McDonald et al. thought they would find strong agreement - whether or not there should be use of medication in chiropractic practice. Approximately 1 in 2 thought chiropractors should be permitted to write OTC prescriptions (54.3% – 77.1% of broad scope chiropractors, 17.6% of focused scope) and prescriptions for musculoskeletal medicines (48.8% – 71.3% of broad scope chiropractors, 19.2% of focused scope). Of Life College graduates 1 in 3 supported prescription of OTC (33.3%) and musculoskeletal (35.3%) medicines. Figures for Palmer graduates were similar. Again, a difference in degree, not in kind.

G. Conclusion

Each profession has internal debate on principles and a variety of methods of practice. This is true of chiropractic, but on the evidence of recent years the profession appears to have greater agreement on a shared philosophy and conceptual framework than most others. Which other profession has well-attended, representative, international educational and professional meetings leading to consensus on philosophical issues?

Perhaps the strength of the contemporary philosophy of chiropractic lies in its acceptance of a blend of innate healing powers, art and science in health and healing consistent with a biopsychosocial paradigm. Chiropractic, as accepted at the Orlando Congress, is at the intersection of intelligence and matter. Its contemporary philosophy is well expressed in the ACC Chiropractic Paradigm, and by Coulter, whose following description of the philosophy of chiropractic is adopted by the World Health Organization in its 2005 guidelines on chiropractic education and practice for its member countries:

"A majority of practitioners within the profession would maintain that the philosophy of chiropractic includes, but is not limited to, concepts of holism, vitalism, naturalism, conservatism, critical rationalism, humanism and ethics."[7]

Will the philosophy of chiropractic provide the answer to issues such as whether or not there should be any use of medication in chiropractic practice, the research priorities of the profession, its distinctiveness from other health professionals providing manual care?

Time will tell – but it is certainly the clear starting point for discussion. TCR

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