



Changed Medical and Surgical Attitudes

Working with Chiropractors in Managing Spine Pain Patients

A. Introduction

P RIMARY CARE MEDICAL practitioners are trained and confident in most areas of general practice, but not management of patients with back pain – recently established as the single largest cause of disability worldwide.¹

Spinal pain patients are common but frustrating for family physicians, who typically provide medication for pain control and then, if pain persists, refer the patient for a surgical or other specialist consultation.

Waiting times, both for the consultation and for surgery if needed, can last many months. This delays effective care, complicates recovery, prevents return to work and other activities, and generates huge direct and indirect costs for individual patients and society at large. The inefficiencies are compounded by the fact that most spinal pain patients referred for surgical consultations do not require surgery.

2. For these and other reasons there have been growing calls for a new approach to management of back pain patients based on more extensive use of primary care professionals other than medical physicians, specifically chiropractors and nurses and physical therapists with advanced training. In dental and oral care there are dentists, in vision care optometrists, in mental health psychologists – all non-medical primary care specialists working alongside physicians. Isn't there a compelling case for a similar arrangement in spine care and management of other neuromusculoskeletal problems?

The case for this is now being made repeatedly and in prominent circles. As examples:

a) Two years ago there was a well-argued opinion piece titled *Views and*

*Reviews: We need to rethink front-line care for back pain in the British Medical Journal.*² Authors were Dr Jan Hartvigsen, a chiropractic research leader from Denmark who is Director of Research for Clinical Biomechanics at the University of Southern Denmark, Dr Nadine Foster a physiotherapist who is Professor of Musculoskeletal Health in Primary Care at the Arthritis Research UK Primary Care Centre, Keele University and Dr Peter Croft, Professor of General Practice Epidemiology, also from the Arthritis Research UK Primary Care Centre, Keele University.

The authors observe that patients with back pain are not well-managed by general practitioners who receive little training in common musculoskeletal problems, and reference surveys that indicate that GPs feel ill-equipped to examine and treat patients with back pain. When GPs manage conditions such as angina or diabetes they have toolboxes of diagnostic and practical management skills acquired in training that allow them to provide interventions that make a difference. This is not so with back pain.

Data from the UK, elsewhere in Europe and the US demonstrate that patients are now comfortable with choosing chiropractors, osteopaths, and physical therapists as points of entry in the healthcare system. "The main interests of such professional groups are in musculoskeletal health and back pain, and they drive much research and professional development in these disciplines."

b) Subsequently there was a similar call from Murphy, Justice et al. in the United States.³ This was published in the open access online journal *Chiropractic and Manual Therapies*. First author Dr Donald Murphy is in private practice at the Rhode Island Spine Center and

Professional Notes

Chiropractic Under the African Sun

From April 8–13 the Chiropractic Association of South Africa (CASA) hosted the World Federation of Chiropractic's 12th Biennial Congress, titled *Chiropractic*



CASA President Dr Simon Lawson opens the Congress.

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editor of the text *Conservative Management of Cervical Spine Syndromes* (McGraw Hill, 1999). Second author Dr Brian Justice practices at the Rochester Chiropractic Group in New York and currently serves as a consultant to Blue Cross/Blue Shields in development of spine care pathways for improved evidence-based management of spine pain patients.

Their excellent analysis of the need for and role of new primary spine care specialists in healthcare systems has much excellent detail on the problems involved and how to resolve them.³

3. A question of fundamental importance for policy makers and all other stakeholders in healthcare systems is whether or not the medical profession is ready and willing to collaborate in practice with non-medical clinicians. In the US will physicians and surgeons with a history of opposition to the chiropractic profession now work in partnership with it in a common evidence-based approach to patient care? There are many new signs of changed attitudes and that it will. For example:

a) A new Harvard Medical School booklet for the public titled *Low-Back Pain: Healing your Aching Back* endorses chiropractic care as one good option and reports a review of 12 different research studies concluding that chiropractic care “improved short and medium-term pain more than other treatments, including exercise, physical therapy, and medication.” People who saw chiropractors also reported “being less disabled over the short-term (one month) compared with people who received other treatments such as standard medical therapy.”

Particularly for back-pain patients without nerve impairment “chiropractic care tends to be satisfying and effective for acute low-back.”⁴

b) Last month the Journal of the American Medical Association, not historically a source of support for chiropractic treatment, published a patient information page on low-back pain – for use by its physician members with patients. Treatment advice given was:

“**Treatment** Many treatments are available for low-back pain. Often exercises and physical therapy can help. Some people benefit from chiropractic therapy or acupuncture. Sometimes medications are needed, including **analgesics** (painkillers) or

medications that reduce inflammation. Surgery is not usually needed but may be considered if other therapies have failed.”⁵

c) These contemporary views on chiropractic care from Harvard and the AMA reflect many developments during the past decade. With respect to evidence-based care, one such development is the 2007 joint clinical practice guideline from the American College of Physicians and the American Pain Society recommending spinal manipulation for acute and chronic back pain patients.⁶ With respect to integration of chiropractic and medical care, another development is the expansion of chiropractic services throughout the Veterans Administration (VA) hospital system during the past 10 years. A watershed moment for the further integration of doctors of chiropractic into the mainstream US healthcare system was the announcement in March that the VA will be establishing postgraduate clinical training residencies for chiropractors on a similar model to residencies for medical doctors and dentists.

To what extent are these changed attitudes held by individual physicians and surgeons? Given the opportunity for collaboration, will most orthopedic surgeons and neurosurgeons accept inter-referral of patients with chiropractors – in North America and in other countries?

This is an area in which there has been little research. Individual chiropractors will have anecdotal evidence of cooperation and lack of cooperation. There are case studies reporting that when individual family physicians are exposed to the potential benefits of collaborative co-management of back pain patients with chiropractors they begin to refer a majority of patients with good results.⁷

Just published in *Spine* in April, however, is a first comprehensive survey in this field. This is a survey of spine surgeons throughout Canada by Busse, Riva et al.,⁸ a team of chiropractic and medical researchers, who report:

- Wait times for patients with low-back and low-back related leg pain referred for surgical assessment are excessive, and many referred patients are not surgical candidates.
- More than 3 out of 4 (77.6%) of Canadian spine surgeons are willing to work with non-medical clinicians, specifically including chiropractors and physio-

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therapists, to screen patients with LBP or LBP related leg-pain who are being referred to them for elective surgical assessment – and 75.3% would be comfortable not assessing these patients if indications for surgery were ruled out by the chiropractor or physiotherapist.

Given the strength of this study, which had an 84.1% response rate from members of the Canadian Spine Society, and other information disclosed by the survey, this issue of *The Chiropractic Report* looks at the study in further detail. We then look at other examples of mutually changed attitudes of cooperation between spine surgeons and chiropractors elsewhere, such as countries in the Middle East, Africa and Latin America.

B. The Canadian Survey

4. This new survey of Canadian spine surgeons was by a 12-person team of experienced researchers led by Jason

Busse DC, PhD of McMaster University in Ontario. Others included:

- Charles Fisher MD, FRCSC, orthopedic surgeon, Paul Bishop, DC, MD, PhD and Jeffery Quon DC, PhD, doctors of chiropractic, all from the Department of Orthopedics, University of British Columbia, Vancouver. They are authors of the recent RCT reporting superior results for back-pain patients who received evidence-based care including up to 4 weeks of chiropractic manipulation, in comparison to those receiving usual medical care.⁹
- Raja Rampersaud, MD, FRCSC, Divisions of Orthopedic Surgery and Neurosurgery, University of Toronto, a leading expert in spine care in Canada.
- Brian Drew, MD, FRCSC, orthopedic surgeon, Ottawa Hospital, Ontario, Canada.

The principal objective of this study was to explore spine surgeons' attitudes towards the proposal that non-medical clinicians, such as chiropractors, physiotherapists and nurse practitioners, called low-back pain clinicians (LBP clinicians) in this paper, assume the role of screening patients with low-back or low-back related leg pain who had been referred by their physicians for surgical assessment.

For this Busse et al. administered a 28-item survey to all 101 surgeon members of the Canadian Spine Society in January-February 2012, a survey which asked questions about:

- Demographic variables of the surgeons -e.g. age, years in practice, practice environment (academic, hospital-based, private practice, etc.).
- Patient screening efficiency – how many patients needed to be seen to identify a single surgical candidate.
- Typical wait times for both assessment and surgery.
- Important components of low-back related complaints history and examination.
- Indicators for assessment by a surgeon.
- Attitudes towards use of LBP clinicians to screen patients otherwise referred to them as spine surgeons for elective surgical assessment.

5. Busse et al. hypothesized that the following factors would influence the willingness of surgeons to allow LBP clinicians to screen patients referred to them:

- Older surgeons would be more reluctant.
- More favorable attitudes would be held by surgeons who attended a larger proportion of patients with low-back or low-back related leg pain.
- Surgeons who felt that their wait times for outpatients were not optimal/satisfactory, and/or thought that their screening efficiency was not optimal/satisfactory would be more favorable.

Results showed that only the last hypothesis was correct. Age and proportion of patients with LBP or low-back related leg pain did not influence results.

6. The final questionnaire framed response options for attitudinal questions with a 5-point Likert Scale (strongly agree, agree, undecided, disagree, strongly disagree). It was administered online using SurveyMonkey. 85 of 101 surgeons completed the survey, for a response rate of 84.1%. Characteristics of respondents were:

- a) Approximately 1 in 2 (48.2%) had been in practice more than 20 years.
- b) 59 (69.4%) were orthopedic surgeons, 26 (30.6%) were neurosurgeons.

7. Results – Practice Characteristics. These included:

- a) Most respondents (69.4%) “dedicated more than half of their practice to elective spine surgery”.
- b) 1 in 3 (36%) had to turn away a significant number of referred patients (20% or more), and over 90% of patients had a wait time of either 3 – 6 months (36.5%) or more than 6 months (55.3%), with a result that 9 of 10 surgeons (89.4%) acknowledged that wait times were “not optimal” or unsatisfactory.
- c) 41.6% screened more than 10 patients “to identify a single surgical candidate” and the great majority of respondent surgeons (7 in 10 or 70.5%) did not rate their screening efficiency as optimal.
- d) Once a patient’s complaint was identified as amenable to surgery, 45.3% or nearly half of respondents, reported that patients waited for more than 6 months for their procedure and only 16.5% of surgeons (14 of 85) rated their surgical wait times as optimal.

8. Results – Attitudes to having LBP Clinicians Screen Patients. The survey asked not only about willingness to have chiropractors and other LBP clinicians screen patients being referred to spine surgeons, but also asked in what circumstances surgeons would want to see a patient after screening by a LBP clinician. Results were:

- a) Most surgeons (77.6% or 66 of 85) were either willing to work with LBP clinicians to screen their patients (54) or were already doing so (12). Of the others, most (14.1%) were “undecided,” and only 7 or 8.2% were opposed.

b) Busse et al. proposed 13 standard patient history components to be covered during screening by an LBP clinician, these being:

- Location of dominant pain
- History of presenting complaint
- Symptoms of “red flags”
- Symptoms of “yellow flags”
- Prior treatment for presenting complaint
- Current psychosocial function
- Prior history of presenting complaint
- Fear avoidance beliefs and behaviors
- Occupational demands
- Patient demographics
- Current use of intravenous drugs or steroids
- Review of imaging findings

Reg flags were defined as symptoms associated with cauda equina syndrome, fracture, infection, or cancer. *Yellow flags* were defined as receipt of disability benefits, ongoing litigation, current smoker, or high emotional stress.

Most respondents endorsed all 13 patient history components. Those endorsed by a large majority (90% or more) were the first 4 – location of dominant pain, history of presenting complaint, and symptoms of red flags and yellow flags.

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The Chiropractic World

Under the African Sun, at the International Convention Center in Durban, South Africa.

More than 750 delegates from 42 countries attended the Congress, the largest and most impressive meeting ever held in Africa. Many rated it "the best ever" chiropractic event in their lives.

"This was a wonderful Congress in very, very many respects", said Dr Bill Meeker, President, West Campus, Palmer College, which was one of the major sponsors together with Neuromechanical Innovations and Foot Levelers.

Beyond outstanding academic and social programs there were many special celebrations and events since this was the Silver Anniversary of the WFC which was formed 25 years ago in 1988. These included:

- A video from researchers worldwide honoring Dr Scott Halderman who was retiring as Chair of the WFC Research Council after 25 years of distinguished leadership.
- Renaming of the original research awards as the *NCMIC Louis Sportelli Research Awards* to honor both Dr Sportelli for his career of leadership in building research capacity for the profession, and the NCMIC Group Inc. for its long term funding of the main awards. From the 174 research submissions received, first and second prizes of US\$12,000 and US\$7,500 respectively were awarded for research papers from research teams affiliated with the Canadian Memorial Chiropractic College (CMCC) and led by Dr Jessica Wong and Dr Jairus Quesnele.
- Launch of an illustrated history titled *The Global Advance of Chiropractic: The World Federation of Chiropractic 1988-2013* authored by Dr Reed Phillips. This history documents the international expansion of the chiropractic profession during the past generation, is of exceptional quality, contains over 600 images, and may be purchased through the WFC's website www.wfc.org.
- Honor Awards for outstanding service towards the international growth of the chiropractic profession to Mr. Kent Greenawalt,

CEO, Foot Levelers, USA, Dr Jean Moss, President, CMCC, Canada, and Dr Anthony Metcalfe of the UK, a Past-President of the British Chiropractic Association, the European Chiropractors' Union (ECU) and the WFC.

One important goal of holding this WFC Congress in Africa was formation of a regional organization to represent and advance the chiropractic profession in Africa, the only world region without such a regional organization. That was achieved with the formation of the African Chiropractic Federation (ACF) at the WFC Assembly by chiropractic delegates from 13 nations – Botswana, Congo, Ethiopia, Ghana, Kenya, Liberia, Mauritius, Mozambique, Namibia, Nigeria, South Africa, Uganda and Zimbabwe.

The first ACF seminar meeting is to be held in Nairobi, Kenya from April 3-5, 2014, hosted by the Chiropractic Association of Kenya.

"Our Silver Anniversary Congress was such a success because of many partners and individuals," said WFC President Dr Dennis Richards of Australia, "but none more so that the members of the CASA Local Planning Committee led by Dr Caileen Walker and Dr Reg Engelbrecht. The WFC and everyone who attended this historic meeting are greatly indebted to them."

Special thanks are also due to many exhibitors and sponsors, led by Platinum Sponsor Neuromechanical Innovations (Dr Christopher Colloca, President). Many of these donated prizes to a fundraising raffle which raised over \$5,000 to support the inspirational work of Sister Brigitte Yengo DC, MD at her orphanage at Brazzaville in the Congo (www.SisterYengosChildren.org).

The next WFC Congress is to be held in Athens, Greece from May 14-16, 2015, together with the annual convention of the ECU and hosted by the Hellenic Chiropractic Association. WFC member associations in the Asia and Pacific Regions are being invited to bid to host the 2017 Congress.

Source: WFC news release.



Photo: Dr Gary Auerbach.

News and Views



Dr Jessica Wong of Toronto, Canada receives the Scott Haldeman Award, First Prize in the original research competition from (left) Dr Haldeman, Dr Louis Sportelli, Dr Greg Kawchuk and Dr Claire Johnson.



Dr Dennis Richards, WFC President, Dr Gary Auerbach, first WFC President 1989-92, and David Chapman-Smith, Secretary-General, cut the silver anniversary birthday cake at the Saturday Gala Banquet.



Sister Brigitte Yengo DC, MD and other African national delegates at the Banquet.

Durban Congress – Original Research Awards

The WFC original research competition, held every two years, is the most prestigious research competition in the chiropractic profession, with prizes totaling US\$45,000. Main awards are sponsored by the **NCMIC Group**, poster awards by the **International Board of Chiropractic Examiners**, and the **FICS sports chiropractic awards** by **Life University**. This year the competition attracted 186 submissions.

Main Awards – NCMIC Louis Sportelli Research Awards

First Prize - Scott Haldeman Award (\$12,000) *Examining the relationship between theory-driven policies and allowed lost-time back claims in workers' compensation: A system dynamics model* Jessica J. Wong, Marion McGregor, Silvano Mior, Patrick Loisel, Canada

Second Prize (\$7,500) *Changes in vertebral blood flow following various head positions and manipulation* Jairus Quesnele, John Triano, Greg Wells, Canada

Third Prize (\$5,000) *Brain activation induced by spinal movement: a novel and promising method for investigating neuroplastic changes in chronic low back pain* Michael Meier, Sabina Hotz-Boendermaker, Bart Boendermaker, Roger Luechinger, Kim Humphreys, Switzerland

Private Practice Award (\$3,000) *Evidence-based guidelines for the chiropractic treatment of adults with neck pain* Rick Ruegg, Martin Descarreaux, Roly Bryans, Phil Decina, Mireille Duranleau, Henri Marcoux, Brock Potter, Lynn Shaw, Robert Watkin, Eleanor White, Canada

Poster Awards

First prize (\$1,000) *Evaluation of a GP-referral multidisciplinary service for manual treatment of back and neck pain: an update* Jennifer Bolton, Mark Gurden, Marcel Morelli, Greg Sharp, Katie Baker, Nicola Betts, UK

Second prize (\$750) *Outcomes from MRI confirmed symptomatic cervical disc herniation patients treated with high velocity, low amplitude, spinal manipulative therapy: A prospective cohort study with 3 month follow-up* Cynthia Peterson, Christof Schmid, Serafin Leemann, Bernard Anklin, B. Kim Humphreys, Switzerland

African Region *The relative effectiveness of non-steroidal anti-inflammatory drugs (ibuprofen) and a taping method (Kinesio Taping Method) in the treatment of episodic tension-type headaches* Justin Henry, Charmaine Maria Korporaal, South Africa

Eastern Mediterranean Region *Treatment of chronic coccydynia by chiropractic manipulation per rectum under epidural sedation: a multiple case study* Nimrod Liram, Amir Hasharoni, Eliad Davidson, Israel

European Region *Children with headache: a demographic survey and treatment outcome of those presenting to a chiropractor* Susanne Lynge Rosing, Joyce Miller, UK

Latin American Region *Chiropractic in the treatment of musculoskeletal conditions in Brazilian Unified Health System's (SUS) users* Paulo Gomes Oliveira Neto, Thiana Paula Schmidt, Brazil

North American Region *Proprioceptive neurons in the cervical myodural bridge: a feedback mechanism of dural tension monitoring* Frank Scali, Matthew Pontell, Dennis Enix, USA

Pacific Region *Cervicogenic headache and spinal manipulative therapy: a retrospective case series* Torje Oesttun, Mats Thorbeck, Haakon Sagstuen, Baard Naess, Peter Tuchin, Australia

FICS Sports Chiropractic Awards

First prize (\$5,000) *The Immediate Effect of Sham Laser and Three Different Spinal Manipulative Protocols on Kicking Speed in Soccer Players* Kyle Deutschmann, Andrew Jones, Charmaine Korporaal, South Africa

Second prize (\$2,000) *The Effects of Instrument-Assisted Soft-Tissue Mobilization (IASTM) and Sham Microcurrent Therapy (MT) on Hamstring Flexibility When Performed on the Plantar Fascia of Healthy Subjects: A Pilot Study* Glen M Harris, Sana Tahir, Avesh Rakkar, Michelle Kang, Canada

Third prize (tied) (\$1,000) *The Combined Effect of Creatine and Sodium Bicarbonate Supplementation on Blood Lactate and Anaerobic Power in Young Taekwondo Players* Mohsen Kazemi, Seyed Abolollah Hashemvarzi, Zia Fallah Mohammadi, Canada and Iran

A Survey of Mental Hardiness and Mental Toughness in Professional Male Football Players Rainer Wieser, Haymo Thiel, UK

c) Busse et al. proposed 8 patient examination components, being:

- Standard orthopedic tests for low-back or low-back related leg pain.
- Straight leg raise, supine
- Lower limb vascular examination
- Orthopedic hip examination
- Lumbar spine range of motion
- Straight leg raise, seated
- Measurement for lower limb atrophy
- Waddell's signs for nonorganic pain

More than 60% of surgeons endorsed each of these components and only 9 respondents suggested additional items, indicating that the list was well-accepted and comprehensive.

d) There was strong endorsement (more than 85% of respondents), of the 4 findings Busse et al. gave as necessitating a surgical assessment:

- Signs or symptoms associated with a red flag condition
- Leg dominant pain
- Low-back or low-back related leg pain with correlating neurological findings
- Low-back or low-back related leg pain with correlating findings on imaging

e) The great majority of surgeons would want to confirm an indication for surgery themselves, whether clearly identified or suspected by an LBP clinician (88.2% and 89.4% respectively).

f) However a clear majority of them (75.3%, or 1 in 3) agreed that they would be comfortable “not assessing a patient with low-back or low-back related leg pain referred to their practice if clear indications for surgery were ruled out by a LBP clinician.” Another 17.6% were unsure – only 7.1% or fewer than 1 in 10 would still want to assess the patient themselves.

9. Conclusion. This survey was not about the willingness of Canadian spine surgeons to work collaboratively with chiropractors or other non-medical practitioners when patients have chosen to consult such practitioners for their problems. It was specifically about willingness where the chiropractor or other non-medical practitioner would be screening patients otherwise being sent for surgical consultation by their primary care medical doctors.

It reports a broad willingness to cooperate from spine surgeons whatever their age, number of years in practice and practice environment (academic, hospital based, private practice).

It should be noted, however, that this is in a healthcare system and environment where surgeons widely acknowledge inefficiencies, inappropriate delays, and their need to screen up to 10 patients to identify one surgical candidate. Attitudes may be different where different conditions apply.

As Busse et al. comment, an essential component of establishing LBP clinician screening of patients referred for surgical assessment will be training in a standardized approach to taking a patient history, and conducting an examination that incorporates items identified in their survey as expected and necessary.

Next research steps must include testing this model of screen-

ing and collaboration, and confirming the preliminary research evidence already published and reviewed by Busse et al. which reports that patients referred for surgical consults are in fact well-satisfied with screenings by other clinicians such as chiropractors and nurse practitioners.⁹

C. Conclusion

10. Is the new level of willingness to collaborate reported in this Canadian survey local to Canada, or North America, or just countries where the profession is well-established with a strong research base and recognition and regulation by government? The answer is no. Medical spine specialists in most countries have trained internationally, today the world is small, and there are calls everywhere for improved, evidence-based, cost-effective management of back and neck pain to address the huge and growing impact of disability from spinal disorders.¹

When the Eastern Mediterranean and Middle East Chiropractic Federation (EMMECF) and the World Federation of Chiropractic (WFC) proposed an interdisciplinary spine conference in Jordan in 2010 this was welcomed by local spine specialists. It led to a conference at the Jordan University of Science and Technology organized by Assistant Professor of Neurology Dr Khalid El-Salem, at which local orthopedic surgeons were joined by chiropractic experts Dr Scott Haldeman, Dr John Triano and Dr Silvano Mior.

This was followed by a second interdisciplinary spine conference in Beirut, Lebanon in June 2012, organized by the Near East Spine Society, with surgeons, pain specialists and other members from many Middle Eastern countries, and co-sponsored by the EMMECF and WFC. Several chiropractic speakers from the region included Dr Mohamad Raslan of the United Arab Emirates, who works in a multidisciplinary clinic in Dubai, and Dr Amy Bowzaylo, then Chair of the Department of Rehabilitation at the Saad Hospital in Saudi Arabia, which has six chiropractors on its multidisciplinary staff.

In Africa, where the chiropractic profession is only well-established in South Africa, chiropractors are welcomed as members of the South African Spine Society. But this openness is seen elsewhere.

When World Spine Care established its clinic in Shoshong, Botswana last year, in which primary spine care services are provided by chiropractors, the local orthopedic community was fully supportive. Clinic Director Geoff Outerbridge and other chiropractors have been given rights of referral for imaging and laboratory tests and to specialists as complete as awarded to chiropractors anywhere. In the past month representatives of the Chiropractic Association of Kenya have met with the leadership of the Kenyan Orthopedic Society and the Ministry of Health and received ready support for an interdisciplinary spine conference to be held in Nairobi next April.

In Latin America the Brazilian Spine Society (SBC – Sociedade Brasileira de Coluna) and the WFC have this year entered a scientific partnership under which the WFC is one of the sponsoring professional organizations of the SBC's journal Coluna/Columna (Spine in Portuguese/Spanish). The March issue has an editorial on the benefits to both professions and patients when the chiropractic and medical professions work together in spine care and research, written by WFC Research Council members Dr Eduardo Bracher

(Brazil) and Dr Scott Haldeman (USA). Brazilian chiropractic researcher Dr Caroline Kolberg has joined the editorial board, and was one of the chiropractors attending the SBC's annual conference in Florianopolis, Brazil last month.

Coluna/Columna is the leading spine journal in Latin America. Other sponsoring professional organizations include national societies for spine specialists in Colombia, Ecuador, Mexico and Venezuela, as well as Portugal, and the regional Latin American Spine Society.

Dr Bracher, mentioned above, is one of several chiropractors working in a spine care group and at the Health Promotion Institute at the Hospital Santa Catarina in Sao Paulo. At this Hospital, operated by one of the largest insurance companies in Brazil, Porto Seguro Saude, chiropractic and medical services are fully integrated with common electronic patient files.

11. Accordingly, this new spirit of cooperation in spine care is found internationally. Reasons, largely apparent from what has already been said in this article, include:

- Clearer evidence that traditional medical and surgical management is proving ineffective – cost of care is increasing but so is the burden of disability with back and neck pain now being the first and fourth largest causes of disability worldwide.
- Since the mid 1990s national and international evidence-based clinical guidelines from multidisciplinary expert panels that provide a similar model for medical and chiropractic management of patients with back and neck pain. The 95% or more of these patients with non-specific mechanical pain should not have bed rest and medications or, where pain persists, routine expensive imaging and invasive treatments (opioids, steroid injections, surgery). They should be managed on a biopsychosocial model with education and encouragement, maintenance of daily activities, and with a short course of NSAIDs or acetaminophen for pain control and/or spinal manipulative therapy for correction of mechanical joint and soft-tissue dysfunctions.^{6,10-13}
- Better evidence, from medical experts themselves and government agencies and insurers, and much greater public awareness, of the frequency and cost of adverse events from inappropriate and excessive use of medications and surgery.
- Greater maturity of the chiropractic profession, in terms of size internationally, educational standards, development of research and research capacity, and commitment to evidence-based practice and collaborative practice within mainstream health care systems.
- The continuing breakdown of the traditional medical monopoly in health care. Physicians and surgeons will be more ready to share spine care with chiropractors in a world where they must also respond to patient and public demand for direct access to many other health professionals with specialized knowledge and skills, from acupuncturists, massage therapists and physiotherapists to midwives, naturopaths and nurse practitioners.

12. So medical attitudes have changed. However it takes two to tango. To what extent are chiropractors and their professional organizations ready and able to reciprocate? To what extent are chiropractors willing to be team players, with all the skills, discipline and changed attitude that this requires? The answer to those questions will have a fundamental impact on the growth and fortunes of the profession in the next 10 years.

There is a huge new market in the management of patients with spinal disorders finally becoming available, those patients for whom there have been medical, employer, insurance and government barriers to chiropractic care. But how much access will chiropractors receive? Access will be given to those who provide quality and value - not as judged by chiropractors alone but also by medical colleagues and all other stakeholders in health care. 

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Professional Notes

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Acute LBP – Manipulation Better than NSAIDs

The evidence supporting the effectiveness of spinal manipulation increases with a new trial published in *Spine* in April and reporting that patients with acute, low-back pain improve much more in terms of both pain and disability, and improve more quickly, with manipulation in comparison with NSAIDs or placebo.

In this new randomized, controlled trial (RCT) from the University of Bremen in Germany 101 adult, ambulatory patients with acute, uncomplicated, mechanical low-back pain (under 48 hours, with no co-morbidities or referred leg pain) presenting at 5 general medical practices were allocated to one of 3 groups:

- A treatment group receiving side posture HVLA manipulation to an “identified lumbar segmental dysfunction” by German medical specialists trained in manipulation (described as the most popular technique used by them and as “almost identical to osteopathic manipulation”), plus placebo tablets. Two treatments were given, the second on Day 3.
- A treatment group receiving NSAIDs (diclofenac 50mg tablets 3 times a day) plus sham manipulation (sacroiliac joint traction on the opposite side to the dysfunction, together with an impulse on the sacrum).
- A control group receiving placebo tablets and sham manipulation.

During early months of recruitment of patients into the trial patients were doing so much better in the two treatment groups than the placebo group that the placebo arm of the trial was closed – and the article in *Spine* reports on the two treatment

groups only. The principal outcome measure was the Roland Morris Disability Questionnaire (self-rated improvement in disability) and secondary outcome measures included completion of a visual analogue scale or VAS (pain), an SF-12 questionnaire (quality of life) and recording of use of rescue medication.

Results, measured up to 12 weeks by blinded observers, were:

- After one week “there was a clear difference between the treatment groups” with the subjects receiving spinal manipulation showing a faster and greater reduction of disability on the Roland Morris Scale. Compared with pre-treatment values, mean reduction in disability in the spinal manipulation group at 12 weeks was 7.71 compared with 4.75 in the NSAIDs group. This difference “was highly significant.”
- Analysis of VAS pain scores also showed a faster and greater reduction in pain after manipulation.
- Rescue medication was calculated for both the average cumulative dose (numbers of 500mg paracetamol tablets taken) and for the number of days on which rescue medication was taken by subjects. Cumulative dose was 3 times higher for NSAIDs/diclofenac patients than manipulation patients (6.41 versus 2.22), and number of days almost twice as high (1.92 versus 1.19).

Noteworthy features of this trial are that patients were more acute than in most other trials – having experienced back pain for 1 to 2 days only, and responded excellently to early manipulation. Most patients experience delays that complicate recovery.

Further, manipulation produced markedly superior results to use of NSAIDs. Most current clinical guidelines for the management of acute back pain recommend each of NSAIDs and manipulation as alternatives. Many family physicians start patients on medication, only referring for spinal manipulation if back pain continues. This trial suggests manipulation should be the first line treatment of choice for many patients.

von Heymann, Schloemer et al. say that 18,000 German physicians have been certified as manual medicine subspecialists. This compares with a population of approximately 120 duly qualified chiropractors in Germany, where there is still no legislation regulating use of the title chiropractor.

It is interesting to observe in this trial that high-velocity, low-amplitude (HVLA) manipulation, commonly described as chiropractic manipulation in German case reports of adverse events after manipulation by non-chiropractors, is here described as osteopathic manipulation, especially since the traditional hallmark of osteopathic medicine is long-lever techniques not HVLA manipulation.

There were no significant adverse effects in the current trial – as indeed is the case in all published trials of spinal manipulation.

(von Heymann WJ, Schloemer P et al. (2013) *Spinal High-Velocity Low-Amplitude Manipulation in Acute Non-Specific Low-Back Pain* *Spine* 38:7 540-548.)

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