The Chiropractic Report

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Professional Notes

Chiropractic for LBP: Another Positive Trial

Michael Schneider DC, PhD, from the University of Pittsburg and Mitchell Haas DC, MA from the University of Western States, are principal investigators for another new randomized controlled trial published in the leading journal Spine and reporting that chiropractic management is superior to usual medical care for patients with acute and sub-acute back pain.

In summary:

• Purpose. The purpose of this study was to compare the effectiveness of manual thrust manipulation (MTM) with mechanical-assisted manipulation (MAM) and usual medical care (UMC) for adults with acute and sub-acute low-back pain (LBP) using a randomized controlled trial (RCT) with follow up for six months.

• Patients. The study participants were 107 adults (age 18 and over) with a new episode of LBP within the last three months. Exclusion criteria included any prior chiropractic, medical or physical

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To Adjust or To Manipulate?

The Role of Traditional Language in Chiropractic

A. Introduction

DO CHIROPRACTORS ADJUST or manipulate a joint? Are they seeking to treat or to correct a joint problem? Is that problem a subluxation or a dysfunction?

For many chiropractors internationally, educated in various university environments and practicing in various integrated healthcare settings, these questions are simply a matter of semantics of little concern. In the office their patients still receive their adjustments, but in reports to third party payors or other health professionals this is described as manipulation if that provides easier communication.

However for many others continued use of the profession's traditional language is a matter of core principle, and is deeply tied to their love of the profession and its practice and identity.

Accordingly, and as for many movements and organizations in society, use of language is a divisive and important issue for the chiropractic profession. That this is so is seen in the fact that the major topic for discussion at the World Federation of Chiropractic's Assembly in Athens, Greece this month is the use of traditional language by the profession. This issue of the Chiropractic Report provides a reflection on the subject. We see more heat than light in most discussions on language, and take a pragmatic approach. The two arms of this approach are:

• There should be respect for traditional language, and continued use where appropriate.

• However the primary purpose of language is effective communication, and there should be readiness to use more widely adopted and profession-neutral language where this improves communication and is therefore in the interest of patients and the profession.

Let's finish this introduction with an anecdote which illustrates the depth of emotion on language and the potential destructive force of that emotion. Some 20 years ago in Canada there was what was then a quite remarkable front page story in *The Medical Post,* a weekly newspaper for the medical profession. A young woman physician in Vancouver told how she had taken the plunge and gone to a chiropractor and received "spinal manipulation" for a whiplash injury, suffered in a motor vehicle accident, that was not responding to other care. She reported an excellent result, and encouraged her medical colleagues to consider the option of chiropractic care.

The letters to the editor in the following week's *Medical Post* featured one letter of response from a chiropractor. The physician was mistaken, he felt obliged to point out. Chiropractors do not provide spinal manipulation and they do not treat injuries. They adjust subluxations and patients heal themselves.

You and I know what he was trying to say. His medical readership was mystified.

We now look at:

• The origins of chiropractic language.

• A major government investigation of chiropractic that has much to tell us about use of language.

• How the World Health Organization, as an independent and important health policy body, deals with the situation.

• Conclusions.

We will show why inappropriate use of language can be a major impediment to the success of the profession in this era of integration and growth – but also why this is an unnecessary area of difficulty that can and should be easily avoided.

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B. Origins of Chiropractic Language

2. **DD Palmer.** In the preface of his 1910 text *The Science, Art of Philosophy of Chiropractic*, the profession's founder DD Palmer acknowledges that the principles of chiropractic "are not new. …I am not the first person to replace subluxated vertebrae, for this art has been practiced for thousands of years."[1] Davenport friends Dr Atkinson and Mr. Colville had inspired him to adopt and expand this art.

Palmer quotes a letter from Colville, written to him following Colville's visit to Paris in 1895, the year in which Palmer would found his new profession. In Paris, Colville watched lay doctors using spinal manipulation, and heard them explain that they were reviving an ancient Greek art. Most interestingly Palmer quotes this report from Colville: "I there heard of 'luxations and subluxations of the spinal column,' and of adjustments thereof… I occasionally heard a faint sharp clicking sound as the treatment proceeded."

Palmer chose the name chiropractic because of the Greek origins of his treatment method and then, as he says in his book, wanted to "clothe new ideas with suitable language". It seems that he received this language from Colville and Paris.

3. Perhaps the finest review of the place of chiropractic within the history of spinal manipulation is by Palmer College historians Wiese and Callendar.[2] They observe:

- The adjustment is a form of manipulation.
- Palmer "never claimed to have been the first to replace subluxated vertebrae".
- He did claim "to have been the first to use the spinous and transverse processes as levers" – but was wrong. They quote others who were doing just that at that time.

Wiese and Callendar open their excellent chapter on The History of Spinal Manipulation with this delightful quote from Whitehead: "Everything of importance has been said before by someone who did not discover it."

4. **Defending Prosecutions.** DD Palmer may have developed language to clothe his new profession, but that language was expanded and locked in to fight legal battles and keep chiropractors out of prison.

The early chiropractors faced prosecution for the illegal practice of medicine, or, where osteopathy was licensed, of osteopathy. The Universal Chiropractors Association (UCA) was founded by BJ Palmer principally to defend such prosecutions.

The first prosecutions were in the State of Wisconsin in 1906 where the UCA hired the prominent lawyer and state senator Tom Morris. He devised successful defenses based largely on language differentiating chiropractic from osteopathy and medicine. Chiropractors did not *diagnose* or *treat* a *condition;* they *analysed* and *corrected* or *adjusted* an underlying cause of disease called a *subluxation.*

In his fine history, *BJ of Davenport: The Early Years,* Keating covers this era well. He explains how Morris, elevated to Lieutenant Governor of Wisconsin in 1907-1910, "brought both his considerable legal talent and his national respectability to the chiropractors' cause" while traveling the country for 22 years to supervise 3,300 cases with an 85-90% success record. In the words of BJ Palmer:

"We are always mindful of those early days when UCA… used various expedients to defeat medical court prosecutions. We legally squirmed this way and that, here and there. We did not diagnose, treat, or cure disease. We analyzed, adjusted cause, and Innate in patient cured. "[4]

The new lexicon was dismissed by Dr John Howard, founder of the National College of Chiropractic, as semantic maneuvering. "In the early days it was necessary to protect the "child" (as D.D. was wont to refer to his Chiropractic) by evasive terminology in order to avoid the chill and ice of the law and "analysis" was used for diagnosis, "adjustment" was employed for treatment, "pressure on the nerve" was used for reflex stimulation or inhibition, etc. These terms were garments to protect the child until legal clothing could be secured."

5. So grew what became the traditional lexicon of the chiropractic profession in North America, the only world region with chiropractic education and large of numbers of practitioners through to the 1970s. At that time the profession was still under legal and medical attack in many jurisdictions. It continued to practice in isolation from the rest of the healthcare world, answerable only to its patients. It was free to adopt whatever terms of art or lexicon it chose. It's now traditional language remained important.

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C. The Language of Interdependence Illustrated

6. In *The 7 Habits of Highly Effective People* Stephen Covey agrees that when a person or organization moves from dependence to independence that is an important achievement. Doctors of chiropractic are justly proud for having established an independent profession.

However, says Covey, to be highly effective and successful requires a move from independence to interdependence. This involves partnerships with others for mutual benefit – win-win situations. For chiropractic it requires partnerships

with other health professions, the wider research community, private and government insurers and all other stakeholders in healthcare. If the average family physician and nurse practitioner and athletic trainer and massage therapist is recommending chiropractic care the profession goes much further than it can alone.

To flourish in an interdependent world a profession needs to use language understood by and common to the world at large. The chiropractor who wrote to *The Medical Post* failed to understand that when he insisted that a chiropractic adjustment was not a manipulation.

In this review of chiropractic and its use of language we have reached the 1970s. An excellent illustration from that time of the unnecessary barrier that chiropractic traditional language can provide for a profession moving from independence to interdependence is found in the 1979 report of a commission of inquiry into chiropractic in New Zealand.[3] This thorough inquiry, following a large public petition to government asking for funding for chiropractic services under the national healthcare plan, was conducted by three commissioners who knew nothing about the profession - a lawyer, an educational expert and a professor of chemistry. At the time the chiropractic profession was recognized and regulated by law in the country, but there was a medical ethic against referral of patients to chiropractors. The New Zealand Medical Association (NZMA) strenuously opposed the chiropractic profession, and indeed all spinal manipulation, as dangerous and ineffective.

The chiropractic subluxation, how it was defined and whether it even existed, were key points of controversy before the commission. On this:

• The NZMA pointed out that subluxation was a medical term meaning a partial dislocation of a joint, a structural problem that was always visible on static x-ray when present. Chiropractors claimed they found and treated subluxation in patients where nothing was visible on x-ray. Chiropractic subluxation was a meaningless figment of the imagination.

• The first chiropractic witness to give evidence to the commission, a Palmer graduate named Dr Clive Mudgway, was cross-examined for two full days on subluxation. Nearly all subsequent chiropractic witnesses, including international experts called such as Dr Terry Yochum and Dr Scott Haldeman, were grilled on subluxation. In closing submissions after 15 months of hearings and investigation the NZMA maintained its position that the chiropractic subluxation was a myth.

• The commission's report, understandably, has a whole chapter devoted to subluxation, in which the commission:

• Confirms that "the concept of vertebral subluxation is central to chiropractic", and that the NZMA took the direct view and "argued that chiropractic subluxations exist only in the chiropractor's imagination."

• Explains the fundamental difference between a medical view of subluxation, seen as a structural problem, and a chiropractic view, on which subluxation is essentially a functional problem with neurological involvement, no more visible on static x-ray "than a limp or a headache or any other functional problem."

• Observes that "it is therefore understandable why medical practitioners and chiropractors get their wires crossed."

• Accepts that the chiropractic subluxation is a valid clinical entity, despite its incomplete scientific explanation and the NZMA's arguments. Chapter 9 on subluxation concludes: "we accept, for the purposes of this inquiry, that a chiropractor is equipped by his training and skill to locate and relieve a condition which for want of a better term he calls a subluxation."

7. This commission produced a report with recommendations that were overall positive and that represented a substantial victory for the profession. The profession worldwide took notice and celebrated. However the commission's report was written for the government and the public. It needed to be persuasive to them, and furthermore to the NZMA and others who had spoken in opposition to chiropractic.

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Table 1. New Zealand Commission – Some Principal Findings

• Chiropractic is a branch of the healing arts specialising in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level.

• Chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy.

• General medical practitioners and physiotherapists have no adequate training in spinal manual therapy, though a few have acquired skill in it subsequent to graduation.

• Spinal manual therapy in the hands of a registered chiropractor is safe.

• The education and training of a registered chiropractor are sufficient to enable him to determine whether there are contraindications to spinal manual therapy in a particular case, and whether the patient should have medical care instead of or as well as chiropractic care.

• Spinal manual therapy can be effective in relieving musculoskeletal symptoms such a s back pain, and other symptoms known to respond to such therapy, such as migraine.

• In a limited number of cases where there are organic and/or visceral symptoms, chiropractic treatment may provide relief, but his is unpredictable, and in such cases the patient should be under concurrent medical care if that is practicable.

• Although the precise nature of the biomechanical dysfunction which chiropractors claim to treat has not yet been demonstrated scientifically, and although the precise reasons why spinal manual therapy provides relief have not yet been scientifically explained, chiropractors have reasonable grounds based on clinical evidence for their belief that symptoms of the kind described above can respond beneficially to spinal manual therapy.

• In the public interest and in the interests of patients there must be no impediment to full professional co-operation between chiropractors and medical practitioners.

• Chiropractors should, in the public interest, be accepted as partners in the general health care system. No other health professional is as well qualified by his general training to carry out a diagnosis for spinal mechanical dysfunction or to perform spinal manual therapy.

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therapy treatment for this episode, current use of prescription drugs and leg pain distal to the knee.

• Treatment Groups. Patients were randomly allocated to one of three treatment groups:

• MTM. They received HVLA side-posture chiropractic manipulation, at levels indicated by static and motion palpation. Treatment was twice weekly for four weeks.

• MAM. Treatment in the prone position by a certified Activator Methods chiropractor using an Activator, with segmental level determined by palpation and Activator leg-length analysis. Again treatment was twice weekly for four weeks.

• UMC. Patients saw a physical medicine and rehabilitation physician, with an initial visit (30 minutes) then follow up visits during weeks two and four (15 minutes each). Patients were given care consistent with current clinical guidelines – OTC medications and advice to avoid bed rest, stay physically active, that the pain was typically self-limiting, etc.

The same clinician provided all care within each treatment group – and had more than 15 years' experience and "provided strong enthusiasm for his respective treatment approach." All patients received the same educational booklet.

• Outcome Measures. The primary outcome measure was the Oswestry LBP Disability Index, the secondary measure was three pain scales – for current pain, worst pain in the past 24 hours, and average pain during the past week. At baseline, or the beginning of the trial, patients were well-balanced across the three groups and had moderate average disability (33.9%) and pain (5.7 on a 10 point scale).

• Results. Interestingly, results were calculated not only for groups as a whole but also for sub-groups that demonstrated major improvement.

• At the point of primary interest – conclusion of treatment at four weeks - MTM patients had significantly reduced pain and disability compared with MAM and UMC patients. However there was no significant difference between MAM and UMC.

• At four weeks 50% of the MTM group achieved at least a 50% reduction in disability which compared with 39% in the UMC group and 16% in the MAM group.

• At four weeks 76% of the MTM group achieved at least a 30% reduction in disability compared with approximately 50% of each of the MAM and UMC groups.

• With respect to pain reduction at four weeks, 76% of the MTM group had more than 50% reduction compared with 47% of MAM and 41% of UMC. 94% of the MTM group achieved greater than 30% reduction, which compared with 69% of MAM and 56% of UMC.

• Schneider, Haas et al. conclude that the greater short-term reductions in pain and disability for those in the MTM group "were both statistically significant and clinically meaningful."

Finally, what makes this paper particularly impressive and persuasive is the measured discussion and analysis by Schneider, Haas et al. They avoid overclaim and acknowledge that the superiority of chiropractic manipulation in their trial was comparatively modest. However they point out it is "still relevant to patients with back pain" which is a condition for which patient preferences need to be considered.

Their basic message to their medical audience is that chiropractic manipulation is effective, different patients will have different preferences as to whether they favor medication or not, and that treatment options including manipulation need to be given to all patients – particularly since patients get better results with the treatments they prefer.

(Schneider M, Haas M et al. (2015) *Comparison of Spinal Manipulation Methods and Usual Medical Care for Acute and Subacute Low-Back Pain*. SPINE 40(4)209-217.)

Other Research

1. **Brazil – Chiropractic Adjustment: Mechanisms of Action**

There is much ongoing chiropractic research not only into whether different forms of chiropractic treatment work – but also how. JMPT has just published a new study by Carolina Kolberg BSc (Chiro), PhD and colleagues from the Federal University of Rio Grande do Sul, Porto Alegre, Brazil, reporting that a course of chiropractic manipulation (twice weekly for five weeks) increased the blood levels of two antioxidant enzymes (superoxide dismutase (SOD) and glutathione peroxidase (GPx)) in 23 patients with chronic neck or back pain.

They conclude that "it is possible that changes in these enzymes might be related to the analgesic effect of HVLA spinal manipulation". As they explain:

• In pain conditions there is a neuronal excitability giving increased production of reactive oxygen and nitrogen species (RS).

• This increase in RS "seems to be essential not only for the induction but also for the maintenance of central sensitization in the spinal cord."

• This oxidative stress may cause cell damage.

• Biological systems have evolved mechanisms to protect against this damage. Enzymes relevant to these mechanisms are superoxide dismutase (SOD), catalase, and glutathione peroxidase (GPx).

In a previous study Kolberg, Horst et al. demonstrated an increase in systemic catalase activity after 6 sessions of HVLA manipulation in 2 weeks of treatment. There was a tendency only towards increased GPx activity – suggesting a significant increase would require a longer period of treatment. That was the reason for this second study - where longer treatment did show a significant increase in GPx and SOD.

(Kolberg C, Horst A et al. (2015) *Peripheral Oxidative Stress Blood Markers in Patients With Chronic Back or Neck Pain Treated With*

High-Velocity, Low-Amplitude Manipulation. J Manipulative Physiol Ther; 38:119-129)

2. **Canada – Chiropractic Boot Camp for Neurogenic Claudication**

Last year's Association of Chiropractic Colleges Research Agenda Conference (ACC RAC) award-winning paper by Carlo Ammendolia DC, PhD and Ngai Chow BSc, DC on their Boot Camp Program for patients with degenerative lumbar spinal stenosis (DLSS) has now been published in JMPT. It is only a retrospective case series, but is significant because:

• Neurogenic claudication from DLSS is a leading cause of pain, disability and loss of independence in older adults, often leading to inability to walk.

• The ageing population is increasing.

• No non-surgical treatment method has good evidence of effectiveness.

• Here is preliminary evidence of effectiveness of a new chiropractic approach, delivered in a major hospital in Toronto and combining "chiropractic manual therapy", education and advice.

• The authors acknowledge the need for a randomized controlled trial and are proceeding to do such a trial.

Points on this study are:

• It reports results on a consecutive series on 49 patients with average age 70 years who received a six-week, structured, multimodal and self-management training program developed by Ammendolia and known as his Boot Camp Program for Lumbar Spinal Stenosis. The goal is providing patients with effective self-management by means of "the knowledge, skills, self-confidence and physical capacity to manage their symptoms and maximize their function on their own."

• The program involves one on one sessions with each patient, up to three times per week depending upon the severity of symptoms, and including:

• Education. Education on problem solving, relaxation, body positioning etc. to maximize function "particularly walking ability."

• Exercises. Muscle stretching, strengthening and conditioning exercises to improve overall back and lower extremity fitness and facilitate lumbar flexion.

• Manual Therapy. All patients receive chiropractic joint and soft tissue therapies based on identified functional impairments and aimed at improving lumbar spine intersegmental flexion.

• Results at six weeks (end of treatment program) were based on these patient-centered outcome measures:

• Physical Function. The physical performance scale of the Swiss Spinal Stenosis Questionnaire (SSS).

• Symptom Severity. The symptom severity scale of the SSS.

• Functional Disability. The Oswestry Disability Index (ODI).

• Leg and back pain intensity while walking. An 11 point numerical scale (NRS).

• Treatment Satisfaction. The treatment satisfaction scale of the SSS questionnaire.

• In these patients with average duration of 11 years for back pain and 8.6 years for leg pain "all outcomes demonstrated statistically significant and clinically important improvements."

(Ammendolia C, Chow N (2015) *Clinical Outcomes for Neurogenic Claudication Using a Multimodal Program for Lumbar Spinal Stenosis: A Retrospective Study*. J Manipulative Physiol Ther 38:188-194.)

World Notes

Chiropractic in Norway

The results of two new surveys of the profession in Norway have just been published in Chiropractic and Manual Therapies and are of interest – first to see what is happening in a country where the profession is expanding rapidly but has no chiropractic college of its own and many graduates from Australia, the UK (largest number recently) and the USA, second to compare with other countries.

Has there been a recent national survey where you live and practice? Points are:

• As of 2014 Norway had 650 chiropractors, 90% of whom were members of the Norwegian Chiropractors' Association. This represents a fivefold increase in the last 20 years, but there will be about 1,000 chiropractors by 2020 as there are approximately 300 students currently in chiropractic college.

• Chiropractic has been regulated in Norway since 1989, for the past 15 years the NCA has pushed for a mainstream collaborative evidence-based profession, and since 2006 chiropractors have had expanded legal rights which include direct referrals to medical specialists, authorization of sick leave/disability and funding for services under the national health care system. The chiropractor/population ratio is the highest in Europe

• Two surveys were given to all 530 registered chiropractors in Norway in 2011, one to all chiropractors (response rate 61%) and the other to all chiropractors who owned clinics (response rate 71%). Those who responded were representative of all. The surveys were based on similar ones in Denmark in 2010.

• A major conclusion was that "There is a clear difference from the earlier practice pattern in that intra- and inter-professional collaboration is more common and it is considered desirable. The profession seems to follow the modern trends in evidence-based practice by using X-rays more sparingly than previously, adhering to guidelines and being positive about research."

• See the paper, available online free with open access, for much interesting detail. On clinical settings for example:

• Most (61%) had more than four treatment rooms in their clinic, about 75% of clinics consisted of more than one chiropractor, "almost half included at least one physiotherapist and one additional health practitioner (usually a massage therapist)", and "10% of the clinics reported to have a general practitioner linked to the clinic".

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There may have been weeks of evidence and a whole chapter on the central issue of subluxation. There was similar debate on the significance of the term adjustment. But these terms, notably, are completely absent from the commission's principal findings and recommendations. Relevant ones are shown in Table 1 (*see page 3*). Look at the choice of language in these findings, the first of which is:

"Chiropractic is a branch of the healing arts specialising in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level."

As we have already suggested, there is a considerable lesson for the profession in this.

D. WHO's Chiropractic Lexicon

8. Since the 1980s the roles of the chiropractic profession, spinal manipulation, and all manual therapies have been growing in acceptance and use in national healthcare systems worldwide. Back and neck pain are primary causes of disability and evidence-based, clinical guidelines from multidisciplinary and medical panels recommend spinal manipulation and mobilization as being among the first options for care. Much of the research supporting these guidelines is from chiropractic researchers.

These changes have generated interest and policy with respect to chiropractic at the world's central health policy agency, the World Health Organization (WHO), which is the United Nations' agency for health-related matters. In 2005 WHO published its *WHO Guidelines on Basic Training and Safety in Chiropractic,* recommending to governments that their national healthcare systems should include chiropractic services, and providing the minimum recommended educational requirements for regulation and practice. How does WHO describe chiropractic and define its traditional language? See Table 2 for its definitions of adjustment, chiropractic, joint manipulation, joint mobilization, spinal manipulative therapy and subluxation. Observations are:

- An adjustment may be a joint manipulation or joint mobilization, and all three are forms of spinal manipulative therapy.
- In the definition of chiropractic the words adjustment and manipulation are used interchangeably, paving the way for chiropractors to adopt traditional language in the clinic (patients getting their adjustments) but more inclusive language externally.
- Subluxation requires a footnote, because the chiropractic definition conflicts with the medical definition. However, on WHO's definition, subluxation is simply a chiropractic term for "a lesion or dysfunction in a joint or motion segment."
- Many readers will see this as a realistic and helpful approach to use of language. On one hand WHO uses and is respectful of traditional language. On the other hand it provides alternative common language that explains and demystifies chiropractic terminology for the Minister of Health from Thailand, the Dean of Medicine from Egypt, the average member of the public and all those who have little or no knowledge of the profession.

Table 2. WHO Guidelines – Glossary of Chiropractic Terms

Adjustment

Any chiropractic therapeutic procedure that ultimately uses controlled force, leverage, direction, amplitude and velocity, which is applied to specific joints and adjacent tissues. Chiropractors commonly use such procedures to influence joint and neurophysiological function.

Chiropractic

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

Joint Manipulation

A manual procedure involving directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit.

Join Mobilization

A manual procedure without thrust, during which a joint normally remains within its physiological range of motion.

Spinal Manipulative Therapy

Includes all procedures where the hands or mechanical devices are used to mobilize, adjust, manipulative, apply traction, massage, stimulate or otherwise influence the spine and paraspinal tissues with the aim of influencing the patient's health.

Subluxation*

A lesion or dysfunction in a joint or motion segment in which alignment, movement integrity and/or physiological function are altered, although contact between joint surfaces remains intact. It is essentially a functional entity, which may influence biomechanical neural integrity.

*This definition is different from the current medical definition, in which subluxation is a significant structural displacement, and therefore visible on static imaging studies.

E. Conclusions

9. Over the years there has been much internal debate and anxiety over appropriate use of language in chiropractic education and practice. In some quarters it continues. Numerous definitions of subluxation have been advanced and, unfathomably, some suggest the concept should be abandoned because it is indefinable. Our letter writer to *The Medical Post* is passionate about the supposed distinction between an adjustment and a manipulation.

This summary tour we have had through the profession's development and use of language suggests the following conclusions:

- DD Palmer was simply building on a long tradition of spinal manipulative therapy when he founded the chiropractic profession. He probably took the terms subluxation and adjustment from European lay healers or doctors, adopting the terms to give distinctiveness and market attention to his new movement.
- This distinct language became entrenched because of its importance in defending against prosecution for practicing medicine or osteopathy without a license. New language could

be adopted and could flourish because the profession was small and practiced in isolation and by its own rules.

• Whatever the reasons, the traditional terminology became part of the heritage and identity of the profession. Chiropractors liked the apparent uniqueness of the adjustment, but just as much patients liked to announce "I need an adjustment". (On the other hand very few patients had much idea of what a subluxation was, though they posed as listening attentively because they could see it was important to their chiropractors.)

• There is no reason why chiropractors should not continue to adjust and correct subluxations in their offices or, if they prefer, use spinal manipulation to treat joint dysfunction. People and practice settings are different. Either use of terminology makes sense. The time has passed when there are compelling reasons for uniformity – or any likelihood of it in what is now a large, worldwide profession.

(An interesting point overlooked by many in these disputes over terminology is that today many chiropractors practice in countries with languages that have no words that are an accurate translation of adjustment or subluxation – for example Afrikaans in South Africa and Korean in Korea.)

• External to a chiropractic practice, however, use of the word subluxation is generally problematical.[5] This is because the medical profession, the dominant speech community in healthcare, has a competing and contradictory meaning for the word. (In the 19th century as Terrett reports[6], that was not so, but that is a historical point of little relevance now.)

10. Will there still be a heated discussion about the role of traditional language in chiropractic? Given human nature and the frequency of dispute about language in life in general, yes of course there will be. But this review suggests there is no need. The formerly valid reasons for insisting on using a unique chiropractic lexicon with the rest of the world have gone. Chiropractic is defined by its unique education, philosophy, principles and range of clinical skills, not by its language. TCR

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3 Chiropractic in New Zealand: Report of the Commission of Inquiry (1979) Hasselberg, Government Printer, Wellington, New Zealand.

4 Keating JC (1997) B.J. of Davenport: The Early Years of Chiropractic, Association for the History of Chiropractic, Davenport, Iowa; 65.

5 An exception is the US Medicare program which, for historical reasons, still links reimbursement to correction of a subluxation.

6 Terrett A (1987) The Search for the Subluxation: An Investigation of Medical Literature to 1985, Chiropractic History 7(1):29-33.

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• The most common treatment approaches ("those used on more than 50% of patients") were manipulation (97%), soft-tissue techniques (80%), and instructions on home exercises (67%).

f) "Despite the high density of chiropractors in Norway, as compared to other countries, only a few chiropractors reported working part time and none of them were registered as being unemployed." However "only very few are employed in hospitals and research positions". A career path for academic chiropractors will only come, the authors note, when there is university-based chiropractic education within Norway. The NCA is currently in productive negotiations with two universities and the authorities on this.

(Kvammen OC, Leboeuf-Yde, C (2014) *The Chiropractic Profession in Norway 2011. Chiropractic and Manual Therapies* 22:44.)

Mexico – Three Schools and the Profession Grows

With the opening of a school of chiropractic at the University of Veracruz in 2013, Mexico now has three chiropractic programs and 800 graduates in recent years. This brings the total number of chiropractors in Mexico to approximately 900.

During March Dr Carlos Ayres of Peru, Latin America representative on the Council of the World Federation of Chiropractic (WFC) and Past President of the Latin American Federation of Chiropractic (FLAQ), visited all three schools and leaders of the profession on behalf of the WFC and reported. With him was Dr Sira Borges, FLAQ Executive Director. Here are highlights from Dr Ayres' report on the three schools:

The first and most established chiropractic program is at the State University of the Valley of Ecatapec (UNEVE), to the north of Mexico City, where we were met by the Dean Dr Angel Fernandez and had the opportunity to address faculty and students. There are 200 students in the program, which like all three programs in Mexico is in a public university, and UNEVE has already graduated some 600 chiropractors. The campus is impressive.

On March 17-18 we traveled to the University of Veracruz on the east coast where we were met by Dr Pedro Gutiérrez, Dean of the School of Medicine, and Dr Jorge Castillo, a Logan College graduate who is Dean of the School of Chiropractic. As in Denmark and Switzerland, the chiropractic program is within the School of Medicine, with chiropractic and medical students taking many of their classes together. There are 60 chiropractic students and we had a chance to address them. The biggest challenge for the program is attracting qualified chiropractic faculty.

On March 19-20 we traveled to the State University of the Valley of Toluca (UNEVT), which is to the south west of Mexico City, where we met with Dr Francisco Lopez Millan, Dean, Dr Roberto Cortes, Program Director, and faculty member Dr Noe Velasquez. UNEVT has graduated 200 students during the past 3 years. They see about 200 patients daily in their spacious, modern and attractive on-site clinic. There is a second clinic at UNEVT's campus at Valle de Bravo about an hour away.

On March 20 we were joined by Dr Oscar Otero of Puerto Rico and Dr Brent McNabb of Wisconsin, USA in presenting a seminar for students. This was very well received – we were asked to return to give another.

*Dr Ayres (*center right*) and Dr Borges with UNEVE Dean Dr Jose Angel Fernandez (*center*) and faculty.*

*Drs Ayres and Borges with University of Veracruz faculty including Dr Gutiérrez, Dean of Medicine (*second right*) and Dr Castillo, Dean of Chiropractic (*back row, left*)*

USA – Harvard Health Review on Chiropractic

You can register free online for the Harvard Health Review, from the Harvard Medical School, which will bring you health news almost daily. See this recent positive item on chiropractic.

Chiropractic Care for Pain Relief

Chiropractic is a health care system that holds that the structure of the body, particularly the spine, affects the function of every part of the body. Chiropractors try to correct the body's alignment to relieve pain and improve function and to help the body heal itself.

While the mainstay of chiropractic is spinal manipulation chiropractic care now includes a wide variety of other treatments, including manual or manipulative therapies, postural and exercise education, ergonomic training (how to walk, sit, and stand to limit back strain), nutritional consultation, and even ultrasound and laser therapies. In addition, chiropractors today often work in conjunction with primary care doctors, pain experts, and surgeons to treat patients with pain.

Most research on chiropractic has focused on spinal manipulation for back pain. Chiropractic treatment for many other problems – including other musculoskeletal pain, headaches, asthma, carpal tunnel symdrome, and fibromyalgia – has also been studied. A recent review concluded that chiropractic spinal manipulation may be helpful for back pain, migraine, neck pain, and whiplash.

There have been reports of serious complications, including stroke, following spinal manipulation of the neck, although this is very rare and some studies suggest this may not be directly caused by the treatment.

"Spinal manipulation" is a generic term used for any kind of therapeutic movement of the spine, but used more precisely it is the application of quick but strong pressure on a joint between two vertebrae of the spine. That pressure twists or rotates the joint beyond its normal range of motion and causes a sharp cracking noise. That distinctive noise is believed to be caused by the breaking of a vacuum or the release of a bubble into the synovial fluid, the clear, thick fluid that lubricates the spinal and other joints. Spinal manipulation can be done either directly by pushing on the vertebrae or indirectly by twisting the neck or upper part of the body. It should be done to only one spinal joint at a time. Chiropractors and other practitioners accomplish this by positioning the body so the force they exert is focused on one joint while parts of the spine above and below it are held very still. Most spinal manipulation treatments take somewhere between 10 and 20 minutes and are scheduled two or three times a week initially. Look for improvements in your symptoms after a couple of weeks.

In addition, a chiropractor may advise you about changing your biomechanics and posture and suggest other treatments and techniques. The ultimate goal of chiropractic is to help relieve pain and help patients better manage their condition at home.

(Chiropractic Care for Pain Relief, Harvard Health Publications, Harvard Medical School, February)

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