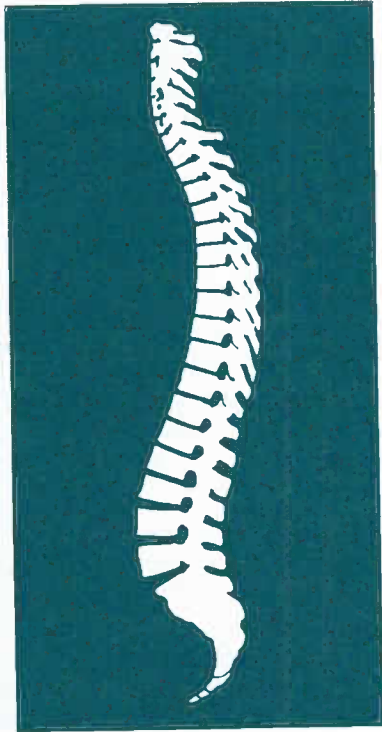


THE CHIROPRACTIC REPORT

Editor: David Chapman-Smith LL.B. (Hons.)

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PROFESSIONAL NOTES

The Real Response to Bad News

In 1998 a patient died following chiropractic treatment in Canada. This event, a first in the history of the Canadian profession, drew extensive media coverage. The Canadian Chiropractic Association commissioned a national poll to assess the impact.

Key findings of the Angus Reid random telephone survey of 1,515 Canadian adults, performed last November about one month after the media scare, are that only 2% of Canadians had heard of this incident and felt that chiropractic was not safe, 83% said that a woman dying of a stroke after undergoing a chiropractic treatment would make no difference to them approaching a chiropractor, and that – even after national publicity of this unfortunate event – lack of knowledge of the educational qualifications of chiropractors was a much higher impediment to non-users consulting a chiropractor than risk of harm. More detailed findings include:

- 15% of the respondents had used chiropractic services during the past 6 months

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COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) Its Definition, Use and Significance to the Chiropractic Profession

A. INTRODUCTION

In the early 1990s, when the concept of alternative medicine broke into new prominence and health authorities decided chiropractic was a part of it, chiropractors were immediately uncomfortable. For example:

a) In Australia RMIT University in Melbourne, which has schools of chiropractic, osteopathy and traditional Chinese medicine, indicated it was going to combine them in a Department of Complementary Medicine. The Chiropractors' Association of Australia, responding to membership outcry, voiced strong opposition. Chiropractic was a separate, distinct and mainstream profession. It was no more *complementary* or *alternative* than the medical or dental professions, and it certainly wasn't *medicine*. (In due course RMIT University created a Department of Chiropractic, Osteopathy and Complementary Medicine.)

b) In 1993 the US chiropractic profession responded to a national survey from Eisenberg et al of Harvard, which was titled *Unconventional Medicine in the United States*¹ and placed chiropractic under this title together with folk remedies, energy healing and commercial weight-loss programs, by explaining that chiropractic was neither *unconventional* nor *alternative* nor *medicine* but simply *chiropractic* – a separate profession recognized and licensed in all 50 states since the 1970s.

c) In 1995 in Denmark, where chiropractic services were fully integrated into the national health care system, the Danish Chiropractors' Association responded to this outside labelling of the profession as *unconventional* or *alternative* by submitting the following draft policy to the World Federation of Chiropractic (WFC) for adoption:

"WHEREAS there is increasing use of the term *alternative* in the description of health care professions.

AND WHEREAS this term is often used to suggest that alternative medicine or health care is not as accepted or based on scientific principles or mainstream as is modern medical practice.

AND WHEREAS the chiropractic profession is sometimes referred to as an alternative profession, notwithstanding the fact that it is based on the same anatomical and physiological sciences as is modern medical practice, and is fully integrated by legislation into the health care systems of many countries throughout the world.

AND WHEREAS there is sound scientific evidence or commonly accepted clinical experience supporting the safety and effectiveness of chiropractic treatments, including joint adjustment or manipulation, so that these treatments must now properly be viewed as conventional and accepted rather than alternative and unproven.

NOW THEREFORE IT IS RESOLVED that it is inappropriate to refer to the chiropractic profession as an alternative profession . . . (as it is) a mainstream profession the services of which are integral to a successful, modern health care system."

This summarized chiropractic concerns. The response to the WFC's survey of its member national associations in over 60 countries was virtually unanimous support for the DCA position.

1. However, by the time the Danish resolution came before the WFC Assembly in June 1997 chiropractors were much less certain that identification with alternative or complementary medicine was inappropriate. A policy position that had resounding support 12 months previously was tabled until 1999, with the Australian and US delegations drawing attention to the power and depth of the public swing to acceptance and use of alternative medicine. This was forcing government and medical authorities to acknowledge and respond to a fundamental shift in societal attitudes about health care. If, as was the case, chiropractic was being seen as the most prominent example of alternative medicine – in terms of professional development and

continued from page 1

NORTH AMERICA

– up from an annual usage of 11% in 1994/95 – with a high of 22% in the Western provinces (BC, Alberta and Saskatchewan), 16% in Ontario, and a low of 3% in Atlantic Canada.

27% were users but not in the past six months, 5% were potential users (thinking of consulting a chiropractor) and 53% were non-users (principal reasons being “I believe I have no need” (75%) and “I do not see any benefits”. (16%)).

- 90% agreed that “chiropractic treatment is good for certain people” and 71% that “chiropractic treatments are safe.”
- Of the 29% who thought chiropractic treatment was *not* safe, only about 1 in 5 (22%) said this was because “treatment can be dangerous”. Almost equally strong reasons were “chiropractors are not qualified” (20%), “I have heard of bad experiences” (18%) and “I do not believe in chiropractic” (18%).

6% of this sub-group had “knowledge of a woman dying”. This means that only 2% of the whole sample had heard of this incident and felt that chiropractic was not safe – very different from the impression of the impact of the incident held by chiropractors.

- Of the total sample unaided recall or awareness of the incident was 30%, but this was focused heavily in the province where the incident occurred, Saskatchewan (73%) and was much lower elsewhere in Canada (13%).

• Message testing – testing the impact of specific statements made to respondents – showed that the message most likely to improve opinions of chiropractors was “chiropractors are highly trained professionals” (37%). This had approximately twice the power of any other message including “there are minimal risks associated with chiropractic treatment” (23%).

• Angus Reid, echoing earlier survey work by the CCA in Canada and the ACA and ICA in the US, conclude that the main message chiropractors need to give the public relates to their education, qualifications and professional standing. Even immediately after this incident the major public concern is not safety. Any communications campaign should have an educational focus “promoting positive information” . . . rather than negative information about risk rates, and the goal should be “to enhance public opinion about the chiropractic profession . . . not necessarily to sell people on starting to use chiropractic.”

2. Blue Cross Drops Chiropractic from Medicare HMO. In the last issue (January 1999) we reported new ACA litigation against the US government because the government was allowing HMOs providing Medicare chiropractic services to have those given by medical doctors and others. The Medicare benefit, which no one disputes was introduced for chiropractic services, is actually defined as “manual manipulation of the spine to correct a subluxation.”

The plot has now thickened with Blue Cross of California announcing that chiropractic care will no longer be covered under

its Senior Secure Plan in the Northern California region. This brought an ACA letter to the Health Care Financing Administration (HCFA) requesting its position on this policy. HCFA has replied with its interpretation of the law that the benefit in question may be provided by any category of physician – namely a DC, MD or DO.

This underlines the importance of the ACA lawsuit. Medicare has become the payment model in the state and private sectors. Accordingly this issue has major potential consequences for chiropractors – not only throughout the US but also in Canada and internationally.

EUROPE

1. Research

Chiropractic Manipulation for ETTH. Tension-type headache, non-pulsating bilateral headache without the nausea, photophobia and other symptoms of migraine, is the most common form of headache and may be episodic (ETTH – 1–15 episodes per month) or chronic (CTTH – 16 or more episodes per month). In a new trial from Denmark the effectiveness of chiropractic manipulation was studied by randomly assigning 75 patients to a manipulation group (receiving 8 treatments over 4 weeks, cervical manipulation and deep friction massage including trigger point therapy from an experienced chiropractor) and a control group (receiving the same soft-tissue therapy, no manipulation, and a low-power laser light therapy shown to have no effect).

The protocol used was similar to that used by Nilsson in his cervicogenic headache trial showing that the addition of chiropractic manipulation did produce significant benefits for patients with cervicogenic headache. Results in the present trial were:

- One week after the treatment phase patients in both groups experienced significant reductions in mean daily headache hours and the mean number of analgesics required per day, but not in headache pain intensity.

• However there was no significant difference between the two groups – meaning that the trial reports that spinal manipulation, as an isolated intervention, did not have a significant effect on ETTH.

An earlier US trial with CTTH patients by Boline, Kassak et al compared medical treatment (amitriptyline) and full chiropractic management (spinal manipulation, soft-tissue therapy and advice on lifestyle/diet) and reported significantly better results for chiropractic patients. The new Danish trial raises the question of whether or not manipulation is the effective element. There are limitations to the new trial which include:

- Chiropractic clinical practice guidelines suggest there was insufficient treatment. Patients were only given manipulation 2 times weekly over 4 weeks and on this protocol one would not expect best or lasting results. In another larger trial for tension-type headache now commencing in Canada, with principal investigators Howard Vernon DC FCCS(C) (Canadian Memorial Chiropractic College) and Gwen Jansz MD PhD (University of

Toronto) patients are to receive treatment 3 times weekly over 6 weeks – twice the amount of treatment with greater frequency and duration.

- There was no measurement of results during care – only one week after treatment was over. Given the insufficient care, this means there may have been significant improvement during care that was never measured.
- Trial numbers were small – 75 patients, 38 receiving chiropractic manipulation. The Boline trial was twice that size and the Ontario trial will have over 300 or more than 4 times as many patients.
- Treatment was given by one chiropractor – for obvious reasons it is better to have more than one practitioner when measuring the effectiveness of management that includes a manual therapy. Boline Kassak et al had several practitioners, the new Ontario trial will offer treatment in approximately 10 different chiropractic clinics, and the Meade et al trial of back pain in the UK, for example, was based on chiropractic treatment at 11 different centres.

The fact remains, however, that a protocol which isolated the effectiveness of chiropractic manipulation for patients with cervicogenic headache has not isolated the same level of benefit for ETTH patients. This suggests something that will seem intuitively right to chiropractors – that it is the sub-set patients with headaches with underlying cervical spine dysfunction or subluxation that respond to chiropractic care, whether labelled ETTH, migraine, cervicogenic or anything else.

(Bove G, Nilsson N (1998) *Spinal Manipulation in the Treatment of Episodic Tension-Type Headache*, JAMA, 280:1576-1579).

ASIA/PACIFIC

1. Australia – Alternative v Orthodox and Good v Bad Medicine. In a December 1998 article in the *Medical Journal of Australia*, Professor Michael Hensley, Professor of Medicine, University of Newcastle and a colleague, both of whom are specialists in respiratory medicine, comment on the use of Chinese herbal medicines and buteyko breathing techniques (BBT) in the management of asthma. In a BBT trial published in the *MJA* there was, similar to the recent chiropractic asthma trial by Balon et al published in the *New England Journal of Medicine*, no improvement in objective measures but marked improvement in subjective responses and significant reduction in the use of medication. Hensley and Gibson's main message is that if patients can cope with less medication this means that "many patients are taking unnecessary medication leading to increases in adverse effects and expenses for these drugs."

What follows is a very supportive review of the potential contribution of alternative medicine to respiratory disorders, and an open and frank acknowledgement that alternative care and medical care face equal challenges of unproven effectiveness. Useful quotes include:

- The need to improve the quality and quantity of evidence that is used to guide health care practice . . . applies equally to both alternative and orthodox therapies."

- "Alternative therapies should be approached in the same way as some parts of orthodox medicine are evaluated now and how most, if not all, will be assessed in the future. That is, if shown to be effective and safe, they should be part of the range of interventions available to patients. Ineffective or unsafe therapy should be abandoned."

- "As proposed in a *New England Journal of Medicine* editorial it may be time to stop using the terms 'orthodox' and 'alternative' and to classify health interventions into whether or not they have been shown to do more good than harm in scientifically valid studies – an evidence-based approach to health care."

2. New Zealand – Charging the Batteries.

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Auckland, New Zealand

May 20–22, 1999

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Format: Lectures, Grand Rounds, Technique Workshops and Technique Seminars.

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ment plans – which fully cover medical services and part cover chiropractic but no other alternative health care – should cover the cost of CAM.⁷

9. With respect to other countries, in Australia a national survey published in 1996 showed that 1 in 2 Australian adults used CAM each year, with about 20% visiting an “alternative medicine practitioner” for this purpose.⁶ In New Zealand a 1997 Consumer Institute survey of 8,007 members on their use of CAM showed that half of them (51%) had used at least one form of CAM, with chiropractic, herbal medicine and homeopathy being the most widely used. No annual usage is given. The Institute found that chiropractic had the highest satisfaction rating (74%) and was “the most regulated and the most respectable” form of CAM.¹⁵

D. WHY DO PEOPLE USE CAM?

10. This question has been examined most thoroughly in Europe by psychologist Adrian Furnham in a number of studies in the UK and Germany which he reviews in the recent text *Complementary Medicine: An Objective Appraisal*.¹⁶ Taking, for example, comparable groups of patients attending medical general practitioners, homeopaths, acupuncturists and osteopaths Furnham and his colleagues find clear results that confirm the speculations of most researchers in this field. Their overall conclusions are:

- a) The two dominant factors for CAM users are dissatisfaction with medical care for their current complaint (the push factor – pushing them towards CAM) and belief in the effectiveness of the CAM approach (the pull factor – attracting them to CAM).
- b) The second factor is actually the dominant one. CAM users have greater awareness of physiology and health than medical patients, have more self-aware and ecologically aware lifestyles, and have greater belief that treatment should concentrate on the whole person. They are pulled towards CAM because it is “more natural, effective, relaxing, sensible and one can take an active part in it.”
- c) However CAM users do not reject orthodox medicine altogether and do not have “noticeably different health belief models compared with similar patients who are exclusive users of orthodox medicine.” None of the simple hypotheses for why people use CAM is true – for example that they are turned off orthodox medicine, they have a pronounced philosophy or lifestyle that fits CAM, or that they have a particular neurotic or psychosomatic profile. The studies show that CAM patients are a normal cross-section of the population shopping for health. Where various forms of CAM are available they will likely use more than one – these health shoppers will use orthodox medicine for broken bones, chiropractic and acupuncture for back pain and headache, and homeopathy for allergies.

11. The definitive study to date in the US is the Astin survey from Stanford.¹⁴ The basic question being investigated by that survey was “what are the socio, cultural and personal factors underlying a person’s decision to use alternative therapy?” The questions asked by Astin tested three theories:

- i) That patients were dissatisfied with conventional medical treatment. (Dissatisfaction).
- ii) That patients sought alternative therapies because they were seen as less authoritarian and offering more personal autonomy and control in health care decisions. (Need for personal control).

iii) Better compatibility with the patient’s values, philosophy and beliefs regarding the nature and meaning of health and illness. (Philosophical congruence).

The results supported theories 2 and 3, but only supported theory 1 in limited form. Those who used CAM fell into two distinct camps:

- *Patients with primary reliance on alternative medicine.* These patients did have a strong distrust and rejection of physicians in the conventional medical system. However, they were very few in number - only 4.4% of CAM users, 2% of the total population.
- *Combined users of conventional and alternative medicine.* These people, all other CAM users, were not disillusioned with conventional medicine. Just as many were highly satisfied (39%) as dissatisfied (40%) overall with conventional practitioners.

As in Europe, respondents were shopping for health. The most frequently cited health problems treated with CAM were chronic pain (37%), anxiety/chronic fatigue syndrome (31%), strains/muscle sprains (26%) and headaches (24%). Chiropractors were commonly used for all of these and provided “close to 50% of all alternative treatments used for headaches”. Other predictors of use of CAM shown by this survey were more education; a holistic orientation to health; anxiety, back problems or chronic pain; commitment to environmentalism, feminism, and interest in spirituality and personal growth or an experience transforming the person’s world view.

12. Canadian evidence confirms this picture. In the 1997 CTV/Angus Reid national poll already mentioned respondents were asked to agree to various reasons suggested for use of CAM. Strongest agreement, in descending order, was with these reasons:

- Alternative medicines and practices don’t hurt you and may help a bit. (48%)
- Regular medicines on their own aren’t working for me. (34%)
- Alternative medicines and practices are more natural. (33%)
- I am worried about doctor prescribed medicines and practices. (23%)
- I get better service from alternative medicine providers than from the regular health care system. (17%)

Only 6% of CAM users agreed with the reason “I don’t trust modern medicine and practices”. This represents only 2–3% of the total population, the same as in the U.S.

13. In summary U.S. and Canadian findings are consistent with the European experience – CAM patients are partly pulled there by the perceived benefits and attractiveness of CAM and are partly pushed there by the ineffectiveness of medical care for various prevalent lifestyle conditions and holistic health. There is no narrow or strong psychological profile and few are anti-medicine.

14. Commentators agree. In one of the most powerful consumer books, *Reclaiming Our Health* by John Robbins,¹⁷ whose first book was *Diet for a New America*, Robbins:

- a) Analyses the basis of the current rise of CAM in the United States. He links it to dissatisfaction with the ‘medicalization of life’ arising from a combination of the following factors – ignoring the inherent powers of the body; removing personal control of health, and freedom of choice; and doing this in

many circumstances where 'dominator medicine' is less effective than CAM and has unacceptable costs, risks and side effects.

Robbins gives many powerful examples, including the medicalization of childbirth and menopause and the quite ruthless suppression of natural therapies for cancer.

b) Concludes that the public does not want to turn its back on orthodox medicine but that it wants self-determination in health care; the medical doctor as collaborator not dictator; and an end to the medical monopoly and the creation of "a medical system that includes the alternative and drugless modes of healing in true partnership."

(Robbins deals at some length with efforts by orthodox medicine in the US to contain chiropractic but, in a manner that gives helpful perspective, describes many other CAM approaches relying on the inherent self-healing powers of the body that have been suppressed equally strongly).

An eminent, recent, medical commentator in the US is Wayne Jonas MD, Past Director, Center for Alternative Medicine, National Institutes of Health. Writing an editorial in the November 11, 1998 issue of *The Journal of the American Medical Association*, which was fully devoted to CAM, Jonas advises medical doctors that "alternative medicine is here to stay" because it "reflects changing needs and values in modern society in general".¹⁸ He summarizes these changes as follows:

"... a rise in prevalence of chronic disease, an increase in public access to worldwide health information, reduced tolerance for paternalism, an increased sense of entitlement to a quality life, declining faith that scientific breakthroughs will have relevance for the personal treatment of disease, and increased interest in spiritualism. In addition, concern about the adverse effects and escalating costs of conventional health care are fueling the search for alternative approaches to the prevention and management of illness."

E. WHO SAYS CHIROPRACTIC IS CAM?

15. The answer, quite simply, is the medical profession and therefore health care authorities and the general public. Chiropractic is presently an example of CAM whether it wants to be or not - the external forces are simply too strong for chiropractic to escape this imposed classification until it is replaced by something new.

The terms complementary and alternative medicine, certainly as they apply to chiropractic, are likely to lose their current popularity over time - they have major definitional problems, there is no common principle to the health care disciplines they cover, and the increasing integration of CAM and medical practice will force a breakdown. Perhaps the best the chiropractic profession can do is to accelerate this breakdown. The path forward has been shown in recent articles in the US and Australia by impartial medical leaders who suggest "it may be time to stop using the terms *orthodox* and *alternative* and to classify health interventions according to whether or not they have been shown to do more good than harm in scientifically valid studies - an evidence-based approach to health care."^{14,19,20}

F. IS THIS GOOD OR BAD?

16. The presumed disadvantages of chiropractic being seen as part of CAM appear in the DCA resolution. In short chiropractic is not judged on its own merits. On one hand it is placed in a

subservient position to mainstream/orthodox/established medical care, on the other it is seen as only one of many CAM methods competing for recognition, some with little definition, education and regulation. This makes further integration and funding of chiropractic services more difficult in the health care marketplace. Medical services are orthodox and funded whether proven effective or not, chiropractic services must be proven to a higher standard to be funded.

17. However, as a result of the depth of the public's acceptance of CAM, there is now a convincing argument the other way - that the change in societal attitudes represented by the aggressive new use and integration of CAM throughout the world is giving the chiropractic profession an increased recognition it could not have achieved on its own. In 1999 one can now point to these advantages:

a) Much more public and media exposure and debate. The chiropractic profession has benefited greatly from the various surveys discussed and books such as Robbins' *Reclaiming Our Health*. All of this work only exists because of the context of CAM.

b) As a result, better evidence of public acceptance of chiropractic services.

c) As a result more medical debate and acceptance. A good example of this and point b) is the recent Kaiser Permanente survey of physicians and patients at one of its large Northern California HMOs. This would not have been done for chiropractic services alone. It was to survey use of and interest in alternative therapies, and showed that a clear majority of patients (61%) and primary care physicians (55%) wanted chiropractic services available within the HMO.¹²

d) More pressure for, and action on legislative change. Recent examples are the Philippines, where 1997 legislation to recognize chiropractic was part of broader legislation to recognize various forms of alternative care, and Italy where the Associazione Italiana Chiropratici advises the government is finally moving on chiropractic legislation after many years because of wider pressures to regulate the whole field of complementary medicine.

e) More public and independent funding for chiropractic research. Because of CAM there is much wider recognition by health authorities and the medical profession that there is a public responsibility to assist with chiropractic research. An example in the US is the NIH Center for Alternative Medicine, which has assisted in the formation of a Consortial Center for Chiropractic Research and given it an initial grant of \$2.4 million.

f) More pressure for inclusion in public and private third party reimbursement programs.

18. There may be other advantages also. Firstly CAM provides a more secure environment in which to discuss chiropractic principles and philosophy and somatovisceral responses to chiropractic treatment, and to promote research in that area. In a world where there is new acknowledgement that traditional Chinese medicine, Ayurvedic medicine, healing touch, spiritual healing and relaxation therapy are methods of promoting the natural healing powers of the body and influencing many disease processes, chiropractors can discuss all spine-related disorders more freely.

Secondly, with the world seeing chiropractic as not only a profession in its own right but also a leading example of CAM,

chiropractors are encouraged to take a more collaborative and realistic view of where their profession is going. Health care is not a matter of chiropractic vs medicine. Many other health care providers, both inside and outside the medical profession, have similar concerns and aspirations and – depending upon how they are treated – are potential allies or competitors.

G. WHO WILL DELIVER CAM SERVICES?

19. This is obviously a key question. In China modern medical physicians take 6 months of training in TCM, not to use it but to understand its potential and know how and when to refer patients. Eisenberg et al's 1997 survey in the US explains that 60% of medical schools now have courses in CAM. However many physicians express a desire to use CAM themselves and some of these courses will encourage this.

This means that CAM practitioners in the more established disciplines, such as chiropractic, must be assertive in insisting that their educational and licensing standards are met by medical doctors. This need has already been recognized by influential bodies such as HRH Prince Charles' Foundation for Integrated Medicine in the UK²¹ and the College of Physicians and Surgeons of Ontario, Canada's largest medical licensing body, whose policy on complementary medicine recognizes that some physicians will wish to refer and others to practise themselves but notes:

"Many complementary disciplines of healing have established a historical and respected role in healing, and require arduous training and evaluation. Assuming that they have obtained such training and expertise in non-traditional fields (e.g. acupuncture, naturopathy, homeopathy, TCM and chiropractic), physicians practising in this area should regard and maintain the standards of those disciplines."²² (Emphasis added).

However in this context it is very important to appreciate that surveys consistently show that the public, including the medi-

cal profession and legislators, generally has poor understanding of the requirements for chiropractic education and licensure. Now, more than ever, the chiropractic profession – both leaders and individual chiropractors in their communities – need to make known the minimum educational standards for chiropractic practice, and that these provide the minimum educational standards for the practice of spinal manipulation by anyone.



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