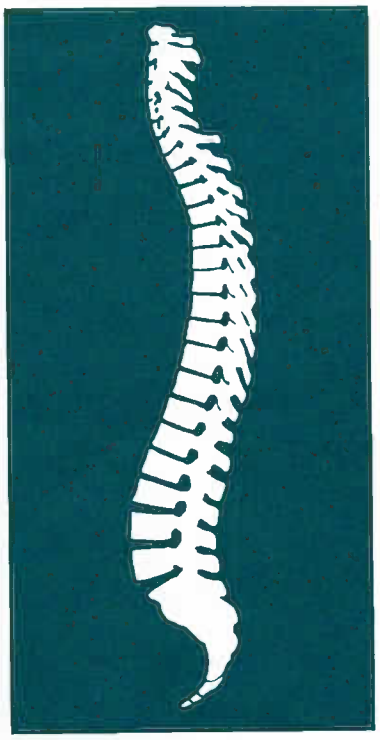
THE CHIROPRACTIC REPORT

www.chiropracticreport.com Editor: David Chapman-Smith LL.B. (Hons.) March 2001 Vol. 15 No. 2



PROFESSIONAL NOTES

Headache – Duke University Report

The bar has been raised for everyone in this era of evidence-based health care. It is no longer acceptable to base claims of effectiveness on individual studies or controlled trials. There must be a significant body of evidence which includes good quality trials, and all of this must be subjected to 'systematic review' by expert epidemiologists and clinicians appointed by government or affiliated with a respected research center.

A new systematic review from Duke University titled *Evidence Report: Behavioral and Physical Treatments for Tension-type and Cervicogenic Headache* is of major importance because:

• It meets the above criteria for evidence.

• It reports substantial evidence supporting chiropractic management of patients with each of cervicogenic headache and tension-type headache.

An earlier report from the Center for Clinical Health Policy Research at Duke looked at migraine headache. The new

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CAM, CHIROPRACTIC AND THE CROSS-OVER POINT

A. INTRODUCTION

Wherever you practise chiropractic your health care world will soon be influenced by a new government report in the UK titled *Complementary and Alternative Medicine,* prepared by the Select Committee on Science and Technology of the House of Lords and released in December.[1] Reasons include:

a) This is by far the most thorough analysis of CAM by any government, and the most outspoken commentary on its rightful place in the health care system.

b) The Report describes a major and growing role for the Group I professions, or principal disciplines, in CAM—firstly chiropractic and osteopathy, then acupuncture, homeopathy and herbal medicine (naturopathy). There are recommendations for significant new public funding for research and for patient access to CAM services demonstrated to be effective, with chiropractic and osteopathy having the first claim on these funds.

The Select Committee recommends that all medical students should be made familiar with CAM in their undergraduate programs but that, if medical doctors want to practise spinal manipulation or acupuncture or other forms of CAM, "they should be trained to standards comparable to those set out for that particular therapy by the appropriate CAM regulatory body."

c) Importantly, the Report has been accepted as authoritative and fair by the British medical profession. The Chairman of the House of Lords' Sub-Committee that conducted the inquiry was the neurologist Lord Walton, a former President of the British Medical Association (BMA). When the Select Committee Report was released the *British Medical Journal,* the BMA's flagship publication:

• Carried an editorial by Lesley Rees, Director of Education, Royal College of Physicians, and the prominent US author Andrew Weil, MD, Director and Professor of Medicine, Program of Integrated Medicine, University of Arizona, Tucson, accepting that the medical profession "can no longer ignore complementary medicine". The editorial acknowledges that the public has spoken, that the most accepted forms of CAM including chiropractic—interestingly called chiropractice—"have a research base" and that the medical profession must support the Report's call for public funding to support CAM services.[2]

• Carried many articles on the new integration of CAM in medical education and practice in Britain. One, from the School of Medicine, University of Southampton, explains that all medical students now have a one day clinical attachment to a chiropractor or visit to a chiropractic college as part of their CAM study module.

"Over the past 3 years Southampton students, student nurses and student chiropractors have taken the module" and "this multidisciplinary teaching has received positive feedback and encouraged us in developing further multi-professional approaches to teaching complementary and alternative medicine."[3]

An editorial in *The Lancet*, also widely respected by medical organizations internationally, announced that with this Report "*there now seems agreement* that complementary medicines deserve serious consideration . . . even if the medical profession has its reservations."[4] (Emphasis added.)

2. This issue of *The Chiropractic Report* looks at the background, content and impact of this new British government Report in some detail. Firstly though, here is a brief discussion of CAM and chiropractic issues that were reviewed at

greater length in *The Chiropractic Report* two years ago:[5]

a) **Definitions of CAM**. There is no agreed definition. The essence of common definitions has been forms of treatment "not usually taught in medical schools." This means that CAM is a catch-all term covering everything from chiropractic to crystal therapy and folk remedies. This explains why established and legally regulated disciplines such as chiropractic and osteopathy have not wanted to be labelled as CAM. The House of Lords gives an interesting and much more acceptable new approach to classification and definition—see paragraph 6 below.

b) **Is chiropractic part of CAM?** Yes, because the medical profession and therefore health care researchers and authorities have said so. Chiropractic is presently perceived as the leading 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.

c) **Is this classification good or bad?** Most chiropractors still prefer to be seen as part of a separate and distinct profession, rather than part of CAM. There are both advantages and disadvantages to being lumped into CAM. However, overall—and against all expectations five years ago—it is proving to be a good thing. Seen as the leading force in CAM, chiropractic is getting much greater government, legislative, media and research attention than it could have achieved on its own. Brief examples are:

• In the US it has been the formation of the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health (NIH) that has finally led to significant research funding for the profession, federal funding for the Consortial Center for Chiropractic Research based at Palmer College in Davenport, Iowa, and since last year the first federal employment of a chiropractor at the NIH—Christine Goertz Hegetschweiler, DC MPH a health policy expert who formerly worked for Northwestern College of Chiropractic and the American Chiropractic Association.

• In Europe it is the European Parliament's 1997 adoption of the Lannoye Report on CAM[6] that has led to legislation recognizing the chiropractic profession in Belgium and will finally bring the same recognition to the profession in important countries such as France, Italy, Portugal and Spain.

• There have been recent national surveys on the use of CAM in Australia and New Zealand, Canada and the US, most European countries and Israel. All identify high use of and satisfaction with chiropractic services—little or none of this data and resulting media comment on chiropractic would have existed without CAM.

• Importantly, CAM provides a secure environment in which to discuss somato-visceral 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.

d) **How widespread is the use of CAM?**

• *United States*. 4 in 10 adult Americans, and 1 in 2 adults aged 35-49, used CAM in 1997. Total annual visits for CAM increased between 1990 and 1997 by 47% and, at 629 million visits, exceeded total visits to all US primary care physicians by 243 million.[7]

According to the two major surveys from Harvard[7] and Stanford,[8] chiropractic is the single most used form of CAM, being used by 11-16% of the adult population annually.

• *Canada*. Approximately 4 in 10 Canadian adults (42%) used CAM in the year to August 1997, and during the previous five years there had been a 146% growth rate amongst young adults aged 18-34 (from 14% to 34% utilization).[8]

Chiropractic is more than twice as popular as any other form of CAM, and was used by 11% of the adult population in 1994[9]—that figure will now be higher.

• *Europe*. Overall use of CAM is probably higher in most European countries than it is in North America, though use of chiropractic is lower because of fewer numbers of chiropractors. In the Netherlands, for example, a 1987 survey of Dutch family physicians reported that 90% of them referred patients for CAM, the most common forms being "manipulation, homeopathy and acupuncture".[11] 'Manipulation' is provided by chiropractors, specialists in manual medicine (MDs), and manual therapists (specialist PTs).

• *Australia and New Zealand*. A 1996 national survey in Australia showed that 1 in 2 Australian adults used CAM annually, with approximately 20% visiting an "alternative medicine practitioner" for this purpose.[12] 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. The Institute found that chiropractic had the highest satisfaction rating (74%) and was "the most regulated and the most respectable" form of CAM.[13]

e) **Why do people use CAM?** Quite extensive research in Europe and North America shows that CAM patients are a normal cross-section of the population shopping for health. In North America a small number of patients distrust and

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

reject the conventional medical system and therefore place their primary reliance on CAM—about 4.4% of CAM users or 2% of the total population—but the great majority want integrated care.[8] They use the medical profession for acute infections, cancer and broken bones, chiropractic and acupuncture for back pain and headache, and homeopathy for allergies.

f) **Who delivers CAM services?** This is obviously a key question. Eisenberg et al.'s 1997 survey in the US explains that 60% of medical schools now have courses in CAM.[7] Some of these include basic instruction in spinal manipulation. Will physicians use these courses to practise manual medicine themselves or to understand the need for referral to skilled specialist practitioners?

There are very clear recommendations in this area in the new House of Lords Report—which we now turn to consider.

B. House of Lords Report

3. The House of Lords is the upper chamber of the British Parliament and the equivalent of the Senate in the United States. The reason for its inquiry into CAM, as explained in its Report, was the fact that the use of CAM is now "widespread and increasing across the developed world", giving rise to the need to consider:

- Whether good structures of regulation to protect the public are in place;
- Whether an evidence base has been accumulated and research is being carried out;
- Whether there are adequate information sources on the subject;
- Whether the practitioner's training is adequate; and
- What the prospects are for provision of CAM services through the government-funded National Health Service.[14]

4. The Sub-Committee that conducted the inquiry comprised 11 members of the House of Lords, five of whom are physicians. Specialist advisors were Professor Stephen Holgate, Clinical Profession of Immunopharmacology, University of Southampton and Mr. Simon Mills, Director of the Centre for Complementary Health Studies, University of Exeter. Evidence was presented by over 150 organizations and individuals. These included the British Chiropractic Association and the General Chiropractic Council, and similar bodies representing dentistry, medicine, nursing, many CAM practitioners and medical schools.

5. The final Report, dated November 21, 2000, was released in December. It may be downloaded from *www.parliament.uk*. (Click on House of Lords/Select Committee Report/Science and Technology). The Introduction (Chapter 1) establishes the elegant and informed tone of the Report and notes:

- Until aspirin, the first chemical drug, was manufactured by Bayer in Germany in 1899, treatment in Western medicine, as in Chinese and Ayurvedic and all other forms of medicine, was very largely based on the use of herbs and preparations from metals and animals. "The preparations in the Herbal of Dioscarides published in 55 AD remained largely unchanged in Western pharmacopeias until the twentieth century."
- The claims of physicians "usually lacked any clear supporting evidence or a sound foundation."
- The principal method of care, apart from herbal remedies, was "tender loving care (TLC)" to supplement the natural healing process or vis medicatrix naturae.
- There have since been "remarkable developments" in surgery and synthetic drugs. However there are many common and chronic diseases such as arthritis, low-back pain and asthma, "for which new drugs and surgical interventions have so far failed to provide outcomes that are satisfactory for many patients."
- Modern Western medicine "is both complex and expensive", primary care physicians can seldom offer "the attention and TLC which were important therapeutic weapons for (their) predecessors", and adverse reactions are common. For these and other reasons it is unsurprising that patient satisfaction is diminished and that patients turn to CAM "to replace or supplement their conventional medical advice."
- The widespread and increasing use of CAM across the developed world raises questions "of substantial significance in relation to public health policy" and thus this inquiry.

6. **Definition of CAM.** The Select Committee acknowledges that any exact definition of CAM, a broad and heterogenous field of health care, is impossible. However it rejects the British Medical Association's approach of defining CAM as forms of treatment not taught in medical and paramedical schools. Apart from other considerations, this approach "is now unsatisfactory" because medical schools are offering familiarization courses in CAM, and use of various forms of CAM by medical doctors is growing. Support is given to the philosophical position in the "more encompassing" definition of CAM by the Cochrane Collaboration:

"A broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period".

7. This definition, however, requires practical refinement. The Select Committee acknowledges that it is inappropriate to group "well-established and generally-accepted CAM therapies such as osteopathy and chiropractic", which have a substantial research base, with those that are undeveloped and have no evidence base. For this reason they divide CAM into "three broad groups":

a) **Group I.** (*Complementary and alternative*). These are the "principal disciplines" of acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy, "seen as the 'Big 5' by most of the CAM world." They are the most organized and regulated professions, have "an individual diagnostic approach", and a research base.

b) **Group 2.** (*Complementary*). These are therapies that "do not purport to embrace diagnostic skills" and "are most often used to complement conventional medicine." Examples given are aromatherapy, Alexander Technique, bodywork therapies including massage, counselling, stress therapy, hypnotherapy, reflexology and shiatsu, meditation and healing.

c) **Group 3**. *(Alternative*). These disciplines, like those in Group 1, have an individual diagnostic and treatment approach but are "indifferent to the scientific principles of conventional medicine" and propose "various and disparate frameworks of disease causation". Group 3 has two sub-groups:

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report, co-authored by Douglas McCrory, MD, Co-Director, Duke Evidence-Based Practice Center and Rebecca Gray, PhD, and prepared in partnership with the Foundation for Chiropractic Education and Research (FCER) on funding from NCMIC Insurance, compares the safety and effectiveness of pharmacological, behavioral and physical treatments for cervicogenic and tension-type headache. Key findings include:

• Chiropractic manipulation is effective for the treatment of cervicogenic headache, producing more sustained reduction in frequency and severity of headaches than various other physical and soft-tissue procedures with which it has been compared. (Evidence relates to diversified and/or toggle recoil adjustment).

• Chiropractic manipulation is effective in the treatment of tension-type headache, producing markedly superior long-term results in comparison with standard pharmacological treatment with amitriptyline.

This Duke Evidence Report will be reviewed more fully in the next issue of *The Chiropractic Report*. The Executive Summary is available at *www.fcer.org* (click on research/Duke evidence report), and the full report will be available from March 1 from FCER, P.O. Box 4689, Des Moines, IA, 50306-4689, for US$39.00 plus $7.00 shipping (Canada $12.00 shipping). *Orders: 1-800-622-6309 Fax. 1-515 272-3347, E-mail: FCERnow@aol.com*

Research Points

1. **Functional Rating Index—A Valuable New Clinical Tool.** Even the best patient questionnaires can be time-consuming, especially for patients who have both back and neck pain and need to complete two of them. Therefore clinicians will love the new Functional Rating Index (FRI) developed by US chiropractors Dr. Ronald Fiese and Dr. Michael Menke, validated in a study just published in *Spine*, and partly illustrated in Figure 1. The FRI measures pain and disability for back and/or neck problems, and because of its new chart format, greatly reduces the time for completion by patients and scoring by staff. (Feise RJ, Menke JM. *Functional Rating Index. A New Valid and Reliable Instrument to Measure the Magnitude of Clinical Change in Spinal Conditions*, Spine 2001; 26(1):78-87.)

2. **LBP—HIZ is Not Diagnostic.** Since a 1992 study by Aprill and Bogduk medical researchers have thought that the presence of a bright high-intensity zone (HIZ) on lumbar MRI, evidencing anular disc disruption, may be a reliable sign of a specific cause of mechanical low-back pain—indeed, the first cause demonstrable by non-invasive methods. A new trial from Stanford University, which has been awarded the 2000 Volvo Award in Clinical Sciences, says no. In the new study LBP patients with HIZs were compared with asymptomatic control patients for the first time—it was found that asymptomatic patients also had HIZs, and that joint injections produced as much pain as for patients with LBP. (Carragee EJ, Paragioudakis SJ, Khurana S. *Lumbar High-Intensity Zone and Discography in Subjects Without Low-Back Problems*, Spine 2000; 25(23):2987-2992.)

3. **Ankle Sprains.** A new trial from Pellow and Brantingham at the Technikon Natal, Durban, South Africa demonstrates the effectiveness of the mortise separation adjustment for patients with subacute and chronic ankle inversion sprains. For a maximum of 8 treatment sessions over 4 weeks 30 patients were randomly assigned to either chiropractic adjustment (with the ankle set up in dorsiflexion and eversion prior to thrust to avoid stress on a lateral ligament complex) or a placebo group receiving detuned ultrasound treatment.

Both groups improved, but there were statistically significant benefits to the treatment group in terms of reduction in pain, increased ankle range of motion and ankle function measured subjectively (short-form McGill Pain Questionnaire and Numerical Pain Rating Scale) and objectively (ankle dorsiflexion range of motion—goniometer, and pain threshold over the ankle lateral ligaments—algometer). There is a good review of other ankle sprain research, and of the significance and classification of ankle sprains which are "probably the single most common injury in sports". (Pellow JE, Brantingham JW. *The Efficacy of Adjusting the Ankle in the Treatment of Subacute and Chronic Grade I and Grade II Ankle Inversion Sprains*, J Manipulative Physiol Ther, 2001; 24(1):17-24.)

4. **Cancer—Palliative Care.** An excellent article in the January 2001 issue of JMPT presents the best commentary yet on the role of chiropractors in the co-management of many cancer patients. By Jeffrey Schneider, DC and Scott Gilford, DC, staff chiropractors at the Naval Hospital, Camp Pendleton in California, the article presents commentary and case examples and is written principally for physicians, nurses and others involved in the care of cancer patients. Schneider and Gilford explain that most cancer patients do not receive adequate pain relief and 40-70% of patients with colon, lung and prostate cancer

Figure 1: Functional Rating Index—Sample Extract

For each item below, please circle the number which most closely describes your condition right now.

1. **Pain Intensity**

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain pain	Worst possible

2. **Sleeping**

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

To download the FRI for your use visit www.chiroevidence.com/FRI_license.html

have severe ambulation problems. To quote: "The cancer rehabilitation team is faced with among other things, complications of prolonged bedrest, chronic pain related to radiation fibrosis, chemotherapy-related neuropathies, and gait or functional abnormalities associated with the disease or the associated treatment regimen. The chiropractor can assist in the treatment of these entities, thereby potentially decreasing the patient's reliance on pain medication." (Schneider J, Gilford S. *The Chiropractor's Role in Pain Management for Oncology Patients*, J Manipulative Physiol Ther, 2001; 24(1):52-57.)

North America

1. **US—FSU Implementation Plan**. In May 2000 the Florida legislature voted $1 million for the development of an implementation plan for a school of chiropractic at Florida State University (FSU) in Tallahassee. FSU hired the consulting firm MGT of America to study all the relevant issues and report with a plan. MGT's report, which contains an independent description of the chiropractic profession and much else of interest, was submitted in January and can be downloaded from *www.mgtamer.com* (click on MGT Selected Reports/Studies).

2. **Canada—Workers' Comp Requirements for Management of Acute LBP**. Canada, unlike the US, the UK and many other countries, has not developed government-sponsored practice guidelines for the management of patients with acute low-back pain (LBP). However the government affiliated workers' compensation agency in the province of Ontario, called the Workers' Safety and Insurance Board (WSIB), has recently completed the evidence-based development of a new program of care for injured workers with acute (the first four weeks post-accident) and sub-acute (weeks 5-12) LBP.

This program, now under pilot testing, calls for injured workers without certain red (pathological) and yellow (psychological) flags to receive spinal manipulation and/or other manual therapy and stretching exercises in the acute phase. In the sub-acute phase the WSIB is requiring that they receive spinal manipulation and/or other manual therapies together with structured supervised exercises. Based on current evidence, many other treatments are now excluded and not reimbursed. In the acute phase these include flexion exercises, mechanical traction, electrical stimulation, acupuncture, hydrotherapy and biofeedback. The full program of care, including background on how it was developed will be on the WSIB's website by March 15 and may be downloaded from *www.wsib.on.ca*.

Europe

1. **The Netherlands—New Survey Data**. The October 2000 issue of JMPT has the best descriptive study of chiropractic practice in the Netherlands yet published—by Dutch chiropractors Sydney Rubinstein, DC and Charles Pfeifle, DC together with prominent Dutch health services researchers Maurits van Tulder, PhD and Willem Assendelft, MD, PhD. Chiropractic in the Netherlands remains unregulated and has relatively little third party funding, but services are in demand and the number of chiropractors has more than doubled to approximately 130 during the past decade.

On a survey of 10 consecutive new patients for each of 94 chiropractors in the Netherlands Chiropractic Association (78% of the NCA's 121 members), it was found that the chief complaints for 86% of patients were "spine-related neuromusculoskeletal problems". Other complaints were extremity pain (4%), headache (7%—apparently classified here as not spine-related), other NMS problems (under 2%) and non-NMS problems (under 2%). Most patients had chronic problems—68% for six months or longer, 58% for one year or longer before they consulted a chiropractor. Most common sources of referral for chiropractic care were friend/acquaintance/family member (71%), general medical practitioner (17%), and other health care practitioner (10%). See the study for much more. (Rubinstein S, Pfeifle CE et al. *Chiropractic in Patients the Netherlands: A Descriptive Study,* J Manipulative Physiol Ther, 2000;23:557-563).

2. **UK—Chiropractors Offered the Use of Prescription Drugs**. In the UK Section 68 of the draft Health and Social Care Act, which proposes many significant changes in the health care system, would amend the Medicines Act to extend prescribing rights to pharmacists—but also to chiropractors, osteopaths, physiotherapists and others. Exact prescribing rights, if any, would be set forth in subsequent regulations under the Medicines Act. The draft Act, which passed second reading on January 10, is expected to become law soon in advance of a spring general election.

The British Chiropractic Association (BCA) has not asked for prescribing rights. UK chiropractors now face a similar situation to their colleagues in South Africa in 1998. The Chiropractors' Association of South Africa (CASA) was offered prescribing rights but refused. CASA followed the fundamental tenet of the chiropractic profession, endorsed in the mid-1990s by the Association of Chiropractic Colleges in its Position on Chiropractic and the World Federation of Chiropractic in its Policy on Use of Drugs, that the goal of chiropractic practice is to assist the natural healing powers of the body using non-invasive treatment methods only, and specifically without the use of drugs or surgery. Will British chiropractors follow suit?

Other Countries

a. **South Africa—New Law Requires a 12 Month Internship**. Since the 1970s Denmark and Switzerland have required graduate chiropractors to practise under supervision for 12 months, now 24 months in Switzerland, before gaining a full licence to practise. The purpose is to provide a bridge between undergraduate clinical education and independent practice, providing graduates with increased clinical practice and business principles experience within a private practice environment. Under new legislation gazetted in December, South Africa also now requires graduate chiropractors to complete a period of 12 months internship or supervised practice. Another country on the point of introducing a similar requirement is the UK.

i) "Traditional systems of health care" which have been long established, such as Ayurvedic medicine and traditional Chinese medicine.

ii) "Alternative disciplines which lack any credible evidence base", such as crystal therapy, iridology and radionics.

Accordingly, under this House of Lords or British government classification, chiropractic is a Group 1 form of CAM. By definition that means that it:

- Is based on scientific principles compatible with Western medicine (unlike Group 3 disciplines);
- Has established a research base (unlike Group 2 and Group 3 disciplines);
- Has its own distinct diagnostic and treatment approach (unlike Group 2 therapies);
- Has well-developed professional organization (more than Group 2 and Group 3 disciplines);
- May be complementary or alternative to medical services.

For chiropractic this is a significant advance upon simply being described as CAM, and represents a classification that most chiropractors will find useful if not totally acceptable.

8. **Attitudes and integration**. The Select Committee, whose Subcommittee heard a full range of opinions and visited several centers where physicians and CAM practitioners worked together funded by the National Health Service (NHS), takes an even-handed approach in judging the attitudes of 'conventional doctors' and 'CAM practitioners'. On one hand many conventional scientists and doctors "accuse CAM practitioners of being anti-scientific and illogical", and on the other hand many CAM practitioners "accuse conventional medicine of taking an over-simplistic view of illness and of neglecting important areas of a patient's experience." There has been antipathy and hostility on both sides.

However "in recent years many practitioners in conventional and complementary medicine have begun to take a more open-minded view." In the medical profession there has been "increasing support for the view that medical practitioners should begin to work with CAM practitioners", and experience at integrated centers is that medical doctors and CAM practitioners "have gained increasing respect for each other's approaches." Having regard to the needs of patients and the health care system, integration is the way of the future.

9. **Research**. A major focus of the Report, found in Chapter 7, is research. Central observations, and recommendations long-awaited in the chiropractic profession, are:

a) Over the whole field of CAM little high-quality research exists. Reasons include the lack of any historical support from government, industry and charity, inadequate research funding and infrastructure, and lack of awareness of the methods and importance of research amongst most CAM practitioners.

b) In light of these problems "we recommend that a central mechanism for coordinating and advising on CAM research and for making available research training opportunities be established with resources from the government." This central coordinating center, for which the NCCAM at the US National Institutes of Health provides an excellent model in the opinion of the Select Committee, will provide the infrastructure to produce the necessary researchers from the CAM community.

c) Next there should be government dedicated research funds for "centres of excellence for conducting CAM research on appropriate disciplines". The funds to "pump-prime this area" for the next 10 years should come through the NHS Research and Development Directorate and the Medical Research Council. Group 1 disciplines, such as chiropractic, "should command the highest proportion of research resources."

10. **Training and Education**. Who should provide CAM health care services? In the case of manual therapies, what minimum training and competencies should be required of anyone seeking to practise spinal manipulation? This issue has been highlighted by the growing number of long weekend courses in manipulation for medical doctors and the recent US trial by Curtis, Carey et al. showing that training primary care physicians in this limited manner is not useful.[15,16]

In Chapter 5 (Regulation) and Chapter 6 (Professional Training and Education) the Select Committee has strong views and recommendations that the chiropractic profession has—as with the recommendations on research funding—been waiting to hear from an authoritative government source for a long time. These include:

a) "All those who deliver CAM treatments, whether conventional health professionals or CAM professionals, should have received *training in that discipline independently accredited by the appropriate regulatory body*." (Emphasis added).

b) "Each existing regulatory body in the health care professions should develop clear guidelines on competency and training for their members . . . In drawing up such guidelines the conventional regulatory body should communicate with the complementary regulatory bodies . . . to obtain advice on training and best practice and to encourage integrated practice."

c) "We recommend that if CAM is to practised by any conventional health care practitioners, they should be trained *to standards comparable to those set out for that particular therapy by the appropriate CAM regulatory body*." (Emphasis added).

d) "We encourage the bodies representing medical and non-medical CAM therapists, particularly those in our Groups 1 and 2, to collaborate more closely especially on developing reliable public information sources."

11. There are recommendations that the undergraduate curriculum of each medical and nursing school should provide students with exposure to a level of CAM familiarization that gives them competencies for dealing with patients who are accessing CAM or have an interest in doing so. Royal Colleges and other training authorities for doctors, dentists, nurses and veterinary surgeons should provide appropriate continuing professional development (continuing education) opportunities for familiarization with CAM therapies.

There are also recommendations on professional training for chiropractors and other CAM professionals including:

a) Every CAM professional "should have a clear understanding of the principles of evidence-based medicine and health care". For Group 1 and 3 professionals, who diagnose and operate

independently of medical supervision, "an in-depth understanding of research methods . . . may be particularly appropriate."

b) "We recommend that all CAM therapists should be made aware of the other CAM therapies available to their patients and how they are practised."

12. **NHS Funding for CAM Services** (Chapter 9). In the UK government funding for chiropractic and other CAM services through the NHS is presently only upon medical referral. Patient access to funded services depends upon the attitudes of GP partners in the primary care groups (PCGs) or trusts (PCTs) in which patients are enrolled. Access is "very patchy" with a 1995 study showing that only 40% of GP partnerships provide access to CAM for their NHS patients.

The Select Committee steps carefully in this area, as all government committees do regardless of the merits when addressing potential new funding for services. On one hand the Committee notes the frequent successful integration of CAM in primary care and, with respect to chiropractic and orthopaedics, in secondary care. It appears to support the Foundation for Integrated Medicine's position that "if established CAM services are available for some people in the NHS, they should be available for all."

On the other hand the Committee recommends that "all NHS provision of CAM should continue to be through GP referral." Only well-regulated CAM disciplines, principally chiropractic and osteopathy—the only CAM professions with statutory regulation in the UK, should have their services funded and available through the NHS.

13. **Other Recommendations**. This is a comprehensive report with many other important recommendations. These include:

a) **Information on CAM** (Chapter 8). The NHS should develop and provide a comprehensive source of information on CAM which should then be readily available to the public. This is "particularly important" for, without this, the diversity of opinion, information and organizations in the CAM world "make it almost impossible for individuals to gain an overview." Current plans of the UK Department of Health to make information on CAM available are supported with the advice that "they be carried out in the very near future." Information available through the NHS Direct service should guide patients and doctors on the evaluation of different CAM services, list NHS provision of CAM in each local area, and give contact details for relevant CAM organizations.

b) **Integration**. Integration is the way of the future, and in its final chapter the Select Committee provides this advice:

"We also urge CAM practitioners and GPs to keep an open mind about each others' ability to help their patients, to make patients feel comfortable about integrating their health care provision, and to exchange information about treatment programs and the perception of the health care needs of patients."

It is worth reiterating that all of this is from an inquiry led by Lord Walton, a former BMA President. The chiropractic profession plainly owes debt of thanks to him and his Sub-committee for their impartiality, and to the British Chiropractic Association for establishing standards of continuing education, research and practice that have given the House of Lords such confidence in the chiropractic profession.

C. Conclusion

14. For chiropractors and their patients this Report on CAM from the House of Lords, and its acceptance by British medical leaders, is a very major milestone. It is probably fair to say that it marks the cross-over point in the history of health care in the Western world at which a national government, assessing the health care needs of its citizens, finally accepted the duty to support the chiropractic profession and other Group 1 CAM disciplines on a similar basis to the medical profession. The medical profession remains dominant—but it has admitted limitations, cannot meet all health care needs, and must be complemented by various other professions in an effective and efficient contemporary health care system. Therefore for example, as for medicine, there is a duty to support the development of chiropractic education, chiropractic research infrastructure, and relevant research and access to chiropractic services.

15. Older chiropractors remember the era through to the 1960s in which the medical profession suppressed research favorable to chiropractic, undermined chiropractic education, and used ethical rulings to prevent cooperation between chiropractic and medical doctors. In the US, as decided by the court in the anti-trust case of *Wilk* vs *AMA et al.* there was an illegal conspiracy between medical organizations to eradicate the chiropractic profession, a conspiracy based upon a misinformation campaign portraying chiropractic as an unscientific cult.[17] Traces of that linger on.

However, in the last quarter of the 20th century patients chose chiropractic and other non-medical or CAM services in unprecedented numbers, principally for chronic lifestyle disorders. Most significantly two of these, back pain and headache, are the second and third most common reasons adults consult a health professional.[18,19] As research has now demon-

strated and the House of Lords reports, patients have sought this alternative health care because medical treatments proved ineffective for those conditions and produced unwanted side effects. In CAM the great majority of patients have found more personal, more effective and more satisfying care.

16. Now, at the opening of the 21st century, the cross-over point has been reached. On the basis of the House of Lords' Report patients and CAM practitioners from Group 1 disciplines can hold governments accountable for providing a reasonable proportion of their health budget for CAM education, research and services. The medical and chiropractic professions have corresponding duties of cooperation. This has now been generously acknowledged by many medical leaders. In the words of Mark Micozzi, MD PhD from the Philadelphia College of Physicians and Surgeons, writing for primary care physicians in 1998 in *The Annals of Internal Medicine,* the official journal of the American College of Physicians:

"The Agency for Health Care Policy and Research (AHCPR) recently made history when it concluded that spinal manipulative therapy is the most effective and cost-effective treatment for acute low-back pain. . . . One might conclude that for acute low-back pain not caused by fracture, tumor, infection, or the cauda equina syndrome, spinal manipulation is the treatment of choice.

"Because acute low-back pain is the most prevalent ailment and most frequent cause of disability for persons younger than 45 years of age in the United States, adherence to these practice guidelines could substantially increase the numbers of patients referred for spinal manipulation. Chiropractors provide 94% of spinal manipulation.

"As physicians are becoming increasingly willing and able to justify referral for complementary care . . . we must foster the development of training, research and clinical protocols to support integration . . . in a way that promotes favorable clinical outcomes.

"Alternative medicine can benefit from the kind of support from which mainstream medicine has benefited over the years. When all is said and done, what works will no longer be called mainstream or complementary—it will just be called good medicine."[20]

Make that "good health care" Mark. TCR

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