

THE CHIROPRACTIC REPORT

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The Wilk Case

A. Introduction

1. The American Medical Association ('AMA'), representing 225,000 MDs, is the most powerful medical organization in the world. It has the second strongest lobby in the United States (after the aerospace industry). On 2 momentous days that will shape social history in the United States and the history of health care internationally:

a. On August 27, 1987 a U.S. Federal Court in Chicago found that the AMA, and various affiliated organizations such as the American College of Radiology ('ACR'), had between 1966 and 1980 pursued an illegal conspiracy designed to contain and destroy the chiropractic profession.

The conspiracy was planned from 1963 because of the AMA's dismay at the degree to which individual MDs were choosing to practice in association with chiropractors, undermining the medical monopoly on private and hospital health care services. AMA activities included suppressing research favourable to chiropractic, undermining chiropractic colleges and postgraduate education programs, using new ethical rulings to prevent cooperation between MDs and chiropractors in education, research and practice, subverting a 1967 US government enquiry into the merits of chiropractic, and basing an extensive misinformation campaign against chiropractic on the calculating portrayal of chiropractors as 'unscientific', 'cultist', and having a philosophy incompatible with western scientific medicine. Although AMA ethical changes technically ended the conspiracy in 1980 "the AMA has never acknowledged the lawlessness" of its "systematic longterm wrongdoing and intent to destroy a licensed profession".¹

b. On September 25, 1987 the Court delivered an injunction, or permanent restraining order, against the AMA in these far-reaching terms:

"The AMA, its officers, agents and employees, and all persons who act in active concert with any of them ... are hereby permanently enjoined from restricting, regulating or impeding, ... the freedom of any AMA member or any institution or hospital to make an individual decision as to whether or not that AMA member, institution, or hospital, shall professionally associate with chiropractors, chiropractic students, or chiropractic institutions".

Subsequent paragraphs in the injunction require the AMA to forward a copy of the

order to all members and employees, and to publish the order in the Journal of the American Medical Association and otherwise index and publicize it.²

2. Prior to the judgement there was an important settlement with the American Hospital Association ('AHA').³ Between judgement and injunction there were landmark settlements with the ACR⁴ and the American College of Surgeons ('ACS').⁵

3. This Report looks at the legal issues in the Wilk case, the history of the action with details of recent settlements, the Court's findings, consequences of the action to date, and future consequences in the U.S. and internationally.

B. Legal Issues

4. The Wilk case was an anti-trust action brought by 5 individual chiropractors against the AMA and others pursuant to the Sherman Act (1970), Section 1 of which forbids any "contract, combination or conspiracy in restraint of trade or commerce". In other words in the U.S. it is illegal to seek a monopoly or enter into anti-competitive agreements with others that amount to an unreasonable restraint of trade.

5. In the early 1970s it was unclear whether this legislation applied to the activities of professionals, as opposed to the outright business sector. The argument by professional associations was that some of their activities might tend to be anti-competitive or even create a monopoly for their members, but that this was in the public interest in ensuring that only properly qualified people designed buildings, gave legal advice, provided health care, etc.

6. Various court decisions established that the Sherman Act did apply to professionals but that special defenses were open to them. Anti-competitive activities by professional groups would not be in breach of the anti-trust law if they could be justified on professional grounds seen to be in the public interest.

7. The Wilk case first went to trial in 1980, and to appeal in 1983. The Appeal Court made a precise analysis of the legal issues, and set forth a 'patient care defense' that the AMA and other defendants would have to satisfy at re-trial.

This was that, if the plaintiff established an otherwise illegal combination in restraint of trade, the AMA and other defendants would be excused and not liable under the Sherman Act if they could show:

Professional notes:

Report on The First International Chiropractic Conference September 24-26, 1987, London, England

Organized by the British Chiropractic Association on behalf of the European Chiropractors' Union, and attended by nearly 700 chiropractors from 23 countries, the First International Chiropractic Conference featured a most impressive faculty of leading international experts from chiropractic and medicine. Alan Gardner, a senior British spinal surgeon, described the conference as "one of the most impressive spinal programmes I have come across anywhere".

The program speaks for itself, and the core program is given below. A text based on the proceedings of the conference, and edited by Brian Hammond, D.C. Ph.D., is to be published by Churchill Livingstone in 1988.

Thursday Orientation Session

John P. O'Brien, Ph.D., FRCS, FACS, U.K.
"Mechanisms of Spinal Pain"

John H., Evans, B.Eng, MSc. Ph.D., U.K.
"Biomechanics of the Normal and Abnormal Motion Segment - an Update"

William H. Kirkaldy-Willis, FRCS, FACS, CANADA
"The Pathophysiology and Pathoanatomy of Low Back Pain"

Henry V. Crock, FRCS, FACS, AUSTRALIA
"The Pathophysiology of the Vascular Supply of the Lumbar Spine"

continued on page 5

- a. In their opposition to chiropractic they were genuinely concerned for the use of proper scientific method in the treatment of patients
- b. This concern with respect to chiropractic was objectively reasonable
- c. This concern was the dominant motivating factor in the conduct complained of; and
- d. This concern could not have been adequately satisfied in a manner less restrictive of competition.

8. Accordingly all the AMA had to do to succeed was to show that it was acting in general good faith. Some degree of bias and hostility to chiropractic would not make its activities illegal.

9. In its recent judgement the retrial court held that the AMA, ACR and others had failed to establish the 'patient care defense' in 2 respects. One was item 7d. The "highly restrictive" activities of a "boycott and conspiracy designed to eliminate a profession that was licensed in all 50 states" was obviously illegal. The AMA's responsible course, if it had a genuine concern about the use of scientific method in chiropractic care, was a public education program as had been done in other areas of health care.

Most significantly, however, the court held that the 'patient care defense' failed also on item 7b. On the evidence the AMA had failed to show it was objectively reasonable to be concerned about the scientific basis of chiropractic practice during the period of the boycott. (On this point "... most of the defence witnesses, surprisingly, appeared to be testifying for the plaintiffs (chiropractors)").

10. The relief claimed by the 5 plaintiffs was damages for loss of reputation and income on account of the defendants' actions, and injunctions forbidding the defendants from engaging in further anti-chiropractic behaviour in violation of the Sherman Act. To establish a case for injunctions the plaintiffs had to prove a continuing violation or "a real threat of future violation" i.e. an AMA conspiracy was still in existence or, if technically terminated, that the AMA had had no fundamental change of heart.

C. History of Action

11. This multi-million dollar legal battle was commenced in 1976. The claim was filed in Chicago, the home of the AMA, various other defendants, and many of the nation's political medical organizations. The

plaintiffs were Dr. Chester Wilk, Dr. James Bryden, Dr. Patricia Arthur, Dr. Steven Lumsden, and Dr. Michael Pedigo, chiropractors in practice in Illinois, California, Michigan, Colorado and Missouri, 5 states where at all relevant times:

- a. Chiropractic was a licensed health care profession; and
- b. There were no laws prohibiting chiropractors from practising in a hospital setting or preventing hospitals from providing x-ray and laboratory services to chiropractors, or preventing hospital x-ray departments or radiologists from making x-ray films available to chiropractors at the request of their patients.

The lawsuit followed a frustrating period of years during which the plaintiffs alleged that, despite these laws, they and all members of the chiropractic profession had been frustrated from acting in cooperation with MDs in the interests of their patients because of AMA threats to its members, hospitals and other institutions.

12. The defendants included:

- a. The AMA, a federation of state medical societies representing the majority of the medical profession in the U.S.
- b. The American Hospital Association ('AHA') a corporation composed at the time of 7,000 organizations and 30,000 individual members. Approximately 6,000 of the 7,000 hospitals in the U.S. belonged to the AHA.
- c. The American College of Surgeons ('ACS'), then having as members about 40,000 of the 100,000 U.S. physicians identifying themselves as surgeons.
- d. The ACR, a corporation having as members approximately 13,000 of the 14,000 radiologists in the U.S. The ACR's high membership, and its pivotal position offering advice to government, hospitals and the medical profession in the field of radiology, made it particularly powerful.
- e. The American Academy of Orthopaedic Surgeons ('AAOS') then comprising 9,000 members specializing in orthopaedic surgery, more than 75% of the U.S. total.
- f. The Joint Committee on Accreditation of Hospitals ('JCAH') a corporation having the AMA, AHA and ACS as members. The JCAH is governed by 22 commissioners, a majority of 14 of whom come from the AMA and AHA. The JCAH controls hospital accreditation in the U.S. The court accepted loss of accreditation is "devastating", likely leading to closure of the hospital. The JCAH must be obeyed.

13. The plaintiffs claimed injury to reputation and loss of income because of illegal activities by the defendants evidenced in part by leaked documents which, if the AMA had an Oliver North, would have been shredded years before.

14. The case came to trial in Chicago in December 1980 before a judge and jury. It lasted 2 months. The record of the case consists of 3,634 pages of transcript, 1,265 exhibits, and 73 depositions. The plaintiffs lost. Because of the presence of a jury the issues were submerged in what the Appeal Court subsequently described as a "free-for-all between chiropractors and medical doctors".

15. The chiropractors appealed, citing various wrongful directions by the judge during the trial and in instructing the jury at trial-end.

16. The appeal was argued before a U.S. Court of Appeal during January 1982 and, following extensive analysis of the voluminous trial evidence and law, the appeal was allowed in a 47 page judgement given in September, 1983.⁶ The case was sent back for re-trial with specific directions on the law to be applied.

17. The plaintiffs, to achieve a trial before a judge alone, and thereby avoid another jury circus, discontinued their claim for damages.

18. The re-trial was before Federal District Court Judge Susan Getzendanner in Chicago during May/June, 1987.

19. On June 12, during the trial, the AHA settled with the plaintiffs in terms that satisfied one of the major goals of the lawsuit. The AHA adopted and issued an agreed policy statement, not to be retracted for at least 10 years, principal features of which were:

- a. Individual hospitals were free to determine their own policies concerning chiropractic services in a hospital setting.
- b. The AHA "has no objection to a hospital granting privileges to doctors of chiropractic for the purposes of administering chiropractic treatment ..., furthering the clinical education and training of doctors of chiropractic, or having ... x-rays, clinical laboratory tests and reports thereon made for doctors of chiropractic and their patients and/or previously taken x-rays, clinical laboratory tests and reports made available to them by (hospital medical staff and consultants) upon the authorization of the patient involved.
- c. Decisions concerning chiropractors should be "no different from other licensed health care professionals" and the AHA

“specifically disavows any unlawful ethic (by anyone) ... to undermine the public’s confidence in the profession of chiropractic.”³

20. On August 27, 1987 the Federal Judge delivered a 101 page decision entering judgement against the AMA, ACR, ACS and AAOS – the principal defendants remaining in the action following five settlements. They had formed an illegal boycott of the chiropractic profession as alleged. This justified injunctions and the case was remanded for argument on the precise form of the court orders.

21. On September 24, 1987 the ACS settled:

a. Adopting and publishing a policy, not to be altered for at least 5 years, acknowledging that there are “no ethical or collective restraints to full professional cooperation between doctors of chiropractic and medical physicians”, and that such cooperation should include referrals, group practice, participation in all health care delivery systems (HMOs, PPOs, etc.), treatment and services in and through hospitals, participation in student exchange programs between chiropractic and medical colleges, and cooperation in research and continuing education programs.

b. Paying \$200,000 to the Kentuckiana Children’s Center, a respected center for handicapped children whose work had been impeded by medical organizations because of work there by a chiropractor.⁴

22. Most significantly the ACR also settled on September 24, 1987. The ACR, the only defendant with an open policy against cooperation with the chiropractic profession at the time of trial:

a. Adopted and published a policy, to remain in force for at least 10 years, that “there are and should be no ethical or collective impediments to inter-professional association and cooperation between doctors of chiropractic and medical radiologists in any setting where such association may occur, such as in a hospital, private practice, research, education, care of a patient or other legal arrangement”.

“Radiologists ... are urged to be sensitive to and consider the legitimate radiologic needs of all licensed members of the healing arts, including doctors of chiropractic”.

“Any prior statements of the ACR inconsistent with this position statement are rescinded”.

b. A payment of \$200,000 towards legal costs.⁵

23. On the following day, September 25, 1987, the Court gave final judgement issuing a permanent injunction against the AMA in terms already discussed. (See p.1 para 1 b.). Costs against the AMA, which will be several million dollars, are yet to be quantified. The plaintiffs, although willing to settle with all other defendants, required and have received final judgement against the AMA.

24. An appeal by the AMA can be anticipated. However, it would be most unlikely to succeed following a judge alone trial where the form of relief given, an injunction, is in the discretion of the trial judge. Any appeal filed will be a device to negotiate costs. After 11 years the plaintiffs have won the war.

D. Court’s Findings – Facts

25. Findings of fact include:

a. Concerned in the early 1960s that medical physicians were cooperating with chiropractors, by September 1963 the AMA set an objective of “the complete elimination of the chiropractic profession”. (P.10).

b. The AMA established a Committee on Quackery directed by Mr. H. Doyl Taylor, Attorney, who repeatedly confirmed the AMA’s objective over the next 10 years. Before the Court Taylor denied his Committee was working for the elimination of chiropractic, saying the real concern was chiropractic as a health hazard. This evidence for the AMA was found “incredible and unworthy of belief”. (P.11).

c. The Committee “worked aggressively” in many areas to achieve its goal. Two prime tactics were “to discourage colleges, universities and faculty members from cooperating with chiropractic schools” and establishing an ethical framework that would frustrate and prevent professional association between medical physicians and chiropractors. (P.11).

d. The ethical boycott was set up in 3 moves:

i. Principle 3 of the AMA’s Principles of Medical Ethics made it unethical for a physician to associate with an “unscientific practitioner”.

ii. In 1966 the AMA’s House of Delegates passed a resolution specifying chiropractic “an unscientific cult”.

iii. In 1967 the AMA’s Judicial Council published an express opinion under Principle 3 directing it was unethical for a physician to associate professionally with chiropractors. “Associating professionally” included making or accepting referrals, providing any services, practising together in any form, and taking part in educational programs with chiropractors (P.12).

e. The AMA then worked with the other defendants over a period of years to establish similar ethical bars to professional cooperation with chiropractors. Because of the power of the JCAH and others it became increasingly impossible for physicians and hospitals to cooperate with chiropractors in the delivery of health care. “Sharing clinical experience and research results” was discouraged. (P.25).

f. Throughout the early 1970s JCAH staff, when receiving enquiries from hospitals and others about the role of chiropractors in hospitals, replied that “the Commission would withdraw and refuse accreditation of a hospital that granted privileges to chiropractors”. Withdrawal of accreditation would be “devastating” and likely lead to closure. (Pp.53-54).

g. The ACR was particularly antagonistic towards chiropractic. “Almost all radiologists are members of ACR. Radiologists would heavily influence any hospital decision relative to chiropractors”. “Throughout the mid-1970s ACR informed its members in response to member enquiries that it was unethical to associate with chiropractors, because chiropractic was

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unscientific". The ACR, beyond its conspiracy with the AMA, established an independent conspiracy of its own. (Pp.85-101).

h. The Wilk lawsuit was filed in 1976. That year the AMA suspended distribution of its 1967 antichiropractic policy. Over the next 2 years it fashioned a new policy statement on chiropractic (Report UU). The Court rejected the AMA's evidence that this was a genuine change of heart. The Report "was obviously written by lawyers in an effort to bring the AMA into compliance with antitrust laws, and not a bold change of position designed to reverse the attitudes of AMA members formed ... by the then 11 year old boycott". (Pp.15-17).

i. The AMA boycott was in existence from 1966 to 1980, when the AMA adopted a completely revised set of ethics, and Principle 3 relating to unscientific practice was eliminated.

j. In law the boycott ended in 1980. However, the AMA has never "acknowledged the lawlessness of its past conduct", has never made "an affirmative statement that it is ethical to associate with chiropractors" and the effects of the boycott continue. (P.48).

k. Throughout the period of the boycott the AMA had evidence from its own members and independent sources as to the effectiveness and cost effectiveness of chiropractic services, and that "chiropractors were better trained to deal with musculoskeletal problems than most medical physicians". This was suppressed. The aim was to destroy the profession as a competitor. (P.31). As a member of the Committee on Quackery said in 1964 "it would be well to get across that the doctor of chiropractic is stealing the young medical physician's money". (P.22).

E. Consequences – U.S.

26. When the lawsuit was filed in 1976 the AMA was 10 years into a boycott that was isolating and weakening the practice of a competing licensed profession that the public had found effective in an area neglected by medicine – conservative treatment of many ailments, notably musculoskeletal pain and headache, emphasizing precise techniques of spinal adjustment or manipulation. Because of the lawsuit:

a. Medical organizations (the powerful Illinois State Medical Society almost 10 years ago) altered their ethics to allow cooperation between MDs and DCs. This immediately led to great advances in joint chiropractic and medical research and practice.

b. Now there are express policies of cooperation from the official bodies representing the medical specialties who have been most threatened by and antagonistic towards the chiropractic profession – surgeons, orthopaedic surgeons and radiologists. Additionally, and this is the most potent new ally of the patient and force for change, any AMA member who works covertly to frustrate the natural cooperation of MDs and DCs is in contempt of a permanent court order and liable to penalty. If he/she takes steps to promote the medical profession's interests above those of the patient it is illegal. He/she must hearken to the law before the medical profession.

c. Many hospitals, which formerly risked loss of accreditation at the hands of the JCAH, AHA and AMA and closure if they cooperated with chiropractic as the law allowed and their individual staff members often wished, now have chiropractic staff. This trend will now explode as natural market forces and the integrity of individual MDs flow into action.

d. The worldwide 'official' source of medical information on chiropractic has been exposed for what it is. The great majority of individual MDs obviously have their patients' interests foremost and are prepared to work with any skillful and ethical practitioner who can help. MDs are busy – many have not investigated or had any personal exposure to chiropractic. They, not unreasonably, have relied on official views of the AMA, ACR, AHA, and others expecting these to be based on intelligent inquiry. They must now re-think their position and, over time, will. The worldwide independent evidence documenting the specialized skills and effectiveness of chiropractic is now compelling. (They might start by examining the program of the recent inter-disciplinary conference in London set forth in this Report. See Insert).

e. Having regard to the awesome power of the AMA and the medical profession in shaping public and government attitudes towards health care, it is probably fair to say that the Wilk case will prove to be as important as licensure in achieving broad public acceptance of chiropractic within the United States.

F. Consequences – Internationally

27. Chiropractic was born in the United States and internationally the medical profession, which holds similar political influence in each country – arguably greater in Western Europe than in the U.S., has turned to the AMA for information on chiropractic.

Worldwide chiropractors hear patients reporting that their MD or physiotherapist told them that chiropractic is 'unscientific', a 'cult', somehow philosophically incompatible with western scientific medicine. Worldwide chiropractic leaders hear the same recurrent theme from medical associations, hospitals, worker's compensation boards and ministries of health. These views echo the central policy of the AMA conspiracy.

28. Chiropractic representatives worldwide can now document that all of this proceeds from an illegal AMA plan to destroy the chiropractic profession, and has been found in comprehensive antitrust litigation to be an "objectively unreasonable" view of the chiropractic profession during the past 20 years. (See para 9).

In France and England and Australia and Hong Kong, politicians, courts and hospital administrators now have independent evidence allowing them to confront the attitudes of political medicine as never before.

29. Is the court right about the AMA and this conspiracy? There is no room here for the wealth of evidence presented and

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accepted by the court. However, here is one example not given to the court which illustrates the international scope of the boycott and how closed the AMA's mind was to real evidence concerning the chiropractic profession. Emphasis is given to the field of radiology in these brief comments.

a. In 1974 the State of Victoria in Australia was contemplating legislation regulating the chiropractic profession. The medical profession was bitterly opposed. Sensibly the government sent a senior orthopaedic surgeon, Mr. John Jens, to North America on a fact finding mission.

b. On arrival in the United States Jens consulted the AMA, met on several occasions with the Committee on Quackery attorney, Mr. Doyl Taylor and reported the "very deep professional antipathy" towards chiropractic of the AMA which "was going to considerable lengths to prevent any recognition of the chiropractic profession".⁷

c. However, Jens also visited the chiropractic profession and 3 of its colleges – Palmer, National and the Canadian Memorial Chiropractic College. His findings:

- i. "A remarkable warmth of welcome". (P.3).
- ii The chiropractic college radiology departments "for the most part are excellent and led by very capable radiologists". (P.28).
- iii. Chiropractors from the better schools "are highly skilled and practise in a rigid course of ethics". (P.3).
- iv. "I was more than impressed by the overall chiropractic picture that is being built up in North America".⁸

d. This Jens report was prepared and filed in 1975, in the middle of the AMA boycott. Such evidence was open to the AMA if it had wished to investigate impartially. (Victoria today has legislation regulating the practice of chiropractic and a government funded chiropractic college).

e. In 1978, still within the period of the boycott, there was a comprehensive government Commission of Inquiry into chiropractic in New Zealand. The New Zealand Medical Association ('NZMA') bitterly opposed recognition of chiropractic alleging the profession was an unscientific cult, philosophically incompatible with western scientific medicine. Its case was led by a radiologist, Dr. Boyd Wilson, who gathered his evidence in the United States from the AMA, the ACR and sources traceable to them. The NZMA made no independent investigation of chiropractic, and no reference to Jens' work.

f. At the conclusion of formal evidence the 3 New Zealand commissioners also travelled to the United States as had Jens. Their report was even more positive than Jens' on the strong foundation of the modern chiropractic profession and they held "the chiropractor is at least as well trained in (his field of x-ray) as the medical radiologist".⁹

This investigation, also completed during the period of the AMA boycott, again shows how closed the AMA mind on chiropractic was.

g. Now that the illegal activities of the AMA have been documented by the U.S. courts, these words of the New Zealand Commission carry new impact: "Chiropractors have for years been claiming that chiropractic treatment is beneficial... Yet it is astonishing to find that little if any constructive effort has been made by the medical profession to investigate these claims. In the face of that neglect it would appear unreasonable that organized medicine should be so bitterly and adamantly opposed to chiropractic. The approach of organized medicine to chiropractic is not one of detached scientific interest and curiosity about a form of treatment that appears to have helped a large number of patients. That is an approach which might have been expected; but instead it has been one of remorseless and unrelenting opposition".

Major reasons for this opposition according to the Commission? "... the history of chiropractic... coupled with misinformation about modern chiropractic theory and practice".¹⁰

References

- 1 Wilk et al v American Medical Association et al U.S. District Court (Northern District of Illinois Eastern Division) No. 76 C 3777, Getzendanner J, Judgement dated August 27, 1987. (101 pp. cost if ordered from this Report \$20.00 or 10£).
- 2 Wilk et al v American Medical Association et al Getzendanner J, Judgement dated September 25, 1987.
- 3 Agreed Settlement Statement dated June 12, 1987.
- 4 Agreed Settlement Statement dated September 24, 1987
- 5 Agreed Settlement Statement dated September 24, 1987
- 6 Wilk et al v American Medical Association et al, U.S. Court of Appeals (7th Circuit) No. 81-1331, Swygert, Sprecher and Doyle, JJ, Judgement dated September 19, 1983.
- 7 'A Report to the Victorian Parliamentary Committee on Chiropractic Osteopathy and Naturopathy' J. Jens (unpublished), p.4.
- 8 Letter J. Jens to Dr. D. Sutherland, President CMCC dated March 17, 1975.
- 9 'Chiropractic in New Zealand' Report of Commission of Inquiry (1979) P.D. Hasselberg, Government Printer, Wellington, New Zealand, 87.
- 10 Ibid, 28.

Professional Notes – continued from page 1.

Scott Haldeman, DC, PhD, MD, FRCP(C), FCCS(C), U.S.A.

"Clinical Neurophysiology and Neuropathology of the Spinal Motor Unit"

Clinical Assessment

Alan D.H. Gardner, FRCS, U.S.

"The Management of the Clinical Problem of Spinal Pain with the Assistance of a Micro-Computer"

Adrian Grice, DC, MSc, FCCS, CANADA

"Clinical Examination Techniques in the Identification and Management of Spinal Pain Syndromes"

John Triano, DC, MA, U.S.A. "Paraspinal Soft-Tissue Mechanical Properties"

Friday Program

1. (Great Hall)

Diagnostic Imaging Techniques

Lindsay J. Rowe, BAppSci, DACBR, AUSTRALIA
"The Scope of Plain Radiology in the Diagnosis of Spinal Pain"

Iain W. McCall, FRCR, U.K.

"Provocation Radiology Techniques"

Kenneth B. Heithoff, MD, U.S.A.

"High-Tech Imaging of Degenerative Nerve-Root Entrapment Syndromes – a Comparison of Myelography, CT and MR"

Brian Hammond, DC, PhD, U.K. "Diagnostic Ultrasound in the Diagnosis of Lumbar Spine Disorders"

Panel Discussion

Kenneth B. Heithoff, MD, U.S.A.

"MR and CT of Degenerative Disc Disease with a Double-Blind comparison of MR and CT in the Evaluation of Post-operative Recurrent Disc Herniation Versus Fibrosis"

Psychological Assessment

Chris J. Main, MA, M.Phil, PhD, FBPsS, U.K.

"Psychological Assessment in Low Back Pain"

Functional Assessment

John Triano DC, MA, U.S.A.

"Functional Assessment Criteria in Evaluation & Rehabilitation of Low Back Pain Patients"

Management Session

Scott Haldeman, DC, PhD, MD, FRCP(C), FCCS(C), U.S.A. "The Objective of Conservative Care"

Howard Vernon, DC, FCCS(C), CANADA

"The Upper Cervical Syndrome: Vertebrogenic Headache and Vertigo"

Panel Discussion

Program 2. (Small Hall)

Kim Jeffrey, BSc, DC, U.K.

"The Use of Traction in the Management of Lumbar Disc Syndromes"

William H. Kirkaldy-Willis, FRCS, FACS, CANADA

"Lumbar Supports in the Management of Low Back Pain"

Adrian Grice, DC, MSc, FCCS, CANADA

"Practical Demonstration – Cervical Spine Manipulative Techniques"

J. John Faye, DC, U.S.A.

"Practical Demonstration – Lumbar Spine Techniques"

Adrian Grice, DC, MSc, FCCS, CANADA

"Practical Demonstration – Lumbar Spine Techniques"

Don Fitz-Ritson, DC, BA, CANADA

"High-Tech Pain Relief – CODETRON"

Panel Discussion

Alan C. Breen, DC, UK

"X-ray Digitilisation – The Way Forward?"

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Brian E. Kendall, FRCP, FRCR, U.K.
"Magnetic Resonance Imaging in the Diagnosis of Spinal Pain"

John P. O'Brien, Ph.D., FRCS, FACS, U.K.
"Videotape Session Techniques of Spinal Fusion – Simultaneous Combined Anterior and Posterior Fusion"

Peter Collinson, MCSP, DipTp, BSc, U.K.
"The Effects of Exercise in Low Back Pain"

Ole Jochumsen, DC, DENMARK
"Back School in Chiropractic"

Panel Discussion

Saturday Program

Program 1. (Great Hall)

Management Session (continued)

Don Fitz-Ritson, DC, BA, CANADA
"Management of Cervical Pain Syndrome"

William H. Kirkaldy-Willis, FRCS, FACS, CANADA
"The Diagnosis and Management of Spinal Myofascial Pain"

Henry V. Crock, FRCS, FACS, AUSTRALIA
"The Management of the Clinical Syndrome of Spinal Canal Stenosis"

John A. McCulloch, MD, FRCS, FACS, U.K.
"Surgical Fusion Techniques in the Management of Intractable Spinal Pain"

John P. O'Brien, PhD, FRCS, FACS, U.K.
"Surgical Fusion Techniques in the Management of Intractable Spinal Pain"

Panel Discussion

L. John Faye, DC, U.S.A.
"The Palpation and Adjustment of Long-Axis Dysfunction of the Spinal Joints"

Allan G.J. Terrett, DipAppSci, DipTertEd, FACCS, AUSTRALIA
"Vascular Accidents of Cervical Spine Manipulation-Frequency, mechanisms, sequelae and their implications for Chiropractic"

Gunilla Myrner, RPT, SWEDEN
"Prevention of Back Pain in the Workplace"

Chris J. Main, MA, M.Phil., PhD, FBPsS, U.K.
"Psychological Approaches to the Treatment and Management of Low-Back Pain"

Panel Discussion

CLOSING ADDRESS

Andries M. Kleynhans, DC, AUSTRALIA
"The Future of World Chiropractic Education"

Program 2. (Small Hall) Presentation of Research Papers

"An Image Processing Method for Spinal Kinematic Measurement – A Feasibility Study"

Alan C. Breen, DC, Robert Allen, Ph.D., Andrew Morris, FRCR, U.K.

"The Use of Diagnostic Ultrasound to Observe Intersgemental Joint Motion in the Neck"

Sally A. Ruston, MCSP, U.K.
"Stereoscopic Video Recording of Gait – An Investigation of the Sacro-iliac Gyroscopic Mechanism"

Claude B. Illi, DC, Dominique O. Klinckenbergh, DC, Jacques L. Charpentier, DC, Pierre-Louis Gaucher-Peslherbe, DC, MA, Ph.D., SWITZERLAND AND FRANCE
"A New Way of Evaluating Scoliotic Curvature Radiological Measurement Using a Known Reference Phantom"

James Baker, DC, John Triano, DC, MA, John Aikenhead, DC, U.S.A.
"Percutaneous Automated Lumbar Discectomy"

Gary Onik, MD, Kevill Gill, MD, Vert Mooney, MD, John McCulloch, MD, FRCS, U.S.A.

"The Habitual Standing Posture and Intrinsic Spinal Muscle Function"

Barbara Polus, BAppSci(Chiropractic), MSc., AUSTRALIA

"The Effect of Glycosaminoglycan Polysulphate on the Development of Experimental Intervertebral Disc Degeneration in Rabbits"

Kevin, Gill, MD, T. Viderman, MD, T. Shimzu, MD, Vert Mooney, MD, U.S.A.

"The Relationship between Whiplash Injury and Subsequent Lower Back Complications"

Sarbjit Singh Neel, DC, Vancouver CANADA
"Acute and Chronic Factors in the Management of Increased Muscle Tone"

Barbara Polus, BAppSci, MSc, AUSTRALIA

"Sensitivity Study of H-Reflex Alterations in Acute Idiopathic Low Back Pain Patients within a Health Population"

C. Robert Humphreys, MS, DC, John J. Triano, MA, DC, U.S.A.

"The Effect of Motion on the Development of Experimental Disc Degeneration in Rabbits"

T. Videman, MD, Kevin Gill, MD, T. Shimzu, MD, V. Mooney, MD, U.S.A.

"Changes in Lumbar Kinematics as a Result of Sacroiliac Joint Manipulation"

Draw Mallory DeMann, DC, U.S.A.

"Physiological Studies of the Dorsal Horn"

Alan W. Tyler, BSc, U.K.

"Neck Muscle Strengths of Clinic Patients"

Sean Moroney, DC, Ph.D., U.S.A.

Observations

1. Does the chiropractic profession engage in adequate research? To quote Prof. Kirkaldy-Willis, orthopaedic surgeon of Canada, reviewing the above program: "The claim that chiropractic is unscientific is gone".

2. "Plain film radiology remains the focal point of spinal imaging. It is the most simple and cost effective form of diagnostic imaging available in clinical practice today". Lindsay J. Rowe, DC, DACBR, Australia, coauthor of the text 'Essentials of Skeletal Radiology'.

3. "The diagnosis of back pain is an art awaiting to become a science", Alan Gardner, FRCS, orthopaedic surgeon, U.K.

4. Perhaps the best sessions were those which showed medical experts and chiropractors how much they need each other's different perspectives and clinical skills. At the Saturday morning panel discussion John McCulloch, MD, FRCS, formerly of Toronto now of Akron, Ohio, and a leading figure in chemonucleolysis and disc microsurgery, disagreed with chiropractic and medical experts speaking of the prominent role of facet pain. He was unconvinced on the existence of facet pain at all. What was interpreted as facet pain was probably just myofascial pain and "how would you distinguish between these two?"

Kirkaldy-Willis gave a medical response, listing the precise tests he used to distinguish between myofascial and facet pain, and commenting that where there was facet pain injection of saline into the painful facet brought immediate relief.

A Swiss chiropractor from the floor then gave the chiropractic answer. He explained to the panel of medical experts how simple it was for

a chiropractor to distinguish myofascial and facet pain through techniques of palpation, eliciting and comparing pain in various ranges of flexion and extension that put the muscles fascia and facet joints under varying biomechanical loads.

This comment showed, said Henry Crock, an orthopaedic surgeon, how much medicine and patients needed the chiropractic profession – surgeons had no training in or understanding of the movement palpation tests just referred to.

The whole panel discussion, Crock said, showed "how dangerous experts are". He illustrated this with a tale of his illness with suspected polio as a young man while studying at Oxford. A world renowned polio specialist examined him and announced he did not have polio. As he felt most unwell, Crock asked the specialist what he might have, and received the reply, "If it isn't polio I haven't the slightest idea my dear fellow".

5. During the conference a number of medical experts emphasized the value of skilled spinal manipulation for patients after spinal fusion operations. This was to relieve residual pain after a settling period of 6 weeks to 3 months. Such chiropractic care was valuable both for the lumbar spine (Kirkaldy-Willis) and the cervical spine (O'Brien).

6. All the old chestnuts, producing disagreement between different medical specialists, different chiropractors, and medicine and chiropractic emerged, including movement of the sacroiliac joint, the role of facet pain, the degree to which spinal fusion surgery should be used, and whether fusion produces subsequent mechanical difficulty at adjacent levels. What is so valuable at an inter-disciplinary conference with many of the world's leading experts present is that everyone must be humble and acknowledge how little they understand.

While some medical experts present were satisfied concerning movement of the sacroiliac joint and the clinical importance of S/I subluxation or fixation, others disagreed. However, they were then exposed to a lucid and compelling explanation by Adrian Grice, a prominent Canadian chiropractor, of the role of sacroiliac fixation. Grice added that it was his clinical observation that sacroiliac fixation was a frequent result of lumbosacral fusion, and that manipulation gave excellent pain

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relief. Nothing was written on this because "we don't have sufficient numbers in practice for a good study" which could only be performed in a long-term cooperative research project. However, the clinical results were compelling.

7. John O'Brien, a British spinal surgeon speaking on 'Mechanisms of Spinal Pain', confirmed the "staggering confusion" within medicine on the causes and diagnosis of spinal pain. Pain referral patterns from simple vertebral mechanical problems were poorly understood by surgeons who "don't examine and listen to the patient". Vertebrogenic abdominal pain is not recognized. Hysterectomies are commonly performed for simple L4/5 mechanical problems. Of particular interest were O'Brien's recent research and slides confirming that the outer annulus of the disc is in fact richly supplied with nerves. O'Brien concluded that the disc may be "the cause of major pain in the presence of a negative examination". While the disc has a rich nerve supply it is avascular, and thus has poor healing ability. This supports the view that the disc may be responsible for intermittent back pain again in the presence of negative medical findings.

8. Henry Crock, a senior orthopaedic surgeon from Australia, reported on his recent research into the vascular supply of the lumbar spine. Like most speakers he emphasized that much was not yet understood.

While arterial supply to the vertebral body is well documented "very little has been done on venous drainage" and this has been his area of recent research. While the disc is avascular, he explained how in his experiments dye from the disc had drained into the venous system at the end plates of the adjacent vertebral bodies. This exchange from the disc represented a source of pain not previously considered.

His comments on veins in the intervertebral foramen and nerve root canal were of interest. While arteries were "hard to compress" within these structures, the thinner walled veins were much more open to obstruction through facet subluxation or buckling of the ligamentum flavum into the intervertebral foramen. This represented another little considered mechanical source of low back pain.

VAS

9. Allan Terrett, a prominent Australian chiropractic researcher, presented a beautifully illustrated and thorough overview entitled 'Vascular Accidents of Cervical Spine Manipulation' and came up with a controversial recommendation. Essential points made were:

- Upon review of all cases reported to date there is no correlation between vascular accidents and sex, age, or degeneration.
- Risk arises from rotation not thrust. (In a

recent study on cadavers 19 vertebral arteries out of 20 were occluded reducing blood flow to under 10% by cervical rotation. When lateral flexion was combined with rotation only 1 out of 20 was significantly occluded).

- George's test (comprising history, bilateral blood pressure testing, auscultation for neck bruit and certain premanipulative tests) can elicit contraindications to spinal adjustment, but on the other hand is overall a poor predictor. Thus a negative George's test can engender a false sense of security. (The single most important point in taking a history relates to experience of vertigo or ischaemic symptoms. If this is present enquire whether it could possibly be related to neck position).

- Most problems in practice, believe it or not, have arisen from repeat adjustments after symptoms following the first adjustment. The single most important piece of advice is do not adjust again following difficulties.

- His conclusion was that, since the problem is rotation not thrust, in upper cervical adjusting there should be no movement to lock the spinal joints and no use of significant rotation. Until more reliable screening tests are known chiropractors should use alternative techniques – toggle recoil or techniques that take up tension using lateral flexion.

Many present felt this was extreme advice having regard to the rarity of significant vascular accidents (2 or 3 per 1 million treatments) and the importance of restoring correct rotational movement in the upper cervical spine.

Questioned on the matter Scott Haldeman, chiropractor and consulting neurologist of California, an acknowledged expert in this field, said that controlled rotational techniques to the upper cervical spine in the absence of positive contraindications remained within the reasonable and normal standard of chiropractic care. Interestingly however, he personally has not used techniques with significant rotation for 10 years now.

Opening address

The privilege of the opening address was given to Dr. Louis Sportelli, an ACA Governor from Pennsylvania, who gave 2 reasons why this World Conference was timely. Firstly the modern professional world is small and closely inter-connected – "what one chiropractor does in practice in Denmark or Switzerland has immediate relevance in the United States or Australia." Secondly, because of this interdependence and shared future, chiropractors must present a consistent identity internationally. "Chiropractors graduating in Paris, Bournemouth, Davenport, Lombard or Melbourne must have a similar understanding of what it is to be a chiropractor. Every

chiropractor will have experienced the difficulties of referring a patient to another chiropractor when the patient moves across town or across the ocean. Whether the patient be in Brussels or Tel Aviv, Sydney or San Francisco, he or she should have the right to similar expectations and experiences when visiting a chiropractic office".

To achieve a clear chiropractic identity in the world health care community Dr. Sportelli suggested "the time is now ripe for a World Federation of Chiropractic" and recommended urgent steps to form such a body. Unity was also important, Sportelli said, in educational standards, research efforts and the direction of public relations.

Another major shift in chiropractic should be a new and better level of interprofessional cooperation. Chiropractic has in the past claimed to be, and been viewed as, an alternative healing art separate from the established health care system. However, the chiropractic world has "changed dramatically" over the past 20 years, with research and government enquiries worldwide finding chiropractors "to be well-educated, highly competent in their field of practice, safe, effective, cost efficient and in increased public demand". Prime reasons why chiropractic had to form an integral part of the established health care system, rather than seek separate identity, included the ever-increasing government involvement in health care, third party influences, and competitive realities in the increasingly over-crowded health care marketplace.

Closing Address

The conference was closed by Dr. Andries Kleynhans, President of one of Australia's 2 chiropractic colleges, the Phillip Institute of Technology in Melbourne. Dr. Kleynhans spoke on "The Future of World Chiropractic Education". He was well qualified for this, having trained and done postgraduate work at National College in the U.S.A., and having been President for 10 years of a major accredited chiropractic college during its sometimes stormy transition from professional to government funding.

Kleynhans' theme, indeed warning, followed naturally from Sportelli's advice that chiropractic must establish itself as an integral part of national health care systems. He explained that if chiropractic was to have an assured future, if it was to have adequate funding for education and significant research, and if it was to attract continuing government and community support, it was imperative that chiropractic education enter the university systems in each country where the profession was established. This should be a major and urgent priority for the profession internationally.

(Program, International Chiropractic Conference – including biographies of faculty and abstracts of some presentations – may be ordered through this Report's paper back up service PNI).

This Issue: extended to 8 pages because of the importance of the Wilk Case and the London Conference.

Next Issue: the promised article on cost effectiveness of chiropractic, bumped from this issue by the Wilk Case, will now appear in the January 1988 issue.

Presidents' Summit

The First Chiropractic World Presidents' Summit was held in London, England on September 23, 1987. Convened by the European Chiropractors' Union (ECU), in conjunction with the ECU's International Chiropractic Conference (see Insert to this Report), it was attended by national association presidents from the U.S.A., Canada, Australasia, the Far East, Jordan, Cyprus, Greece and Western Europe, together with other delegates. This was a forum for discussion of issues of common concern to chiropractors throughout the world. Major items were:

1. **Formation of a World Federation.** There was unanimous support for a motion presented by Dr. Miriam Minty, President, Australian Chiropractors' Association, seconded by Dr. Paul Carey, President Canadian Chiropractic Association, to establish a working party with representatives of the 5 major national associations (ACA, Aust. CA, CCA, ECU and ICA) to establish a constitution and structure for an international federation of national chiropractic associations. This Committee will consult widely and report to the International Chiropractic Congress in Sydney, Australia in October, 1988.

It was agreed that obvious useful functions of such a World Federation would include a forum for communication on common professional issues, collation and distribution of information, a means of establishing a better and more consistent chiropractic identity worldwide, and an international body representing chiropractic that international organizations can deal with.

Medicine, medical specialties including physical medicine, physiotherapists, specialists in manual medicine, dentists, optometrists and most other significant health care groups already have such world federations protecting their interests.

2. **Unqualified Spinal Manipulation.** A detailed recent submission to government by the Canadian Chiropractic Association had been circulated prior to the meeting. Delegates from all countries with an established chiropractic profession compared experiences. These ranged from jurisdictions such as the U.S. and Canada where 'spinal manipulation' is the domain of chiropractors and practise by MDs and PTs is in its infancy, to countries such as The Netherlands. There, it was reported by the Dutch President, Dr. Roland Blaauw, there is an oversupply of physiotherapists. There are 9,000, 1,000 of whom practise spinal manipulation after some formal training. The 35 chiropractors in The Netherlands are seen as superspecialists encroaching on an area lying within physiotherapists' domain. (Interestingly, Dr. Blaauw was first trained as a PT. In his practice he restricts himself

entirely to spinal adjusting, employing a PT to do supplementary work with modalities).

3. **Country reports – Sweden.** A number of most interesting country reports were made. The Swedish President, Dr. Stroh, spoke of a recent government study of chiropractic in Sweden as follows:

a) In Sweden there is no legislation currently regulating the practice of chiropractic.

b) A Swedish government Commission on Alternative Medicine concluded a thorough study of chiropractic in Sweden in February, 1987. The Commission's investigation included an assessment of the scientific literature by the Department of Social Medicine, University of Umea, and a survey by Statistics Sweden. It reported:

- There are several hundred practitioners calling themselves 'chiropractors' but those with the doctor of chiropractic degree from recognized colleges (DCs-numbering approximately 100) have a distinct and superior level of education and practice.

- These DCs "should become registered practitioners and be brought within the National Health Insurance system in Sweden".

- "DCs follow a 4 to 5 year course of university level training, which is regarded internationally as being good quality. This training has already twice been examined by Swedish authorities and, in its pre-clinical parts, it has been found to be the equivalent to Swedish medical training". DCs have "competence in differential diagnosis" and should be regulated on a primary care basis.

- Because of the large number of naturopaths, osteopaths, lay persons and others using the title 'chiropractor', there must be legal protection of this professional designation as a matter of public safety.

- "Measures to improve cooperation between chiropractors, registered medical practitioners and physiotherapists are vital" in the public interest.

All contacts by the Commission during its enquiry "confirmed that not only the man in the street but also those working in the public health sector have increasing faith in the work of doctors of chiropractic".

- Registration of chiropractors would give health care authorities an additional recognized resource "in a field which has certain queue problems" and at the same time "would possibly achieve some savings" because of the evidence of cost effectiveness of chiropractic.

(*'Legitimization for Vissa Kiropraktorer'* report on Commission on Alternative Medicine, Social Departementete, English Summary, SOU 1987:12, Stockholm (1987) PN2)

A Respected Chiropractor Speaks . . .

"Chiropractic must be to manipulation what microsurgery is to general surgery".

"There can never be routine adjusting for those with visceral problems and this is part of the art of chiropractic and the lore of the profession that needs to be passed from one generation to the next. Regretfully, the scramble for weird and wonderful methods has taken the place of effort to master the art of adjusting. A vertebra does not know, nor care, about the name of the technique or the position of the patient, but may be acutely distressed by force that has not embodied corrective vectors to produce movement in the three-dimensions of the distortion, plus distraction to minimize friction."

Being proficient in the application of "real adjusting" is the answer to the competition of the manipulators in other professions, who are moving into this field of health care".

'The Challenge of the Future', A. Earl Homewood, D.C. *The Digest Chiropractic Economics*, May/June 1987 78-81 and 142. PN3

The Aging Population

The best evidence on social profile of chiropractic patients is this 1985 paper by Ian Coulter Ph.D, a sociologist, now President, Canadian Memorial Chiropractic College, Toronto. This uses data obtained in a large government funded survey of the profession in Canada in 1977. Details:

- The study is based on interviews with 658 patients selected randomly. 349 chiropractic clinics nationwide were chosen at random. These were stratified by province and community size. From these strata a random sub-sample of 70 clinics was then chosen. Each clinic was observed for a day, and interviews were held with 10 random patients. 94% of patients cooperated – a total sample population of 658.

- The study produces 2 fundamental findings of importance:

1. Generally "the patients are barely distinguishable from the general population" in terms of sex, age, occupation, income and education.
2. The exception is that there is a much higher percentage of older patients than in the general population. The age range in which patients most exceeded numbers in the Canadian population was age:
 - 50-64 – 27.5% versus 13.6%, an over-representation of 100%.
 - 14.1% of patients were 65 and over – a figure 60% over the proportion of this age group in the general population – 8.7%.

Here is hard evidence confirming clinical experience that chiropractic care is particularly valuable for older and elderly patients.

'The Chiropractic Patient: A Social Profile', Coulter I.D., *J Can Chiro Assn.* (March 1985) 29(1): 25-28. PN4.