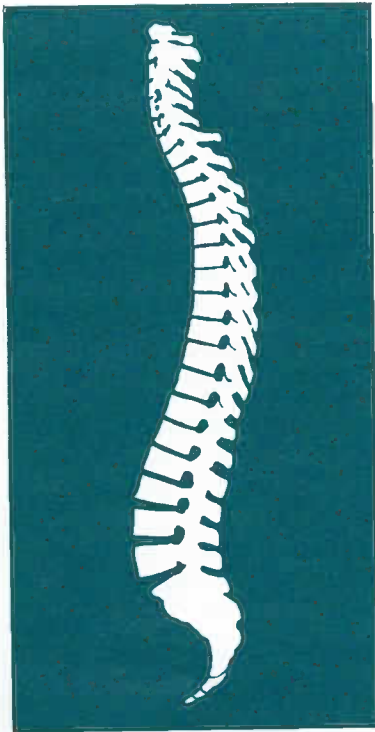


# THE CHIROPRACTIC REPORT

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

May 1999 Vol. 13 No. 3



## PROFESSIONAL NOTES

### Integrated Medicine in New York

A recent interview with Woodson Merrell MD, a physician who is developing an Integrated Medicine Center at New York City's Beth Israel Medical Center, illustrates the radical shift occurring in North America to the integration of chiropractic and other complementary approaches into primary medical care.

Merrell is from a generation of physicians that was raised with alternative medicine – he had successful homeopathic treatment as an infant and has trained in acupuncture, which is about 50% of his practice. But these are the reasons why his comments, published in the journal *Alternative and Complementary Therapies*, are important:

- Merrell explains that the move to integrated medicine at the Beth Israel Medical Center is not just his idea, or that of a few enthusiasts. People are backing this at every level of the Medical Center, which is affiliated with three other hospitals and three medical schools. The president of the Medical Center “is one of the most elegant spokesmen for this” and “when I went to talk to the chairs of

*continued on page 4*

## THE FUTURE OF CHIROPRACTIC IN AN ERA OF RAPID CHANGE

“Although chiropractic has arrived as an institutionalized part of America’s health care system, arrival does not automatically confer permanent success . . . medical movements as well as individuals operate in a dynamic world of constant flux”.

J. Stuart Moore, PhD, Historian, *Chiropractic in America, The History of a Medical Alternative* 1993.<sup>1</sup>

### A. INTRODUCTION

Health care systems in many countries are presently undergoing more dramatic change than ever before. A more informed public, seriously concerned about the lack of safety, ineffectiveness, impersonal nature and cost of much of mainstream health care, is increasingly taking control of health care decisions.

There is the greatly increased use of complementary and alternative medicine discussed in the last issue of this Report (March 1999), with patients shopping for health. A true marketplace based on effectiveness, cost and patient satisfaction is eating into historical monopolies. Technology is providing sophisticated databases with score cards for individual patients and providers. A surplus of medical doctors, nurses and other health care providers is seeking new scope of practice, and competition for the health care dollar is escalating. What is the future of chiropractic in this evolving world?

This question was recently addressed in the US in two expert reports from the Institute for Alternative Futures (IAF), a Washington DC corporation which does health care forecasting in many countries and for the World Health Organiza-

tion, and which was founded by prominent futurists Alvin Toffler and Clement Bezold. This issue of the Report reviews the IAF reports, summarizes the most important internal and external factors that will influence the chiropractic profession’s future, and then ventures several predictions.

### B. INSTITUTE FOR ALTERNATIVE FUTURES’ REPORTS

2. The two IAF reports, *The Future of Chiropractic: Optimizing Health Gains*<sup>2</sup> and *Future of Complementary and Alternative Approaches (CAAs) in US Health Care*,<sup>3</sup> were commissioned by a leading US chiropractic corporation providing professional liability insurance and managed care services, NCMIC Group Inc. NCMIC asked the IAF to look at the profession and US health care trends then provide recommendations on what the profession needed to do in order to prosper over the next 10 years. The IAF’s formal forecasting process included:

- analysis of present facts and trends – based on its own database, consultation with leading practitioners and experts in chiropractic and health care generally, and focus groups with consumers, chiropractors and health care executives;
- identification of key factors; and then
- the development of several alternative scenarios or ‘plausible futures’.

In other words, this is not crystal ball gazing but forecasting based on sound methods and considerable evidence.

3. Key points from its reports include:

- 1) In the next decade there will be oversupply in all the major health care professions and fierce competition. Experts

predict surpluses of 100,000 physicians and 200,000 nurses. There are 55,000 chiropractors in the US today but, on current enrolments and predictions, that number will nearly double to 103,000 by 2010.

2) There will be much more public demand for complementary and alternative approaches (CAAs) to health care including chiropractic/manipulation (currently the most used), oriental medicine/acupuncture, homeopathy, naturopathy, massage therapy, and nutritional therapies. Successful primary medical care practices will have to include these CAAs.

3) Many physicians, nurses, physical therapists and others will try to learn and provide these CAAs themselves, but many others will work with specialists including chiropractors.

4) Success for all health professionals will be ruled by the quality of their data on treatment results or – to use the technical term – outcomes. The key outcomes will be effectiveness, cost-effectiveness and patient satisfaction. To maintain and/or increase its market share the chiropractic profession must have convincing statistics from clinical practice with respect to specific health problems (e.g. headache, arthritis, asthma) and with respect to preventive/wellness care.

Currently an estimated 14%–35% of chiropractic visits are for preventive/wellness visits but, even though the public will be demanding more services in this area, the role of chiropractors will be decreased unless they have the right supportive data. Reasons are that patients will also be looking to other CAAs, such as acupuncture and homeopathy, for preventive/wellness care, and greatly increased numbers of physicians, nurses and others will be seeking to provide CAAs themselves.

5) Managed care by 2010, contrary to what most people think, will not rebound from current cost management mistakes to return to something closer to the more familiar fee-for-service approaches. Managed care will dominate the marketplace, but will be far more effective, prevention-oriented and customized. However one major source of man-

aged care will be self-managed care – individuals and families, using the same information tools as managed care organizations, will choose to manage their own care privately, using only high-deductible catastrophic insurance as backup.

6) Three major priorities for the chiropractic profession are:

1) *To define its role in the rapidly changing health care system. Are chiropractors spinal specialists, primary care providers, partners with medicine in mainstream health care, or holistic practitioners alternative to and separate from the medical profession? The profession lacks a clear role in health care, and a serious coordinated effort from the grassroots up will be necessary to correct the problem. "Without a clear and agreed upon role, and a shared vision, the profession will decline and suffer greatly in the near future because of new competitive pressures."*

2) *To collect convincing data and practice statistics from clinical practice. Currently this only exists for the management of patients with back pain, and to a lesser degree those with neck pain and headache. There must now be a similar effort in all significant areas of chiropractic practice.*

3) *To develop the skills and capacities to work in many different health care environments. Major changes lie ahead for everyone and "the ability to be creative and integrate in various delivery systems is key to survival and growth."*

7) There are four possible scenarios for the US chiropractic profession in 2010. These are summarized in Table 1. On Scenario 1, the best and based on excellent new outcomes data proving chiropractic care is cost-effective for the conditions mentioned, chiropractors will be in Wal-Mart back centers and greatly increased demand will match increased supply.

On Scenario 2, the worst and on which the profession has no shared vision or good data beyond low-back pain, the IAF sees little room for growth, a number of chiropractic colleges closing, and the proportion of spinal manipulation in the US delivered by chiropractors dropping from 90% to 50%.

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In summary the IAF's reports are optimistic if the chiropractic profession can adapt to the challenges of the era but sobering if it cannot. The future of chiropractic as a healing profession "will be shaped by a host of forces" but the greatest of these is "the identity and creativity of chiropractors . . . the future of chiropractic is in the hands of chiropractors themselves."

**(To obtain a copy of the IAF Reports: *The Future of Chiropractic: Optimizing Health Gains and Future of Complementary and Alternative Approaches (CAAs) in US Health Care* are available from NCMIC Insurance Company, P.O. Box 9118, Des Moines, IA 50306-9118, by fax at 515-222-2994, or order online at [www.altfutures.com](http://www.altfutures.com). Cost US\$24.95 each – both monographs for \$39.00 (shipping and taxes included for US orders, for international orders add \$10.00 for shipping). MasterCard or VISA accepted.**

**Table 1: Overview of Four Scenarios for Chiropractic in 2010**

**Scenario 1 – More and Better Health Care** Managed care, outcomes and consumers drive health care. Chiropractic care is proven cost-effective for low-back pain, headaches, neck pain, arthritis, scoliosis, asthma and repetitive stress injuries, and as supplementary therapy for cancer and other conditions where the disease or treatment involves significant pain. Wal-Mart creates “the back center” in its stores and expands access to low cost chiropractic care. There are 103,000 chiropractors, with average visits per week holding at about 120, with back conditions representing 50% of visits and wellness another 20%. Underemployment among chiropractors holds at about 15%.

**Scenario 2 – Hard Times, Frugal Health Care** Chiropractic is drastically affected by frugal universal coverage through managed care; outcomes limit manipulation to back problems. Meanwhile, 50% of spinal manipulation is delivered by physicians, nurses and other health professionals. Chiropractic colleges close, as only 68,000 chiropractors are needed in 2010. Many of those still practising are forced to sell “the \$10 treatment”. Wellness visits decline and underemployment grows to 35%.

**Scenario 3 – Self-Care Rules** Very effective self-care, including advanced home health systems and universal catastrophic coverage, make health care a buyer’s market. Individuals and families can do most of their care very effectively at home, lowering the need for all types of providers. Surplus providers exceed the 450,000 number forecast in the 1990s by the Pew Commission. Health care professionals who provide “tough” are in high demand but competition is fierce. Chiropractors are able to increase demand significantly by ensuring they provide care to 60% of those Americans with back problems (rather than 40% as in the 1990s). Chiropractors also expand the indications they can treat with proven efficacy as well as provide evidence that for many people wellness visits are appropriate. The success of chiropractors leads to 85,000 chiropractors in 2010 (about 20,000 fewer than anticipated in 1997), but they are doing well.

**Scenario 4 – The Transformation** Chiropractors’ clarified and expanded vision for the profession leads them to expand their contribution to health outcomes for their patients and their communities. Wellness and self-healing through enabling the body to function effectively (the innate healing force) becomes a much sought-after contribution of chiropractors through manipulation – so sought-after that 50% of manipulation in 2010 is performed by non-chiropractors. Chiropractors broaden what they do with and for their patients and their communities. For their patients they combine intelligent information systems with high touch and assertive coaching. *From Institute for Alternative Futures, 1998.*<sup>2</sup>

### C. INTERNAL AND EXTERNAL FACTORS

4. The chiropractic profession has now established a permanent presence in the health care systems of many countries. The question is whether that presence will expand or decline. There are a number of important factors internal to the profession and in the external health care marketplace that will determine the future success of the profession generally and therefore influence all individual chiropractors. Some of these are apparent from the IAF report in the US,

some not. Major factors are now reviewed.

#### 5. Internal Factors. These include:

1) *A Clear and Agreed Identity and Role.* As long as chiropractic was a small profession with little direct competition, only needing to attract under 10% of the population and in circumstances where patients were free to make their own health care choices, there was no need for a clear identity. Because most practising chiropractors have lived in such an environment until very recently – and

in some countries still do – they have little appreciation of how much the lack of a clear identity is now hurting them.

Do chiropractors offer mainstream primary care, a holistic alternative to primary medical care, or specialist services in direct contact with the patient analogous to those of a dentist or optometrist? Are chiropractors prepared to work as part of a multidisciplinary team, including teams where the protocol provides a medical or nursing coordinator? These are questions about which the public and the other health professions remain unclear. As the historian Moore puts it, the current position is that chiropractors are “a somewhat curious mix of professional spine specialists still geared towards holistic systemic logic”.<sup>1</sup> This mix is not necessarily bad – in fact it may be very good – but it is confusing when many chiropractors acknowledge an evolution to a specialist role but others firmly deny it.

In recent years there has been substantial agreement on the role of the profession by representative bodies such as the Association of Chiropractic Colleges and the larger national chiropractic associations in North America and Europe. This role may be summarized as a primary contact profession specializing in the diagnosis, prevention and management of neuromusculoskeletal disorders by manual techniques, exercise, patient education and other natural methods. However there needs to be clearer communication of this agreed identity. Quite simply, a product or service not understood is not used. The public, the medical profession, and others in the health care system need to appreciate that:

- Chiropractic provides a specialised service, based on the fields of biomechanics, neurology and the manipulative arts, and addressing *functional* or movement pathology in the neuromusculoskeletal system rather than *structural* pathology;
- There is no medical specialty that provides this service – which is why the chiropractic profession has grown and flourished; and
- The length and quality of the specialised education required – such an educa-

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continued from page 1

the other departments virtually no chair was opposed to the idea of the (integrated medicine center) whereas three years ago these people would have been apoplectic, jumping over themselves to get me out of the room . . . there's been a radical shift".

- Merrell says that he currently refers to chiropractors and mentions that the new Center will have chiropractors.

- He emphasizes that this is not simply an entrepreneurial venture – Beth Israel is an academic center backed by various hospitals and medical schools which is going to combine clinical services and ongoing research.

All of this mirrors what is happening at Harvard, Stanford and several other medical centers around the US that are listed in the interview. Merrell says that his mission is not only to establish a successful integrated center but is also "to transform American medicine to the integrated model".

(Coulter AH (1999) *A Quest to Integrate Alternative Medicine into Conventional Medicine: An Interview with Woodson C. McNeil, MD, Alt and Compl Therapies*, February 1999:29-35.)

## NORTH AMERICA

### 2. US – Physician Survey on Alternative Therapies

A new survey from Ohio asked all 200 internal medicine and family physicians in the Stark County Medical Society about their attitudes towards and use of alternative therapies. On a good response rate of 48% the survey reported:

- 1 in 5 (19%) had used 'manipulation' and 4 out of 5 of these (83%) felt it was "probably or definitely beneficial". Of those using 'manipulation' 13 had consulted a chiropractor and 7 had consulted an osteopath.

- Chiropractic manipulation was the most commonly used practitioner-based form of alternative therapy and had higher reported benefit (77%) than acupuncture (67%), shiatsu (67%), and massage (67%) but not osteopathy (100%). None of the physicians surveyed had used naturopathy.

Current estimates are that 60 million Americans used some form of complementary or alternative medicine during the past 12 months but "approximately 70% did not tell their physicians about this use." (Crock RD (1999) *Confronting the Communication Gap Between Conventional and Alternative Medicine: A Survey of Physicians' Attitudes*, *Alternative Therapies* 5(2):61-66.)

### 3. US – 65% of HMOs Offer Chiropractic.

A new study on complementary and alternative medicine (CAM) in health maintenance organizations (HMOs) based on November 1998 to January 1999 telephone interviews with senior executives from 114 HMOs, representing 25% of the total qualified HMOs in the US, reports:

- 67% of HMOs offer at least one form of alternative care – the most common is chiropractic (65% of HMOs) followed by acupuncture (31%).

- 38% say demand among members led to the inclusion of CAM, 38% say mandates or legal requirements did so. Only 21% believe they will save money through inclusion of CAM –

30% believe CAM benefits will have neutral costs, and 49% believe it will add to costs. In other words, most have only added CAM because of external pressure.

- 85% of surveyed executives think the relationship between medical services and CAM will grow closer. 57% associate chiropractic care with "alternative medicine" but 43% do not consider it alternative. (Landmark Report II, Landmark Health Care, Sacramento, CA. Reviewed in *The Week in Chiropractic*, FCER, March 22, 1999).

### 4. Canada – \$1 Million for Ontario Headache Trial

In April the Ontario Ministry of Health granted \$1 million to the Canadian Memorial Chiropractic College for a trial of patients with chronic episodic tension-type headache which will compare chiropractic, medical and combined treatment. Principal investigators are Howard Vernon DC FCCS, CMCC and Gwen Janz MD PhD, St. Michael's Hospital and the University of Toronto. First patients will enter the trial this summer. Seed funding for the trial came from the Ontario Chiropractic Association and NCMIC Group Inc.

## EUROPE

### 1. Belgium – Laws to Recognize Chiropractic Finally Passed.

On April 22, 1999, following many years of persistent lobbying from the Belgian Chiropractors Union (BCU) led by President Philippe Druart DC, Belgium, one of the most conservative countries in Europe, has finally passed legislation to recognize and regulate the practice of chiropractic. This has great significance for chiropractic throughout Europe. The legislation recognizes four complementary disciplines, the other three being acupuncture, homeopathy and osteopathy. Chiropractic is to have a separate regulatory body or Chamber, and the UBC, which represents Belgium's 70 chiropractors, is being recognized by government as the official representative of the profession. Warm congratulations to all concerned.

### 2. Italy – Another New European School.

Chiropractic education arrived in Italy when the European School of Chiropractic commenced classes in Bologna in January. Located in a former monastery and with Dr. Peter Asselbergs (CMCC) as Principal, the school offer a three year part-time postgraduate course to medical doctors and has a first class of 10 students. Europe now has schools of chiropractic in Denmark, France, Italy, Sweden and the UK (4). Neither the Swedish nor the Italian schools are recognized by the national chiropractic associations in those countries.

### 3. UK – Major Advances in 1999.

The March issue of the British Chiropractic Association's newsletter *Contact* evidences the continuing strong growth of the profession in the UK. There are now four schools of chiropractic, three affiliated with universities. This summer, five years after passage of The Chiropractors' Act, the General Chiropractic Council opens its Register for formal regulation or licensure of chiropractic practice.

Last month there were two other milestones. Firstly on April 28 the College of Chiropractors, a professional organization at arm's length from the BCA that is devoted to continuing educa-

tion and will provide comprehensive professional development programs for the profession, was opened. The College, modelled on UK colleges for other health professions, has a broad network of clinical specialist Faculties and regional coordinators throughout the UK. Its president is Dr. Tim Jay. Secondly, many of the new primary care groups (PCGs) under the National Health Service (NHS) commenced operation in April and these provide the basis for chiropractic service agreements under which chiropractors will receive NHS funded patients.

Late last year this Report roundly criticized a July 18 BMJ editorial on chiropractic management of back pain by Ernst and Assendelft as flawed and biased. These authors have now received a further firm rebuke from Gordon Waddell MD, the Scottish orthopedic surgeon who is a leading authority on the management of back pain and co-author of the two sets of UK guidelines on the subject. In his letter to the editor (BMJ January 23, 1999) Waddell says "I am disappointed by Ernst and Assendelft's editorial on chiropractic. The authors present a critical view of chiropractic under the guise of scientific objectivity, but I had hoped that we had got beyond that stage of interprofessional confrontation." He identifies their review of the risks of manipulation as "particularly biased".

## WORLD CONGRESS ON WHIPLASH

The world's leading experts – health care personnel, traffic engineers, insurers and everyone else associated with the problem – met in Vancouver, Canada, from February 7–11, 1999 to discuss the latest research on whiplash associated disorders. Co-sponsors of this first World Congress included the Insurance Corporation of British Columbia, the BC Workers' Compensation Board and State Farm Insurance.

**Whiplash does have long-term effects.** Berglund et al reported a large Swedish study comparing the frequency of neck pain in the general population and patients with whiplash injury from rear-end auto accidents – at the time of the accident, which was in the period November 1987 to April 1988, and 7 years later. This study asked whether pain from auto whiplash injuries is generally time-limited, as many insurers contend quoting the Quebec Task Force Report, or not. It was found that the risk of neck or shoulder pain was increased "nearly threefold" (2.7) for those injured in auto accidents 7 years previously. In other words many patients have recurring and long-term difficulties. (Berglund A, Nygren A et al, Congress Abstracts, 99).

**• Most patients have genuine injuries and symptoms – the problem is that medicine can't find them.** Professor Nikolai Bogduk, University of Newcastle, Australia, is in that rare position where, because of his qualifications, research and personality he is willing and able to be a powerful critic of conventional management of whiplash patients. In a searing abstract titled *There Can be a Lesion; You Just have to Look* Bogduk explains that the cause of common whiplash symptoms "cannot be determined by conventional history and physical examination, or by conventional medical imaging" because these means are inadequate. "Such negative and pejorative opinions as have traditionally been cast on patients with whiplash disorders reflect the biases, prejudices and lack of knowledge of the so-called

experts . . . who do not know how, or bother, to investigate the patient properly."

"Modern biomechanics research has provided detailed models of what can happen in a whiplash injury. . . . There is now strong data from double-blind controlled trials to show that the single most common basis for chronic pain after whiplash is cervical zygapophysial joint pain. It accounts for at least 49% of patients, and perhaps as many as 65%. It accounts for some 50% of patients in whom headache is the dominant feature. Other putative causes of neck pain, such as discogenic pain and myofascial pain, have not been investigated under scientific conditions. They remain conjectural, but could account for the remaining 35–50% of cases."

"Behavioural studies have refuted the self-serving notion that these patients suffer compensation neurosis. Although there are fraudulent cases, the majority of patients earnestly suffer a genuine condition." (Bogduk N, Congress Abstract, 100–101).

**• Are cervical spine x-rays necessary?** A large Canadian study from two hospital emergency departments in Kingston, Ontario provided data on 669 adult patients involved in rear-end motor vehicle collisions between 1992 and 1998. 25% of patients were x-rayed at the time they were first seen. X-rays identified a fracture in only one patient. The researchers conclude that "a rear-end motor vehicle collision is an improbable mechanism for sustaining radiologically evident cervical spine injury, irrespective of the apparent clinical severity of the injury . . . In the absence of very high force/speed impact clinicians should feel safe in managing patients without the use of x-rays." (Brison R, Congress Abstracts, 102).

**• The importance of psychosocial factors.** Presentations from North America and many European countries suggested different injury patterns and recovery rates following similar vehicle whiplash injuries in different countries. This research supports the view, seen at the Congress and growing amongst payers, that recovery rates depend as much on psychosocial factors unique to each country as the physical injury.

**• The argument for early activity and exercises.** In a study by Bonk et al from Germany, in which 97 consecutive rear-end auto accident victims were randomly assigned to either an active treatment group (exercise and avoidance of immobilization) or a passive treatment group (use of a collar and rest), the active therapy group had significantly less pain and improved neck range of motion at 3 weeks, 6 weeks and 12 weeks. The researchers conclude that the Quebec Task Force recommendation for active therapy and avoidance of collars "is thus clearly justified". (Bonk A et al, Congress Abstracts, 111). Reviewing the international studies on the value of exercise for non-specific musculoskeletal conditions including neck pain, Margarita Nordin PT PhD, a respected authority from the Occupational and Industrial Orthopedic Center, New York, explained that appropriate exercise was effective, low-cost and worked on both the physical and psychosocial aspects of the patient's condition. (Congress Proceedings, 109).

In summary, the Congress reinforced the growing consensus that whiplash injuries have strong biomechanical and psychosocial components, and that optimal management of patients should combine early activity, exercises and skilled manual care.

tion, and the range of clinical skills or competencies it produces, cannot be achieved by other professions at an undergraduate level or in part-time postgraduate courses.

2) *An International Identity.* This is of increasing importance in our global village. Some professions, such as osteopathy which is the equivalent of the medical profession in the US but still has a scope of practice without drugs or surgery elsewhere, have lost an international identity. Fortunately the chiropractic profession has internationally agreed standards of education and legal scope of practice, and maintenance of these will be essential to its continued growth and acceptance.

3) *Clinical and Research Outcomes Data Supporting the Profession's Agreed Role.* The importance of this point is emphasized in the IAF Report, is understood by the profession's leadership, and this should not provide an insurmountable challenge.

4) *Willingness and Ability to Adapt.* This is one of the hallmarks of success for any profession, business or enterprise in this era and perhaps poses the biggest challenge to the future of the chiropractic profession. This is because chiropractors, from their educational process right through to their leadership, must change from a posture of independence – often to the point of open criticism of other providers and their attitudes to health – to interdependence and teamwork. As Stephen Covey has explained in his *The 7 Habits of Highly Successful People*,<sup>4</sup> independence will get you some distance but wider success depends upon networking, teamwork, win-win solutions and interdependence.

Many individual chiropractors have these skills. There are also case examples from countries such as Denmark, Norway and the UK where the profession as a whole has re-positioned itself with the medical profession and health authorities. This starts with education. Most Danish and Norwegian chiropractic students are at Odense University where they share many common basic science classes with medical students during the first three years of study. Chiropractors and medical doctors leave a university setting where they both understand their complementary roles in the health care system. A 1998 publication by the Norwegian Chiropractic Association titled *An Introduction to Chiropractic Management: Disorders of the Neuromusculoskeletal System*<sup>5</sup> and prepared for medical and other health providers, is evidence-based, presents chiropractic as a neuromusculoskeletal specialty complementary to and respectful of medicine and physical therapy, and immediately led to much greater cooperation between the professions.

There are similar trends in the UK and in Canada, where most chiropractic colleges are now affiliated with universities in the public educational system. But will the more volatile and divided chiropractic profession in the US be willing and able to make this transition to teamwork in the health care system? In the US most chiropractic colleges remain private, independent, largely isolated from other health science faculties, and reliant upon alumni support.

## 6. External Factors

1) *New competition in the field of spinal manipulation.* The

single biggest external factor influencing the future of chiropractic – so new in North America it is only now being recognized by the profession – is the recent arrival of competition in chiropractic's core field of skilled manual care for patients with musculoskeletal pain. Chiropractic has grown in a world where no other profession treated common back and neck pain confidently or well. Chiropractors could afford to be second or third choice with access and price disadvantages – enough patients would come to them in the end, find surprising relief after months of unsuccessful care, then tell their family and neighbours.

The 1990s has finally seen the scientific and medical acceptance of spinal manipulation for patients with acute and chronic back pain<sup>6,7,8,9</sup> and neck pain/headache<sup>10,11,12,13</sup>. At the same time clinical guidelines and peer leaders in medicine have rejected bedrest, most use of prescription drugs, most surgery and the physical therapy mainstays of passive machine therapies for most back pain patients. All of this represents a twin-edged sword for the chiropractic profession. It is now acknowledged that chiropractors have the correct approach, but as a result other professions are seeking to duplicate their services.

Fortunately for chiropractors skilled assessment of joint and muscle function, the wide range of manipulative techniques necessary to relieve disorders in the young child, the adult male labourer of 250 lbs and the elderly lady with osteoporosis and arthritis, and the whole approach to patient management that arises from a chiropractic philosophy of health are not easily acquired by other providers. However current international experience suggests:

- On one hand there will be no major competition from medical doctors. Many will take short courses in spinal manipulation, meaning to practice this art, but few will persist. The great majority will simply appreciate the long education and fulltime practice involved, and will end up referring more patients for skilled and specialist manual care. Those medical doctors who do practice will mostly practice part-time and at a rather crude skill level.

- On the other hand there is likely to be new competition from osteopaths, with British and French osteopaths bringing their traditional emphasis on manipulation and holistic care back to North America and into other world regions. Additionally North American osteopathic schools will refocus on their manipulative roots as the over-supply of physicians provides a more competitive marketplace in general.

- There will also be significant competition from the physical therapy (PT) profession. PTs without postgraduate specialization will not have the education and skill levels of chiropractors in biomechanics, manual assessment and treatment techniques and patient management, but many of their patients will get good results and never know the difference. And in Scandinavia and Australia and New Zealand and increasingly elsewhere, a significant number of PTs are doing formal postgraduate courses in manipulation. All the scientific evidence and clinical guidelines are pushing them towards rehabilitation based on manual treatments and exercise.

2) *Competition for access.* It is not sufficient to have excellent

clinical skills if patients have little access to your services. The medical and nursing professions face difficult times because of cost constraints, managed care and over-supply of graduates. Organized medicine's containment of chiropractic, once done openly on supposed grounds of science and safety, is now done covertly at the level of access and economics.

No government in the world has required medical referral as a condition of chiropractic practice, knowing it was both unnecessary and would frustrate patient rights. However third party payors, both private and governmental, have found a referral mechanism attractive as a cost-containment device. As a result the medical profession has often been successful in establishing a gatekeeper function under private and public funding plans. Millions of Americans have been deprived of access to chiropractic services in the 1990s because of HMO medical gatekeepers. In Denmark and Switzerland government plans fund chiropractic services chosen directly by the patient, but more recent funding arrangements in Italy, Norway and the UK all rely upon medical referral for funding. Workers compensation plans once all funded chiropractic services chosen by injured workers in the usual way – directly – but in New Zealand and some Australian states there is now a requirement of medical referral.

A major factor affecting the future of chiropractic in the next 10 years will be the ability of the profession, through its associations and private networks of providers and other entrepreneurs, to maintain public/patient/union/employer support to the degree that there is success in legislative and contractual battles for direct patient access to funded chiropractic services. The battle will remain intense as competition increases.

#### D. PREDICTIONS

7. Here are some predictions for the future:

1) *Acceptance of a primary contact specialty role.* The profession will be forced to devote the majority of its energies to gathering clinical and other research data on, and expanding access to, its core market of manual care, exercise and education for the prevention and management of musculoskeletal pain. In this effort it will acknowledge its evolution to, and status as, a primary contact specialty similar to dentistry or optometry. Expressed as a scope of practice statement this specialty, which gives chiropractic a clear role in the health care system since there is no such medical practice, might be defined as:

“The practice of chiropractic is the diagnosis, prevention and management of neuromusculoskeletal disorders, employing all methods of rehabilitation other than the use of prescription drugs and surgery, and with a primary emphasis on manual treatments, exercise and patient education.”

2) *Achievement of strong outcomes data and maintenance of leadership in spinal manipulation.* Aided by new government and public funding, and pushed by necessity, the profession will be successful in producing continued strong outcomes data showing that the results of chiropractic management of patients with the most common forms of musculoskeletal pain and headache are superior to other treatment approaches in terms of effectiveness, cost-effectiveness and patient satisfaction.

In the same way that chiropractic researchers have represented the field of spinal manipulation on interdisciplinary guideline panels and written chapters on manipulation in interdisciplinary textbooks, chiropractors will retain their leadership in the art and science of manipulation.

3) *No expansion of scope of practice.* The profession will not seek the use of prescription drugs and surgery, and will not alter its undergraduate education to incorporate alternative forms of care such as acupuncture, naturopathy and homeopathy. One reason is the philosophy or conceptual framework of health that unifies the profession. But another is that the study of biomechanics, the relationship between mechanical disorders and altered neurophysiology, and specific manual techniques for different categories of patients will make these areas an ever-more demanding fulltime field of education. There may be introductory courses on acupuncture and other disciplines, but any education sufficient to form a basis for practice will be at a postgraduate level.

4) *Internationally, many physicians and nurses and physical therapists will re-qualify as chiropractors.* An increasing number of medical doctors, nurses, and physical therapists will be given credits by chiropractic colleges and will re-qualify as chiropractors over a period of two to three years of study. This is already happening in several countries in Asia, Europe and Latin America and, as traditional barriers dissolve even further and medical doctors learn more of the quite sophisticated blend of manual skills and patient management skills in chiropractic education, many physicians determined to practice manipulation will seek the best education available. Ultimately, laws may one day force them to.

5) *Loss of market share and contraction of chiropractic education in North America.* Notwithstanding the above developments, and the increased integration of chiropractic services, overall there will be an erosion of market share in North America as physicians, nurses, osteopaths and physical therapists develop education and practice in the field of manual care. Because many more musculoskeletal pain patients will receive manual care, chiropractors will see more patients, but their share will drop from over 90% to 50–60%. This means that US chiropractic colleges must prepare for a period of some contraction. To counter smaller enrolments of North American students, several will enter distance education with campuses and/or affiliations in other countries where there is an under-supply of chiropractors and the profession is in a period of strong growth. That path is already being followed by Palmer College in Brazil and the RMIT School of Chiropractic, Melbourne, Australia, in Korea and Japan. It will become more common.

A related development in the US, following developments seen everywhere else in the chiropractic world, will be the affiliation of at least some chiropractic colleges with universities.

6) *Difficulties with identity and adaptation.* The loss of market share will be larger than it might have been, principally in the US, Canada and Australia, because of difficulties in developing a clear identity and role for chiropractors as providers of expert manual care of the neuromusculoskeletal system, complemen-

tary to medicine. These difficulties will arise because many chiropractic colleges are too insular and resistant to change (a problem with all health professions, but especially so where colleges operate in isolation from other health sciences as with chiropractic education in the US), because there is divided leadership, and because the move from sturdy independence to integrated team health care will be too difficult for a significant number of chiropractors.

**E. CONCLUSION**

8. Finally the future, perhaps 20 years distant yet, will see widespread recognition of the central concept of chiropractic health care that spinal functional disorders – the chiropractic subluxation – can mimic, aggravate or be a cause of many conditions apparently remote from the spine. Some infants with colic, some children with chronic recurring otitis media or asthma, some women with dysmenorrhoea, some older adults with presumed cardiac pain, some senior citizens with chronic constipation, will find relief through the diagnosis and treatment of spinal lesions that fall outside the current education and contemplation of most physicians.

The medical text that provides the most convincing anatomical and clinical basis for this wider scope of practice is the recent third English edition of *Manipulative Therapy and Rehabilitation of the Locomotor System* by Professor Karel Lewit, the internationally renowned neurologist from Charles University, Prague.<sup>14</sup> However physicians and chiropractors must first build a bridge of trust on back pain, headache, and other musculoskeletal pain. It is this that will later lead to a wider path of understanding. The average family physician or medical specialist of 2020, working in a new interdisciplinary world com-

binning medical and complementary care in a way not possible in the 20th century, will be aware that skilled biomechanical assessment and treatment of the spine may be an important option for many patients with conditions such as those given above. **TCR**

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