JOSEPH JANSE MEMORIAL LECTURE

MINIMUM STANDARDS FOR THE PRACTICE OF SPINAL MANIPULATION

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ANNUAL MEETING OF THE FEDERATION OF CHIROPRACTIC LICENSING BOARDS

Seattle, Thursday May 4, 2000

The severe headaches that made Dr. Joseph Janse's mother seek chiropractic care must have been a trial for her, but they were a benediction for the chiropractic profession. The relief she experienced under chiropractic care had such a profound effect upon her son that he determined to become a chiropractor. His towering achievements in promoting high standards in chiropractic education, research and practice are legendary and honored by the profession. Since Dr. Reed Phillips and Dr. John Triano wrote their tribute to him published in the leading medical journal Spine in 1996, Dr. Janse's achievements are also known to many in the medical profession and available worldwide to all through the Medline database.

I first met Dr. Janse at an airport in Auckland, New Zealand in 1977 when I was briefing potential witnesses for the New Zealand Commission of Inquiry into Chiropractic which was to commence a few months thereafter. Despite our differences in age and culture, and the fact that I knew very little about the chiropractic profession at that time, I knew immediately that I was in the presence of a man of unusual integrity and character. I remember thinking as I drove home afterwards that this American leader spoke with the gravity, resonance and presence that must have characterized another great American, Abraham Lincoln. Dr. Janse told me of his mother. Five years later in 1982 he welcomed me at a chiropractic history meeting at the National College of Chiropractic. As many of you may have, I sat with him in his office among his kangaroos and the many mementos of his travels throughout the world.

A final introductory memory. In the 1960s a Japanese bonesetter named Takeyachi invited Dr. Janse to lecture in Japan, and he became the first U.S. chiropractor to visit that country since the atom bombs of World War II severed the relationship between Japan and the chiropractic

profession. Several hundred attended Dr. Janse's Tokyo lecture, which proved to be an historic success. Mr. Takeyachi was so impressed that his three sons subsequently traveled to National College where they in due course graduated as doctors of chiropractic. One, Dr. Hiroaki Takeyachi, is now President of Japan's first recognized school of chiropractic, RMIT Japan of Tokyo, which offers a six year double degree program. Another Dr. Kazuyoshi Takeyachi has been the dominant political leader in Japan for the past 20 years and has two sons who will now enter the profession through National College. He has told me repeatedly that his mentor and continuing inspiration, as he has striven to bring high standards of chiropractic education and practice to Japan, has been Dr. Janse.

Such is the far reaching influence of this great man. It is a high privilege to be delivering the Joseph Janse Memorial Lecture to the annual meeting of the Federation of Chiropractic Licensing Boards in Seattle today.

I am an attorney who has lived and practiced in Toronto in the Province of Ontario in Canada since 1982. Since that time I have acted professionally for chiropractic licensing bodies and professional associations. I have represented defendant chiropractors before disciplinary committees, argued for license exemptions, written many submissions to government on licensing issues, lived through the development and enactment of zero tolerance sexual abuse legislation, and seen conflict and cooperation between licensing boards and professional associations over scope of practice, rules for advertising, record keeping, conflict of interest and even veterinary chiropractic.

During the past 10 years, as Secretary-General for the World Federation of Chiropractic, I have assisted in the drafting and passage of chiropractic licensing laws in several countries. I have presented papers on the international regulation of chiropractic at World Medical Law congresses in South Africa and Hungary and this summer will present a paper titled the Regulation of Chiropractic Practice in Europe at the 12th Biennial Medical Law Congress in Helsinki.

As a result of all this there are many subjects I could address you upon today. One that I was invited to consider was the international regulation of chiropractic. This would certainly be entertaining. In 1939, the Canton of Zurich in Switzerland won chiropractic legislation after a campaign in which medical opponents put up roadside hoardings depicting chiropractors as Nazis stealing infants with cadaverous hands. Chiropractors and their patients replied with hoardings showing contented mothers and families. In April last year Belgium became the first civil law country in Europe to regulate the practice of chiropractic after a skilled and fascinating battle between public and professional interests. However, comments on the international regulation of chiropractic would be of little practical importance to you, and Dr. Janse's memory deserves far sterner stuff than entertainment. Today I want to speak about what I consider to be one of the major issues facing chiropractic licensing boards and professional associations worldwide. It is quite possible, however, that it is a matter which you have given little consideration. It is a national issue, and therefore calls for leadership from your federation.

This issue is the development and adoption of minimum educational standards for the practice of spinal manipulation, in order to protect protecting the public from incompetent and unsafe treatment by unqualified practitioners. I am suggesting today that the Federation of Chiropractic Licensing Boards should first establish a committee to plan national action, and subsequently propose and be seen as the leader of a national interdisciplinary task force to define minimum standards of education for all professionals who seek the privilege and responsibility of practicing spinal manipulation in the United States.

Turning to a discussion of why this is necessary, I must start with some preliminary issues of definition. According to the scientific literature, and the writings of chiropractic, medical and osteopathic doctors and physical therapists internationally, spinal manual treatments fall into two categories. The first is spinal manipulation which involves a sudden thrust, often taking a joint beyond its normal physiological range of movement, and having significant potential for harm and ineffectiveness in unskilled hands. Most traditional chiropractic adjustments are specific and skilled forms of spinal manipulation. The second is mobilization, slower movements without thrust or sudden movement. The joint normally stays within its physiological range of movement, the patient remains in control, and there is much less potential for harm-and, I might add, for benefit. In the rest of this address I am talking principally about spinal manipulation rather than mobilization. There is a clear case for regulation of the act of spinal manipulation, a different and less clear case for regulation of mobilization.

The laws in your various states will be different. Some of these laws will refer to adjustment, some to manipulation. Some will restrict spinal manipulation to doctors of chiropractic, osteopathy and medicine. Some will allow physical therapists to perform manipulation as well as mobilization, sometimes on medical or chiropractic referral only, sometimes on the basis of direct access to patients. I suggest that none of this variance is of great importance. This is because the following settled trends can be seen internationally and in North America, and they will govern the future. These trends will change regulatory laws and threaten the exposure of patients to unacceptable standards of practice in the field of spinal manipulation.

1. Firstly, because of the practice, example and growth of the chiropractic profession, spinal manipulation has recently become widely accepted by the scientific community and by the public.
2. Secondly, this is encouraging a worldwide move into the practice of spinal manipulation by medical doctors, doctors of osteopathy, physical therapists and others.
3. Next, physical therapists are gaining rights of direct patient access, which gives rise to significant issues of diagnosis and assessment relevant to the practice of spinal manipulation.
4. Fourthly, sound educational standards are currently being developed in each of the medical, osteopathic and physical therapy professions. However, few of the members of those professions practicing manipulation-and virtually none in the United States-have that level of education.

5. Next, licensing boards for those professions have not mandated adequate minimum standards, with the result that many of these professionals are practicing manipulation inadequately on the basis of education and clinical skills far below those of the foremost licensed professionals in the field-doctors of chiropractic.
6. Finally, this is clearly against the public interest in two respects-risk of harm, but, probably of at least equal importance, exposure to crude diagnosis and treatment that is ineffective, presents patients with a bad experience of manipulation, and deters them from seeking this form of care from properly trained professionals-chiropractors-in the future.

I suggest that the Federation of Chiropractic Licensing Boards is the most knowledgeable and responsible regulatory organization in this field of practice. Its members have a strong mandate to protect the pubic interest in this area. The Federation should now lead a national cooperative initiative with all stakeholders to establish minimum standards of education. Let me expand on some of the points I have just made.

My first point was that spinal manipulation, until recently the object of medical scorn, has become widely accepted. This is partly because recent scientific evidence and clinical guidelines have supported its use for the highly prevalent conditions of back pain, neck pain and cervical headache. Equally importantly, it is partly because the evidence and these same clinical guidelines reject many of the standard machine therapies, medications, injection techniques and the bed rest that have been the basis of medical management of back pain. These developments have encouraged increasing numbers of medical and osteopathic doctors and physical therapists to enroll in weekend courses and enter the practice of spinal manipulation. So have studies showing that a large percentage of the population with chronic pain or stress in all western countries is avoiding medication and using alternative approaches including chiropractic. To quote the Czech manual medicine specialist Karel Lewit, who has worked with the U.S. osteopathic leader Dr. Phillip Greenman of Michigan State University in recent years to promote adequate medical education for the practice of spinal manipulation in Europe and North America:

> "The great majority of . . . doctors who learn manipulation are taught far too little about how, where and when to use it . . . they are clinically blindfolded. The practice of spinal manipulation, understanding all the many forms of disturbed function of the motor system requires great skill demanding long training."

Consider medical education in this field. To date it largely consists of groups such as the American Association of Orthopedic Medicine providing one or more weekend courses. Cavalier medical attitudes are exemplified by this advice to medical doctors in the British Medical Journal.

> "Courses including manipulation (lasting about a week) are run for doctors and physiotherapists by the Cyriax Foundation and by the Society of Orthopaedic

> Medicine, and intensive weekend courses for doctors are held by the British Association of Manipulative Medicine. These courses provide clinicians with the knowledge and the necessary manual skills to start treating patients safely. Doctors will then need at least six to nine months of regular practice to begin to feel that they are treating the right patients and doing so appropriately-and years to become fully experienced and confident."

Is this acceptable? Is this Federation prepared to stand idly by while medical doctors practice in this way, and their licensing bodies turn a blind eye to the best interests of patients?

For a medical doctor there are three areas of specialized training required-theory, including applied anatomy, biomechanics, neurophysiology and radiology; examination and diagnosis; and treatment techniques. To meet these needs leaders in manual medicine worldwide are organizing a new specialty to be called musculoskeletal medicine. This will demand full-time postgraduate training and certification as with other medical specialties. The very existence of this movement confirms that current levels of education are inadequate. However there remains the strong possibility in the United States that medical doctors, wishing to avoid the demands of formal postgraduate study and to qualify more easily for the practice of manipulation, may seek laws approving certification on a similar basis to acupuncture. For this they will assert that manipulation is merely a set of techniques requiring 100 or 200 hours of part-time study for certification and entry to practice.

Osteopathy is in an interesting position on this issue. Since the 1960s, while osteopaths in the United Kingdom and elsewhere have remained in the field of manipulation and learned and practiced an increasing number of high-velocity techniques developed by the chiropractic profession, U.S. osteopaths have deserted their heritage and essentially become allopathic doctors. Their first professional degree program has now become the equivalent of medical education with little on manipulation. Those relatively few doctors of osteopathy who wish to practice osteopathic manipulation have learnt their detailed skills in a three year postgraduate specialty which is a pre-requisite for those wanting to become fellows of the American College of Osteopathy. But that is now changing. As we speak the American osteopathic profession is engaged in a process of re-writing its educational basis for the practice of spinal manipulation and encouraging DOs back to this field of practice. This part of their heritage, largely deserted as medicine criticized manipulation, is highly attractive now that national clinical guidelines have endorsed and recommended spinal manipulation as a preferred treatment in the multi-billion dollar market place of health care interventions for spinal pain.

Next, consider the equally interesting developments in the physical therapy profession, a profession chafing for freedom from the yoke of medical referral and one that should not be underestimated. Physical therapists do not have, or claim to have, adequate education for the practice of spinal manipulation in their graduate professional programs. This is the case worldwide. In some countries such as Australia, physical therapists wishing to practice manual therapy now take a three year full-time postgraduate master's degree in orthopaedic

manipulative therapy. In others such as Denmark, the Netherlands and Canada, physical therapists complete a three year part-time postgraduate certification course in manual therapy which now has quite demanding standards of study, practice and examination. The physical therapy profession in the U.S. is well behind these countries in developing formal and adequate education, and relatively unstructured weekend courses still proliferate.

However the very existence of three year master's degree programs such as those in Australia, which will inevitably come to the U.S. in the future, makes it evident that physical therapists without this training have insufficient theoretical education and clinical skills to be practicing manual therapy including manipulation. Indeed, that is the open and published view of leaders in the physical therapy profession. Reporting her trial of manipulation for patients with back pain in the U.K. Journal of Manual and Manipulative Therapy last year, the Australian physical therapist Janet Morton states:

> "It should be acknowledged that orthopaedic manipulative physiotherapy is a pre-requisite for any physical therapist wishing to administer manipulation."

To bring things closer to home, consider this admission by Yamada and Montague in Physical Therapy the journal of the American Physical Therapy Association. They wrote as staff directors of a physical therapy department in a Kaiser Permanente HMO in Oakland, California where their staff physical therapists were trying to practice manual therapy with inadequate training:

> "By taking short courses in manual therapy, the physical therapists acquired basic information on orthopedic examination and treatment, but in a haphazard and unrefined way. Applying short course information to practice, therefore, proved not only difficult but frustrating. The PTs found it difficult to select appropriate treatment measures and predict reasonable progress because they could not accurately interpret examination signs and symptoms."

Is this fair to patients? Is this in the public interest? Should these professionals, who have competence and deserve respect in their core areas of practice, be allowed to flow into the practice of manual therapy and spinal manipulation on the basis of unexamined weekend seminars? Why do their licensing bodies have no minimum standards of educational certification? What is the logic of this, and is the public served by having two standards of regulation of spinal manipulation-a demanding one for chiropractors and a low and porous one for other professionals authorized to use manual therapy?

I suggest that the case for a national, interdisciplinary process to establish minimum standards of education and certification, a process that should be led by this Federation, is clear. I am aware that a few states, such as Minnesota in Chapter 146 of its 1998 Statutes, have taken preliminary steps. Minnesota requires 870 hours in relevant basic and clinical sciences including radiographic interpretation and 1,155 hours of supervised clinical practice, as pre-

requisites for certification and practice. However, these requirements apply only to physical therapists, not medical and osteopathic doctors-why not-and I am told are not enforced. At least Minnesota has taken some action. Most states, however, have done nothing.

Finally, if my comments this morning have been persuasive, what should the Federation's first steps be? Firstly it should appoint a committee to plan appropriate action. The members should be chosen with care, having regard to their expertise in relevant educational, clinical, research and regulatory areas, but also having regard to their ability to communicate effectively with other health professionals. I recommend that the chairperson be a doctor of chiropractic who has educational and clinical experience working with other health disciplines. Today there are many chiropractors with dual licenses in either medicine, osteopathy or physical therapy. One of each should either be on, or a consultant to, the FCLB committee. There should be representatives of the Association of Chiropractic Colleges, the Council on Chiropractic Education and the National Board of Chiropractic Examiners, and perhaps the two national associations-though their representation may be perceived as a conflict of interest.

Secondly, the committee should be given a set period to report with analysis of the current position and specific recommendations for a national inter-professional task force that would develop minimum educational standards for adoption by state and national governments, and by third-party payors providing reimbursement for the practice of spinal manual therapy. These recommendations would cover areas such as which regulatory, professional, government and public bodies should be invited to participate, the task force's terms of reference, suggested budget and sources of funding-which should include state and federal funding, process and time line.

Thirdly, the process of gathering current information on the education, practice and regulation of the different categories of health providers practicing spinal manipulation should begin. Thorough data collection will later be a major responsibility of the task force, but good preliminary information will be the necessary platform for the FCLB committee's recommendations and then the initial approach to outside organizations for participation in a task force.

Where will all this lead? Implicit in my comments is recognition and acceptance of the fact that in the future some medical and osteopathic doctors and physical therapists will be authorized to deliver skilled spinal manual care including spinal manipulation to patients in all states of the union. I submit that current trends beyond your individual state's borders make that inevitable. However the suggested national task force would produce recommendations on minimum educational standards which, if adopted by licensing bodies or state legislatures and payors, would provide the public with a much higher guarantee of quality care. It would also limit practice and reimbursement to the comparatively few other health professionals who were prepared to undertake and complete postgraduate education. Another consequence of this process should be recognition by those funding health sciences education that it makes no sense financially to re-qualify medical doctors and others for the practice of spinal manual therapy by means of postgraduate programs when there is another licensed profession-the

chiropractic profession-which provides the service with at least equal skill on the basis of its core education. Why train a medical doctor for over 10 years or a physical therapist for 7 years of graduate and postgraduate education, when doctors of chiropractic offer more comprehensive skills and service to patients on the basis of 4 years of graduate study.

To conclude, when I acted for the New Zealand Chiropractors' Association before the Commission of Inquiry into Chiropractic in that country in 1978, the evidence presented by the New Zealand Medical Association was that spinal manipulation was dangerous, ineffective and that no one should receive it from anyone-especially chiropractors-for anything. In its now famous report the Commission disagreed. It held that "chiropractic is a branch of the healing arts specializing in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level."

Other principal findings were that "chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy"; that "chiropractors should, in the public interest, be accepted as partners in the general health care system"; and that "the responsibility for spinal manual therapy training because of its specialized nature should lie with the chiropractic profession. Part-time or vacation courses in spinal manual therapy for other health professionals should not be encouraged."

This amounts to an express call to the chiropractic profession, through its educational and regulatory bodies, to take the leadership in defining minimum standards of education and practice. My final quote and call to arms comes from the opening comments of a research report from the federal Department of Health and Human Services in 1997, edited by Dr. Daniel Cherkin and Dr. Robert Mootz.

> "Spinal manipulation and the profession most closely associated with its use, chiropractic, have gained a legitimacy within the United States health care system that until very recently seemed unimaginable . . . chiropractic is now recognized as the principal source of one of the few treatments recommended by national evidence-based guidelines for the treatment of low-back pain, spinal manipulation. In the areas of training, practice, and research, chiropractic . . . is playing an increasingly important role in discussions of health care policy."

Members of the Federation, ladies and gentlemen, in the best interests of American people, and invoking the standards and memory of Dr. Joseph Janse, I urge you to take action.