RE: Chiropractors as Primary Spine Care Providers: precedents and essential measures.
JCCA. 2013;57(4):285-291.
W. Mark Erwin, DC, PhD, A. Pauliina Korpela, BSc, Robert C. Jones, DC, APC

To the Editor

I would like to congratulate Dr. Mark Erwin and co-authors for their recent article in the JCCA. They have courageously highlighted the need for the profession to become focused and united in providing evidence-based spine care. This means incorporating the best available evidence into practice and being leaders and innovators in this area. Only then will we as a profession be credible and considered spine experts to the community at large.

Being non operative spine experts comes with responsibility. It must be reflected in our language, our education, our research, and especially our practice. We need to be consistent in our message and treatment approach.

We need strong leadership to bring the profession together and recognize the need for change. Our destiny is in our own hands.

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To the Editor

We read with interest the paper "Chiropractors as Primary Spine Care Providers: precedents and essential measures"[1], which is one out of several papers dealing with this issue published within the past few years[2,3]. We would like to comment on the paper focussing on the needs of society and feasibility of the proposed model.

In societies everywhere there is clearly a need for an increased focus on spine pain and musculoskeletal disorders. Low back pain is omnipresent and accounts for over 10% of the total "years lived with disability".[4] The associated consequences for individuals and societies everywhere are enormous in terms of lost quality of life, work absence, disability, and direct health care expenses. However, contemporary research has convincingly shown that back pain does not occur alone in most individuals, and patients with pain in more than one site experience a greater impact of their pain, have poorer prognosis in a range of domains, and respond less favourably to treatment[5]. Consequently, unlike dental and optical care, spine care may not have clear anatomical boundaries and one could therefore rightfully ask if the future for primary spine pain care lies with a spine care specialist or with a person who has a broader musculoskeletal focus across pain sites and conditions.

Regarding the issue of feasibility, many patients with spine pain would have to seek care from multiple providers for their multisite musculoskeletal conditions. This may not represent an effective use of the patient's or society's resources in particular in the primary care setting. Moreover, patients might experience difficulties in determining what is a spine related condition especially in conditions with diffuse pain patterns or radiating pain such as arm, chest or leg pain, which might lead to inappropriate care seeking, frustration, and chronicity.

We suggest that the real challenge for chiropractors is integration into mainstream primary care as musculoskeletal health care providers rather than focussing exclusively on spine care. Canadian chiropractors and chiropractors in many other countries are already trained as such and 90.6% of the full time practicing chiropractors in Canada do not limit their

treatment to the spine and include treatment of the extremities[6]. In addition and importantly, many of the prevention, diagnostic and treatment strategies appear to be similar between different musculoskeletal pain sites[3] and prognostic factors for chronicity are also very similar[5,7]. Of course chiropractors are not alone in claiming the role of primary care musculoskeletal care provider. In our opinion a continued focus on research and education along with the chiropractor's ability to integrate and function in interdisciplinary collaboration will ultimately determine the fate of the profession in this arena.

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To the Editor

I reviewed the timely article regarding the role played by chiropractors written by Dr. Mark Erwin with tremendous interest.

With the high incidence of spinal conditions in our aging population and the limited number of general practitioners and spinal specialists an opportunity exists to seize for the chiropractic community.

The majority of spinal conditions are non-surgical and are potentially managed through conservative measures by our allied health practitioners.

Dr. Erwin has provided existing models from North America and Europe that have enabled chiropractors to be at the front lines of managing selected spinal conditions which makes sense and would appear to represent an opportunity to streamline the management of non-urgent spinal pain syndromes.

I wholeheartedly agree with Dr. Erwin for the need of evidence based approaches and standardization by chiropractors to manage these conditions. I am aware that each graduating chiropractor is trained in identifying red flags, conditions that require further investigations (laboratory and imaging) and those that ultimately require timely surgical evaluation and it is clear that a closer working relationship between chiropractors and physicians/specialists would be in everyone's best interests.

I have had occasion to give several lectures at CMCC (Canadian Memorial Chiropractic College) and in the process have interacted with the students and faculty - I am confident that the aforementioned objectives may be achieved.

Part of the Chiropractic curriculum should necessarily ensure each graduate evaluates each spinal case in an evidence based manner and manages the patient's through a standardized approach. Ultimately primary practitioners and spinal specialists will develop additional confidence in the chiropractic community and build stronger clinical relationships and this will

potentially result in higher patient satisfaction and timely care.

As a Neurosurgeon and Fellowship trained Spine Surgeon I have had the privilege to work with pioneers like Dr. Erwin to advance the field of chiropractic care in Canada to the benefit of spinal patients. I look forward to better integration of an evidence-based, collaborative relationship with the chiropractic community for as with my physical therapy colleagues it is through an evidence-based, scientific approach that the chiropractic profession will enjoy enhanced legislative scope of practice and even better tools with which to help their patients.

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To the Editor in reply

I would like to thank Drs. Blanchette and Hartvigsen for their thoughtful letter with respect to the recent paper published by my colleagues Dr. Robert Jones, Anna Pauliina Korpela, BSc and me. Drs. Blanchette and Hartvigsen raise the question that unlike dental and optical (and presumably foot) care, spine care may not have clear anatomical boundaries, and perhaps the future for primary spine care may best lie within a spine care specialist or a person with broader musculoskeletal focus. The authors further suggest that many patients with spine pain may consult a number of providers for their 'multisite MSK conditions', a situation that would not make the most effective use of health care funds. Additionally, they suggest that the 'real challenge' for chiropractors is integration within mainstream primary care as MSK health providers rather than focusing exclusively on spine care. They acknowledge that chiropractors are of course not alone "claiming the role of primary care MSK care providers" and conclude with an opinion that continued focus on research and education along with the integration within the multidisciplinary collaborative approach 'will' ultimately determine the fate of the profession in this arena.

First, the title of our paper is "Chiropractors as Primary Spine Care Providers". It is not "Chiropractors as ONLY Primary Spine Care Providers". The purpose of our manuscript was to raise the question whether a chiropractor ought to be the preferred provider of spine care. A chiropractor's education is primarily spine-based (although of course also contains a rich education in differential diagnosis with good training in other MSK-related conditions). DCs of course treat a myriad of diverse MSK problems and at no time did we suggest anything to the contrary; rather our focus was whether the DC might be the suitable 'go to' clinician for spinal pain. In order to address the specific question whether the DC ought to be the Primary Spine Care Provider we contrasted the evolution of optometry and other health professions that have filled such a 'niche' within the provision of specific healthcare needs. I think "anatomical boundaries" have nothing to do with the provision of spine care akin to the example of dental

or optical care. The question posed by Blanchette and Hartvigsen; *"[whether] the future for primary spine pain care lies with a spine care specialist or with a person who has a broader musculoskeletal focus across pain sites and conditions"* fails to advance the notion that the appropriately trained DC could be the preferred spine care provider…or does it? Is the suitably trained DC not qualified in all of these areas? This was precisely the point of our manuscript; a chiropractor who is scientifically trained, evidence-based, and who practices within an integrated model with other disciplines could well be the ideal provider of spine care...but not only spine care. The discussion regarding the 90.6% of chiropractors who do not limit their practice to spine care muddies the water, as does the development of the new discipline of 'musculoskeletal health care provider'. It seems that such a discussion devolves into one of semantics.

Professional Identity: The World Federation of Chiropractic (WFC), the Canadian and Ontario Chiropractic Associations (and many others) clearly state the chiropractor should fulfill the role of the spinal pain expert. None of these associations makes identity statements regarding broader MSK issues although MSK is often included in various definitions of chiropractic and rightly so. One definition of chiropractic listed on the WFC website (American Association of Chiropractic Colleges-1996) states; *"Chiropractic is a healthcare discipline that emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, doctors of chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient". Clearly, this definition emphasizes the spine within the context of the practice of chiropractic.*

We chose to focus our paper with respect to the clearly stated identity statements of a host of chiropractic societies, institutions and associations. In particular, at the conclusion of the June 2005 World Federation of Chiropractic's 8th Biennial Congress held in Sydney, Australia, the WFC adopted the identity statement that DCs should become "The spinal health care experts in the health care system". This conclusion reached 9-years ago, was the product of deliberation of over 100 delegates and observers from national associations in 36 countries, including both the ACA and the ICA and involved an "identity task force" and followed the recommendations of a 40-person WFC Task Force. Additionally, the most recent submission to the World Health Organization by the WFC (January 2013) suggests that the primary reasons for consulting a chiropractor are back pain (60%) and other MSK ailments such as neck pain (is this not also a form of spinal pain?), shoulder, extremity and "arthritic pain" (20%). Therefore, close to 80% of the reasons people consult chiropractors relate to some form of spinal (and related) complaint. Furthermore, this report discusses evidence and clinical trials, practice guidelines and Bone and Joint Taskforce reports concerning neck pain and related disorders. There is no discussion of other 'broad' MSK complaints. Again, and at the risk of appearing repetitive, we do not suggest that chiropractic only treat spinal complaints-but it appears that this is very much, where the profession's emphasis appears to be. Furthermore, it is obvious that a host of MSK-related ailments are relevant to spinal pain and that DCs can and do treat such things.
(Please see attached link from the WFC website under "identity of the profession") http://www.wfc.org/website/

However and of particular relevance to Blanchette and Hartvigsen's letter, despite this WFC identity statement, the chiropractic profession continues to present various professional identities. For example, the Danish Chiropractic Association (DCA) web page states that the aims of the association are (amongst others): "To unite chiropractors aimed at representing and protecting the professional, financial and social interests of the chiropractic profession". There are further statements with respect to the mandate of the DCA such as:

- To establish guidelines for chiropractic business.
- To determine wages and working conditions for graduates in internships.

- To co-operate with other organizations and associations on issues of mutual interest.

What is missing is any specific 'identity' statement. On the other hand, the American Chiropractic Association states that; "Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. Chiropractic care is used most often to treat neuromusculoskeletal complaints, including but not limited to back pain, neck pain, and pain in the joints of the arms or legs, and headaches".

It is plainly evident from these various identity statements and definitions that the chiropractic profession does not present a unified voice to the public, government, third party payers…or to itself; and this speaks to the central premise of our paper.

We agree that chiropractic ought to seek to achieve improved integration into the contemporary healthcare system and to this end, it is vital that the profession continue to invest in enhanced research and education: we make these points quite clearly and succinctly within our manuscript (pages 288-290). We specifically illustrate the success of the CCRF in Canada with the development of Chiropractic Research Chairs, the developing collaboration between the Canadian Memorial Chiropractic College and the University of Ontario Institute of Technology. In fact, we specifically state, "Increased collaboration, an emphasis on evidence based treatment and continued efforts to broadly expand the research base will resolve many lingering obstacles" (page 289).

As illustrated by Drs. Blanchette and Hartvigsen there are hosts of other well-trained, experienced health care providers who are quite capable at the provision of broad MSK therapy-and within this context, the chiropractor is just one more.

Within the context of our manuscript and the letter by Blanchette and Hartvigsen, perhaps the most poignant question is whether the chiropractic profession ought to be a jack-of-all-trades or master of at least one (that is by definition, connected above, down inside and out)?

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