Legitimizing chiropractic clinical research

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In November 1966, a policy passed by the American Medical Association House of Delegates proclaimed: "It is the opinion of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of its substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease and causation."[1]

The National Institute of Neurological Diseases and Stroke 1975 monograph regarding the Research Status of Manipulation, concluded that: "there was insufficient research to either support or refute chiropractic intervention for back pain and other musculoskeletal disorders."[2]

Government inquiries,[3,4] task force studies,[5,6] and multidisciplinary research that demonstrate the clinical and economic benefits of chiropractic care notwithstanding,[7] to this day, the medical profession continues to contain its competitors through exclusion and marginalization.

It is a societal given that medicine's prestige, legitimacy and control of the gatekeeping role in patient management has entrenched a strong boundary demarcation and hierarchical domination over other health care professions. This has led to push-back within the biomedical field and a successful challenge to the status quo. Nursing and clinical pharmacy in particular, have been able to expand their professional scope of practice as well as achieving significant public and political support for their advocacy efforts on behalf of patients' access to care and cost-containment.[8]

The Canadian Chiropractic Research Foundation has been successful in securing Chiropractic professorships in a dozen Canadian universities.[9] The next hurdle is to achieve inclusion of practicing Doctors of Chiropractic in the recruitment, remuneration and accreditation by hospitals, medical clinics and universities. The opportunity is now. Shuval reports that there is: "growing disillusionment with the technology and bureaucracy of biomedicine and increased questioning of its excessive invasiveness; heightened consumer awareness of iatrogenic effects of modern medicine and growth in expectations for quality

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service including structural changes in the physician-patient relationship as well as widespread demystification which have led to considerable erosion of confidence in Big Science as a means of solving problems".[10]

Excluding chiropractors from formal institutional interaction, enables the medical hierarchy to keep alternative practices outside the professional field in which the nature of knowledge translation and trust play a role in determining its market value.[11] This marginalization of chiropractic is further reinforced by rituals of deference and demeanour whereby ones education, dress, deportment and language reflect either acceptable or undesirable characteristics that support services to physicians.[12]

So, should chiropractic research attempt to achieve recognition and legitimacy by imitating the dominant structure of the biomedical model; that is specialization in a narrow, clearly defined area of clinical practice? Although less threatening, this behavioural isomorphism undermines the holistic basis of what has recently been proposed as ***integrative healthcare***: "a system of healthcare that is patient-centered and collaborative, encompassing a diversity of therapeutic options (including complementary and alternative therapy) that have been found to be safe, effective and informed by available evidence to achieve optimal health and healing."[13]

According to Boon et al, integration:

- "seeks through a partnership of patient and practitioner, to treat the whole person, to assist the innate healing properties of each person and to promote health and wellness as well as the prevention of disease;
- is an interdisciplinary, nonhierarchical blending of both conventional medicine and complementary and alternative health care that provides a seamless continuum of decision-making, patient-centered care and support;
- uses a collaborative team approach guided by consensus building, mutual respect and a shared vision of health care that permits each practitioner and the patient to contribute their particular knowledge and skills within the context of a shared, synergistically charged plan of care;
- results in more effective and cost-effective care by synergistically combining therapies and services in a manner that exceeds the collective effect of the individual practices."[14]

A recent survey by the American Hospital Association found that 42% of 714 surveyed hospitals offered at least one complementary or alternative therapy in 2010, as compared with 27% just five years earlier. The most popular therapies included natural products (17.7%), deep breathing exercises (12.7%), meditation (9.4%), chiropractic care (8.6%), yoga (6.1%), and diet-based therapies (3.6%), typically in an attempt to treat back or neck pain, joint pain or stiffness, anxiety and depression. This trend coincides with indications that American health care providers are themselves seeking out complementary and alternative therapies when dealing with their own health problems. In 2007, 83% of American health care workers used complementary or alternative medicine, as compared with 63% of the general population.[15]

A Fraser Institute study found that over 54% of Canadians used a complementary or alternative therapy in 2006, an increase of 4% over 1997 but not all users were reported in the study because many users did not discuss use of alternative therapies with their family physician.[16]

Complementary and alternative medicine (CAM) is becoming increasingly popular in Europe with up to 65% of the population reporting that they have used this form of medicine. Approximately 30-35% of the European population use CAM as self-support and 10-20% of the European population has seen a CAM physician/practitioner within the previous year. The most commonly used CAM therapies in Europe that are practiced by medical doctors are acupuncture, homeopathy, phytotherapy, anthroposophic medicine, naturopathy, Traditional Chinese Medicine, osteopathy and chiropractic. In 18 of 29 EU and EEA countries specific CAM therapies are statutorily regulated.[17]

Physicians generally prefer to use the term "complementary" to refer to unconventional modes of health care. This stance reflects a medicocentric view, which implies greater validity and centrality to bio-medical procedures and a lesser status to unconventional practices that "complement" them. The term "alternative" is viewed by many in the medical establishment as offensive and challenging to their exclusive hegemony.

The National Center of Complementary and Alternative Medicine (NCCAM) defines CAM as "a broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the pol-

itically dominant health system of a particular society or culture in a given historical period."[18] The current definition describes CAM as: "a group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine."[19]

"Consumers are increasingly aware of the iatrogenic effects of modern medicine and prefer to ingest fewer drugs. Many object to the traditional dominance of doctors often seen in the physician-patient relationship. In a period of hyper-differentiation in biomedicine, when it is practiced in large organizations where there is minimal attention to the individual and to their social and psychological needs, CAM offers a non-invasive, holistic alternative that is increasingly attractive to many, in particular to the better educated, women, married persons and the more affluent segments of the population. There is more awareness among consumers of the relationship of lifestyle to morbidity, especially when bio-medicine is unable to provide relief or cure. It has also been noted in the post-modern period, with on-going globalization, that there has been an overall decline in faith in the ability of science and technology to solve health problems. This is seen in the lesser acceptance of traditional authorities such as physicians and a seeking by individuals of increased control over their life and health.

The establishment of CAM services inside hospitals is often dependent on a "motivated champion" – an individual or family who take the initiative to recruit support and funding for CAM services.

In recent years, the labeling of CAM in hospitals has begun to change. In the past, CAM was labeled complementary to medicine. Recently some hospitals have expanded the formal title of CAM services to include the term integrative. This change carries important symbolic implications. Rather than viewing CAM as a secondary complement to medicine, the term "integrative" highlights the partnership of conventional medicine and alternative medicine.

Promoters of integrative medicine are essentially medicalizers of CAM – but at the same time "CAMifiers" of bio-medicine."[20]

Hollenberg highlights the difficulties inherent in integrative practice in an analysis of the relations between physicians and CAM practitioners. He points to the complexities of working together since medical doctors often continue to perpetuate patterns of medical dominance by maintaining control of overall patient care, diagnostic tests, referrals and the use of bio-medical language as the primary form of communication. Research indicates that: "physician-managed CAM clinics often frustrate and stifle CAM practitioners by restricting CAM practitioners to a specific, limited sphere of competence".[21]

In contrast, the gatekeeper in the Swedish primary care clinic is a medical CAM practitioner who is responsible for the full clinical management of the patient including recommendations for both medical and CAM treatment. These recommendations are considered by a "consensus case conference" with the whole provider team. "A deliberate effort is made to avoid medical dominance and attain interdisciplinary, non-hierarchical decision-making involving a mix of conventional and complementary medical solutions to individual case management."[22]

A 2010 poll conducted by Angus Reid Public Opinion for Maclean's found that although most people believe their own medical doctor performs well, 40% of Canadians believe medical doctors care less about patients than a decade ago, and more than half believe medical doctors are reluctant to admit to their mistakes.[23]

As the population ages, the greatest health care need is the management of chronic conditions, accounting for over 60 percent of spending.

Church reported: "a lack of scientific verification and university affiliation as self-reinforcing barriers to enhancing the professional status and societal legitimacy of chiropractors in Canada."[24]

Is chiropractic research translating into clinical practice?

Chiropractic clinician-scientists play a vital role in filling the gap between patient care and discovery research. Splitting their time and interests between clinical practice, teaching and research enables them to translate their research results into the clinic, as well as develop research questions based on clinical issues they encounter in practice. Chiropractic clinician-scientists focus on the uniqueness of patients and individualized treatment.[25]

The benefits of an integrated health care approach extend to patients, caregivers, providers, and the larger health care system. The evidence suggests that coordinated care, which integrates chiropractic providers within primary care, can enhance access to services, improve quality of care, and lower overall health care expenditures.

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