



CHIROPRACTIC IN NEW ZEALAND

REPORT

1979



CHIROPRACTIC IN NEW ZEALAND

REPORT OF THE
COMMISSION OF INQUIRY

1979

*Presented to the House of Representatives by Command of
His Excellency the Governor-General*

LAWRENCE THOMAS HEATH, B.COM., D.P.A., A.C.A.

1916-79

Mr Heath was secretary to this Commission at the time of his sudden death. He was born in Auckland and educated at Auckland Grammar School and Victoria University. He rose to the position of Assistant Director-General of the Post Office, was a life member of the New Zealand Administrative Staff College Council and its chairman from 1973 to 1975. He served as secretary to the Royal Commission on Nuclear Power. He was a well-known sportsman and national sports administrator.

We were fortunate to be able to persuade Mr Heath to undertake the secretaryship of the Chiropractic Commission. He took a constructive and generous interest in the Commission's work, and his distinguished administrative skills made what was essentially a difficult job seem deceptively easy.

During the Commission's hearings, counsel paid tribute to Mr Heath's complete impartiality and to his integrity. Those were the hallmarks of his work, and in drafting our report we found his advice invaluable. We are glad that before his death he had the satisfaction of knowing that our report would be unanimous and was virtually complete.

It will not be easy to forget Mr Heath's thoughtfulness and his kindness. At the last public sitting of the Commission we said: "We have not stopped being thankful that he allowed himself to be talked into managing this Commission. We could not have asked for a better secretary or a better friend."

COMMISSION OF INQUIRY INTO CHIROPRACTIC

Commissioners

B. D. INGLIS, Q.C., B.A., J.D., LL.D. (Chairman)

BETTY FRASER, M.B.E., M.A.

B. R. PENFOLD, M.SC., PH.D., F.R.S.N.Z.

Secretary

L. T. Heath, B.COM., D.P.A., A.C.A. (until 28 May 1979)

L. K. Bennett (from 29 May 1979)

Mrs G. I. A. Dunne, B.Sc.

Mrs M. M. E. McDonald

Counsel

Assisting the Commission

Mr J. A. L. Gibson

For the New Zealand Medical Association

Mr J. T. Eichelbaum, Q.C., and Mr D. A. Webb

For the New Zealand Society of Physiotherapists

Mr M. B. Williams and Mr M. J. Ruffin

For the New Zealand Chiropractors' Association

Mr R. J. Craddock and Mr D. A. Chapman-Smith

For the Department of Health

Mrs O. E. Smuts-Kennedy

For the New Zealand Consumer Council

Mr V. R. W. Gray

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Commission of Inquiry Into Chiropractic

KEITH HOLYOAKE, Governor-General
ORDER IN COUNCIL

To all unto whom these presents shall come, and to:

BRINSLEY DONALD INGLIS, of Wellington, One of Our Counsel Learned
in the Law;

THOMAS ATHOL RAFTER, of Wellington, Scientist; and

BETTY FRASER, of Wellington, Headmistress:

GREETING:

WHEREAS it is considered expedient that inquiry shall be made into the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services:

Now therefore, I, The Right Honourable Sir Keith Jacka Holyoake, the Governor-General of New Zealand, acting by and with the advice and consent of the Executive Council, hereby appoint you the said Brinsley Donald Inglis, Thomas Athol Rafter, and Betty Fraser to be a Commission to inquire into and report upon the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services and, if thought fit that such benefits should be provided, the extent thereof:

And in considering these matters you are hereby directed to have regard to and consider:

- (a) The practice and philosophy of chiropractic, its scientific and educational basis, and whether it constitutes a separate and distinct healing art:
- (b) The contribution chiropractic could make to the health services of New Zealand:
- (c) Any other matters that may be thought by you to be relevant to the general objects of the inquiry.

And, with the like advice and consent, I hereby appoint you the said Brinsley Donald Inglis to be the Chairman of the said Commission:

And for the better enabling you to carry these presents into effect you are hereby authorised and empowered to make and conduct any inquiry under these presents, in accordance with the Commissions of Inquiry Act 1908, at such times and places as you consider expedient, with power to adjourn from time to time and from place to place as you think fit, and so that these presents shall continue in force and the inquiry may at any time and place be resumed although not regularly adjourned from time to time or from place to place:

And you are hereby strictly charged and directed that you shall not at any time publish or otherwise disclose, except to me in pursuance of these presents or by my direction, the contents or purport of any report so made or to be made by you or any evidence or information obtained by you in exercise of the powers conferred upon you except such evidence or information as is received in the course of a sitting open to the public:

And it is hereby declared that the powers hereby conferred shall be exercisable notwithstanding the absence at any time of any one of the members hereby appointed so long as the Chairman, or a member deputed by the Chairman to act in his stead, and one other member are present and concur in the exercise of the powers:

And it is hereby declared that you have liberty to report your proceedings and recommendations under this Commission from time to time if you shall judge it expedient so to do:

And using all due diligence, you are required to report to me in writing under your hands not later than the 31st day of March 1979 your findings and opinions on the matter aforesaid, together with such recommendations as you think fit to make in respect thereof.

Given in Executive Council under the hand of His Excellency the Governor-General this 24th day of January 1978.

A. C. McLEOD,
Acting for Clerk of the Executive Council.

Replacement of Member of Commission of Inquiry Into Chiropractic

KEITH HOLYOAKE, Governor-General
ORDER IN COUNCIL

To all unto whom these presents shall come, and to:

BRINSLEY DONALD INGLIS, of Wellington, One of Her Majesty's Counsel
Learned in the Law;
THOMAS ATHOL RAFTER, of Wellington, Scientist;
BETTY FRASER, of Wellington, Headmistress; and
BRUCE RUSSELL PENFOLD, of Christchurch, Professor of Chemistry:

GREETING:

WHEREAS by an Order in Council made on the 24th day of January 1978*, you, the said Brinsley Donald Inglis, Thomas Athol Rafter, and Betty Fraser, were appointed to be a Commission to inquire into and report upon the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services and, if thought fit that such benefits should be provided, the extent thereof:

And whereas you, the said Thomas Athol Rafter, are no longer able to serve as a member of the said Commission and have asked to be relieved from the duty of so doing, and it is desirable to appoint you, the said Bruce Russell Penfold, to be a member of the said Commission in the stead of the said Thomas Athol Rafter:

Now, therefore, pursuant to the Commissions of Inquiry Act 1908, I, The Right Honourable Sir Keith Jacka Holyoake, the Governor-General of New Zealand, acting by and with the advice and consent of the Executive Council, hereby relieve you, the said Thomas Athol Rafter, from your duties as a member of the said Commission and hereby appoint you, the said Bruce Russell Penfold, to be a member of the said Commission in the stead of the said Thomas Athol Rafter:

And it is hereby declared that all acts and things done and decisions made by the said Commission or any of its members, in the exercise of its powers, before the issuing of these presents, shall be deemed to have been made and done by the said Commission as reconstituted by these presents and as if you, the said Bruce Russell Penfold, had originally been appointed to be a member of the said Commission in the place and stead of the said Thomas Athol Rafter:

And I hereby confirm the said Order in Council made on the 24th day of January 1978, save as modified by these presents:

Given in Executive Council under the hand of His Excellency the Governor-General this 22nd day of May 1978.

P. G. MILLEN, Clerk of the Executive Council.

*Gazette, 1978, p. 302

*Extending the Time Within Which the Commission of Inquiry into Chiropractic
May Report*

KEITH HOLYOAKE, Governor-General
ORDER IN COUNCIL

To all to whom these presents shall come, and to:

BRINSLEY DONALD INGLIS, of Wellington, One of Her Majesty's Counsel
Learned in the Law;
BETTY FRASER, of Wellington, Headmistress; and
BRUCE RUSSELL PENFOLD, of Christchurch, Professor of Chemistry:

GREETING:

WHEREAS by an Order in Council made on the 24th day of January 1978*, you, the said Brinsley Donald Inglis and Betty Fraser, were appointed, together with one Thomas Athol Rafter of Wellington, Scientist, to be a Commission to inquire into and report upon the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services and, if thought fit that such benefits should be provided, the extent thereof:

And whereas by Order in Council made on the 22nd day of May 1978† you, the said Bruce Russell Penfold, were appointed to be a member of the said Commission in the stead of the said Thomas Athol Rafter:

And whereas you, the said Brinsley Donald Inglis, Betty Fraser, and Bruce Russell Penfold, are required, by the said Order in Council made on the 24th day of January 1978*, to submit your report not later than the 31st day of March 1979:

And whereas it is expedient that the time for so reporting should be extended as hereinafter provided:

Now, therefore, pursuant to the Commissions of Inquiry Act 1908, I, The Right Honourable Sir Keith Jacka Holyoake, the Governor-General of New Zealand, acting by and with the advice and consent of the Executive Council, hereby extend until the 31st day of July 1979 the time within which you, the said Brinsley Donald Inglis, Betty Fraser, and Bruce Russell Penfold, are so required to report, without prejudice to the continuation of the liberty conferred upon you by the said Order in Council made on the 24th day of January 1978* to report your proceedings and findings from time to time if you judge it expedient so to do, and hereby confirm the said Order in Council made on the 24th day of January 1978* and the Commission thereby constituted, save as modified by the said Order in Council made on the 22nd day of May 1978† and by these presents.

Given in Executive Council under the hand of His Excellency the Governor-General this 12th day of March 1979.

P. G. MILLEN, Clerk of the Executive Council.

* *Gazette*, 1978, p. 302

† *Gazette*, 1978, p. 1568

*Further Extending the Time Within Which the Commission of Inquiry into
Chiropractic May Report*

KEITH HOLYOAKE, Governor-General
ORDER IN COUNCIL

To all to whom these presents shall come, and to:

BRINSLEY DONALD INGLIS, of Wellington, One of Her Majesty's Counsel
Learned in the Law;
BETTY FRASER, of Wellington, Headmistress; and
BRUCE RUSSELL PENFOLD, of Christchurch, Professor of Chemistry:

GREETING:

WHEREAS by an Order in Council made on the 24th day of January 1978*, you, the said Brinsley Donald Inglis and Betty Fraser, were appointed, together with one Thomas Athol Rafter of Wellington, Scientist, to be a Commission to inquire into and report upon the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services and, if thought fit that such benefits should be provided, the extent thereof:

And whereas by Order in Council made on the 22nd day of May 1978† you, the said Bruce Russell Penfold, were appointed to be a member of the said Commission in the stead of the said Thomas Athol Rafter:

And whereas you, the said Brinsley Donald Inglis, Betty Fraser, and Bruce Russell Penfold, were required, by the said Order in Council made on the 24th day of January 1978*, to submit your report not later than the 31st day of March 1979:

And whereas by Order in Council made on the 12th day of March 1979‡ the time within which you were so required to report was extended until the 31st day of July 1979:

And whereas it is expedient that the time for so reporting should be further extended as hereinafter provided:

Now, therefore, pursuant to the Commissions of Inquiry Act 1908, I, The Right Honourable Sir Keith Jacka Holyoake, the Governor-General of New Zealand, acting by and with the advice and consent of the Executive Council, hereby extend until the 30th day of September 1979 the time within which you, the said Brinsley Donald Inglis, Betty Fraser, and Bruce Russell Penfold, are so required to report, without prejudice to the continuation of the liberty conferred upon you by the said Order in Council made on the 24th day of January 1978* to report your proceedings and findings from time to time if you should judge it expedient so to do, and hereby confirm the said Order in Council made on the 24th day of January 1978* and the Commission thereby constituted, save as modified by the said Order in Council made on the 22nd day of May 1978† and by these presents..

Given in Executive Council under the hand of His Excellency the Governor-General this 16th day of July 1979.

P. G. MILLEN, Clerk of the Executive Council.

*Gazette, 1978; p. 302

†Gazette, 1978; p. 1568:

‡Gazette, 1979, p. 689

Letter of Transmittal

To His Excellency The Right Honourable Sir Keith Jacka Holyoake, Knight Grand Cross of the Most Distinguished Order of Saint Michael and Saint George, Member of the Order of the Companions of Honour, Principal Companion of the Queen's Service Order, Governor-General and Commander-in-Chief in and over New Zealand.

MAY IT PLEASE YOUR EXCELLENCY

By Warrant dated 24 January 1978, we the undersigned BRINSLEY DONALD INGLIS and BETTY FRASER, and, in addition, Thomas Athol Rafter were appointed to report under the terms of reference stated in that Warrant. Thomas Athol Rafter became unable to serve as a member, and so by further Warrant dated 22 May 1978 Your Excellency appointed the undersigned BRUCE RUSSELL PENFOLD in his stead.

We were originally required to present our report by 31 March 1979 but this was later extended to 31 July 1979 and later further extended to 30 September 1979.

We now humbly submit our report for Your Excellency's consideration.

We have the honour to be

Your Excellency's most obedient servants,

B. D. INGLIS, Chairman.

BETTY FRASER, Member.

B. R. PENFOLD, Member.

Dated at Wellington this 5th day of October 1979.

FOREWORD

When the Commission was first set up, in January 1978, it was confidently believed that this would be a relatively simple inquiry. It was thought it would take us no longer than a month or two at the most; that the issues were quite clear and straightforward; and that we would have little trouble in finding quick answers to the questions raised by our terms of reference.

That early stage was our age of innocence. Nearly 2 years have gone by. We can now see how the real difficulties in this inquiry were underestimated. Important issues were involved: important to the public generally; important to public health; and very important to the principal organisations involved—the New Zealand Medical Association, the New Zealand Society of Physiotherapists, the New Zealand Chiropractors' Association, and the Department of Health—which took such pains to ensure that nothing of any significance was overlooked in this inquiry.

We must express our gratitude to all those people who went to considerable trouble to let us have their views and to let us know of their personal experiences. We think particularly of the individuals who came forward to read out their submissions at our public sittings, knowing that they were going to be questioned with considerable thoroughness; people who took time off work to come and see us; people who travelled sometimes quite long distances so that what they had written to us could be properly tested at a public hearing. We are grateful to all these people.

We come back to the professional associations which have been the principal parties in this inquiry. We are very well aware of the sacrifices made by those associations and their individual members in ensuring that all the issues we have to report on were thoroughly canvassed and tested under cross examination. This has certainly been the most thorough inquiry into chiropractic ever held in this country. We know of no similar inquiry overseas in which the facts have been more thoroughly investigated and tested.

The Commission wishes to comment particularly on the part played in this inquiry by counsel. It is fashionable in some sectors of the community to regard lawyers as an expensive luxury. In this inquiry there can be no doubt at all that the professional organisations have been admirably served by their legal representatives. There is no substitute for a lawyer's training in the clear marshalling of fact and argument so that the issues can be seen plainly by everybody. There is no substitute for the lawyer's trained skill in cross examination, and that has been one of the most valuable aspects of this whole inquiry. The two commissioners who are not lawyers particularly wish to record how valuable they found counsel's contribution to this inquiry, and their appreciation of the way counsel conducted the proceedings. Mr J. A. L. Gibson, counsel appointed to assist the Commission, must of course be included in this tribute.

We have dealt with the public side of this inquiry; now we must pay a tribute to those who were no less important to the Commission's work. We mention first the team of shorthand reporters who took down and transcribed well over a million words: Mrs F. M. Brown, Mrs K. O. Burns, Mrs J. M. McLean, Mrs Y. C. Rowland, Mrs J. M. Seagar, and Mrs O. B. Worboys. A great deal of skill and care, and many hours of

work, went into producing a transcript of our proceedings of a consistently high standard.

We are grateful also to the team who manned the Commission's offices. Mr L. T. Heath, the Commission's secretary until the onset of his illness in May 1979, made a distinguished contribution to the Commission's work which we have acknowledged elsewhere in this report. We wish especially to mention the work of Mr L. K. Bennett, Mr Heath's assistant, who took over as secretary and who cheerfully and uncomplainingly shouldered Mr Heath's duties as well as his own while the final drafts of this report were being prepared, and who saw the report through the press. We are particularly indebted to Mrs G. A. Dunne, who throughout the inquiry had charge of our growing collection of exhibits and materials and carried out special research for us, and to Mrs M. M. E. McDonald who typed innumerable drafts and, ultimately, the final report. Each member of this team took over the laborious and thankless task of checking every word we had written from draft to draft, bringing inconsistencies and errors to our attention, and correcting the proofs.

We have particularly appreciated the loyalty and support this team has given us throughout this inquiry: it has been a genuine team effort in a happy and constructive atmosphere.

PART I: INTRODUCTORY

Chapter 1. INTRODUCTION AND GENERAL CONCLUSIONS

1. This report follows an extended inquiry which developed into probably the most comprehensive and detailed independent examination of chiropractic ever undertaken in any country.

2. We entered upon our inquiry in early 1978. We had no clear idea of what might emerge. We knew little about chiropractors. None of us had undergone any personal experience of chiropractic treatment. If we had any general impression of chiropractic it was probably that shared by many in the community: that chiropractic was an unscientific cult, not to be compared with orthodox medical or paramedical services. We might well have thought that chiropractors were people with perhaps a strong urge for healing, who had for some reason not been able to get into a field recognised by orthodox medicine and who had found an outlet outside the fringes of orthodoxy.

3. The terms of our appointment (*N.Z. Gazette*, 1978, p. 302) required us to consider whether health and accident compensation benefits should be made available for chiropractic services; and we were expressly directed in looking at this question to have regard to and consider the practice and philosophy of chiropractic, its scientific and educational basis, whether it constituted a separate and distinct healing art, and the contribution it could make to New Zealand health services.

4. But as we prepared ourselves for this inquiry it became apparent that much lay beneath the surface of these apparently simple terms of reference. In the first place, it transpired that for many years chiropractors had been making strenuous efforts to gain recognition and acceptance as members of the established health care team. Secondly, it was clear that organised medicine in New Zealand was adamantly opposed to this on a variety of grounds which appeared logical and responsible. Thirdly, however, it became only too plain that the argument had been going on ever since chiropractic was developed as an individual discipline in the late 1800s, and that in the years between then and now the debate had generated considerably more heat than light.

5. The matters with which we had to deal were therefore difficult, both because of their substance and because of their emotional overtones. A careful approach was required. We would need solid facts and concrete evidence.

6. We explain in detail in the next chapter the procedure we adopted in pursuing this inquiry. Fortunately the Commissions of Inquiry Act 1908 is a flexible instrument. The early legislators who designed it were farsighted enough to understand that the procedure of an inquiry needs to be moulded to suit the subject-matter of the inquiry. A commission of inquiry is master of its own procedure. Its function is inquisitorial. It is a wider function than that of a court, which is in general bound to confine itself to the evidence which the parties themselves choose to place before it. A commission of inquiry is under no such limitation. It can pursue its

investigations in any way it thinks fit. It may dig as deep as is necessary. Its duty is to investigate, not to arbitrate.

7. It was reasonably clear at a very early stage that the Commission was in essence to be faced with a contest on the one hand between organised medicine, assisted by the physiotherapists, and on the other hand the chiropractors. We will summarise the main principles of policy we decided to follow in that situation. First, we decided that the organisations principally interested in the inquiry must be given every opportunity to place before the Commission any facts, information, or materials that were relevant to the objects of the inquiry. It was decided that in general all evidence should be given under oath. We decided that interested organisations and individuals should have very full rights of cross-examination: it was, we considered, essential that the evidence to be adduced should be thoroughly and effectively tested. We decided that there were some matters which would require independent investigation, and we arranged for the appointment of counsel (Mr J. A. L. Gibson, an experienced barrister) to assist the Commission. Finally, we decided that the inquiry should be conducted, as far as possible, in public.

8. It will be seen from the next chapter that the volume of material we received exceeded all expectations. Our public sittings extended into 1979. We found ourselves obliged to pursue the inquiry overseas, in Australia, the United Kingdom, Canada, and the United States. The inquiry at times took unexpected turns. At the end of it all little could be said either for or against chiropractic that had not been placed before us.

9. Throughout the inquiry we have recognised that it would be unsafe to reach any firm conclusions before we had heard the whole of the submissions, the whole of the evidence, and the addresses of counsel. Although, as we have said, we were faced with what was in essence a contest between organised medicine and organised chiropractic, we did not consider it our function to regard the inquiry as a contest. The Commission's function was to find, determine, and evaluate the facts. Our conclusions had to lie where the facts took us. Where did the facts take us?

10. By the end of the inquiry we found ourselves irresistibly and with complete unanimity drawn to the conclusion that modern chiropractic is a soundly-based and valuable branch of health care in a specialised area neglected by the medical profession. If properly controlled, it is worthy of public confidence and support. Health and accident compensation benefits should be made available, within the limits we define and discuss, for chiropractic treatment.

11. The Commission does, however, have strong reservations about some aspects of modern chiropractic. It must be emphasised that this report must be read as a whole and carefully studied. Among other things, discipline within the chiropractic profession in New Zealand is unsatisfactory. That situation needs to be remedied. We have specific recommendations on this point. But that is only one aspect. The Commission's reservations, the reasons for its conclusions, and its detailed recommendations are set out in the following chapters and should be treated as a package. The whole of the report must be considered carefully.

12. There is, however, one point which we wish to mention particularly. In this report we have been obliged to direct some criticism at organised medicine in New Zealand. Its opposition to chiropractic is, in our finding, largely misconceived. But it is important to realise that it is not the Commission's intention to suggest that there is any ground for any general

loss of faith in organised medicine. The medical profession is the public's guardian against undesirable or dangerous health practices. We have no reason to doubt the sincerity or the integrity of the New Zealand medical profession in the part it played in this inquiry.

13. It was at one stage suggested on behalf of the New Zealand Chiropractors' Association that one of the real reasons for organised medicine's opposition to chiropractic was a financial one: if chiropractors became accepted as members of the health care team, doctors' incomes would suffer. When that suggestion was made we immediately asked what evidence there was to justify it, and we were told there was none. We were not prepared to listen further to such a suggestion. It should not have been made in the first place. We have no doubt that the opposition of organised medicine to chiropractic has been based on honest motives and the sincerely held belief that such opposition was justified in the public interest. The Commission's finding that such blanket opposition must now be regarded as unjustified does not turn an honest motive into an improper one. There is no reason why any of the findings in this report should lead anyone to feel any lack of faith or confidence in the medical profession.

SUMMARY OF PRINCIPAL FINDINGS

14. It will be helpful if we summarise our principal findings. In doing so at this stage it will be understood that we are anticipating a number of points which we explain in detail later in this report. We emphasise again that the report needs to be read as a whole.

General

- Modern chiropractic is far from being an "unscientific cult".
- Chiropractic is a branch of the healing arts specialising 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.
- Chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy.
- General medical practitioners and physiotherapists have no adequate training in spinal manual therapy, though a few have acquired skill in it subsequent to graduation.
- Spinal manual therapy in the hands of a registered chiropractor is safe.
- The education and training of a registered chiropractor are sufficient to enable him to determine whether there are contra-indications to spinal manual therapy in a particular case, and whether the patient should have medical care instead of or as well as chiropractic care.
- Spinal manual therapy can be effective in relieving musculo-skeletal symptoms such as back pain, and other symptoms known to respond to such therapy, such as migraine.
- In a limited number of cases where there are organic and/or visceral symptoms, chiropractic treatment may provide relief, but this is unpredictable, and in such cases the patient should be under concurrent medical care if that is practicable.

- Although the precise nature of the biomechanical dysfunction which chiropractors claim to treat has not yet been demonstrated scientifically, and although the precise reasons why spinal manual therapy provides relief have not yet been scientifically explained, chiropractors have reasonable grounds based on clinical evidence for their belief that symptoms of the kind described above can respond beneficially to spinal manual therapy.

Chiropractors and the Medical Profession

- Chiropractors do not provide an alternative comprehensive system of health care, and should not hold themselves out as doing so.
- In the public interest and in the interests of patients there must be no impediment to full professional co-operation between chiropractors and medical practitioners.
- Chiropractors should, in the public interest, be accepted as partners in the general health care system. No other health professional is as well qualified by his general training to carry out a diagnosis for spinal mechanical dysfunction or to perform spinal manual therapy.
- It is wrong that the present law, or any medical ethical rules, should have the effect that a patient can receive spinal manual therapy which is subsidised by a health benefit only from those health professionals least well qualified to deliver it.
- The present rules of medical ethics prohibiting medical practitioners from referring patients to chiropractors or from co-operating with chiropractors in matters of patient care, are not in the public interest.
- Patients should continue to have the right to consult chiropractors direct.
- The display of the title "Doctor" by a chiropractor who is not a registered medical practitioner should be strictly limited.

Professional Organisation

- The Chiropractors Act 1960 should be administered by the Department of Health.
- The Chiropractic Board should be reconstituted to provide appropriate representation of the Department of Health and the medical profession.
- The disciplinary machinery and the disciplinary standards applicable to New Zealand chiropractors need thorough overhaul.
- In particular, the issuing of any publicity material which suggests that chiropractors provide a comprehensive health care service or should be consulted ahead of medical practitioners for general health problems, should be banned. Such a ban should be enforced by drastic disciplinary action.

Spinal Manual Therapy in the Future

- The responsibility for spinal manual therapy training, because of its specialised nature, should lie with the chiropractic profession. Part-time or vacation courses in spinal manual therapy for other health professionals should not be encouraged.

Education and Research

- The education provided by the International College of Chiropractic at the Preston Institute in Victoria is of a high standard.
- Bursaries should be made available to New Zealand students who wish to undertake a course leading to the B.App.Sc. (Chiropractic) degree at Preston Institute.
- The Chiropractic Board, the Chiropractors' Association, and the Medical Association should make every effort to ensure that all practising chiropractors in New Zealand are kept informed of current relevant developments in medical science and research.
- A properly designed programme of chiropractic research should be instituted, supported by Government funds, and based in a New Zealand medical school.

Hospitals

- The hospital boards should, under suitable conditions, allow chiropractors access to hospitals: (a) to treat patients who wish to have such treatment and would benefit from it; (b) to assist with general health care by providing spinal manual therapy in appropriate cases; (c) to further their clinical education and training.

15. It is emphasised again that the above is no more than a brief summary of some of the principal conclusions we have reached. All these points must be considered in their proper context. We stress that this report must be studied as a whole.

Chapter 2. BACKGROUND, PROCEDURE, AND DETAILS OF THE INQUIRY

BACKGROUND OF THE INQUIRY

1. In 1975 a petition was presented to Parliament by Mr R. A. Houston, a Hamilton barrister, and 94 210 others. The petitioners asked "that Chiropractic services be subsidised under Social Security and Accident Compensation, so that patients of Registered Chiropractors may receive their services on the same basis as they receive other Health services within the community". The Petitions Committee recommended that the petition be referred to Government for most favourable consideration. In July 1976 the then Minister of Health announced the Government's decision to establish a Commission of Inquiry into Chiropractic.

2. There was then some delay, due apparently to difficulty in establishing terms of reference which would be satisfactory to the New Zealand Chiropractors' Association and the New Zealand Medical Association. There were also problems in identifying the precise scope which the proposed inquiry should cover. In the end it was apparently decided that the inquiry should not be limited to a consideration of the petitioners' proposals in isolation, and we think, with respect, that that was plainly the right decision.

TERMS OF APPOINTMENT

3. As we have already seen, the terms of our appointment (*N.Z. Gazette*, 1978, p. 302) required us to inquire into and report upon the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services, and, if thought fit that such benefits should be provided, their extent.

4. In considering those matters the Commission was expressly directed to have regard to and consider:

- (a) The practice and philosophy of chiropractic, its scientific and educational basis, and whether it constitutes a separate and distinct healing art;
- (b) The contribution chiropractic could make to the health services of New Zealand;

and any other matters that the Commission might think to be relevant to the general objects of its inquiry.

5. It was obvious from the outset that we could not possibly decide whether benefits should be payable in respect of chiropractic services until we had thoroughly investigated the practice and philosophy of chiropractic, and its scientific and educational basis. We first had to determine whether chiropractic services were of a kind that ought to be subsidised from public funds. There could be no possibility of a subsidy unless chiropractic, as a health care service, met at least the minimum standards required of health care services in respect of which benefits were already payable. So it was clear from the beginning that this inquiry had to include a thorough investigation of chiropractic as a form of health care. Those seeking to promote health and accident compensation benefits

for chiropractic treatment had first to convince the Commission that chiropractic rested on solid foundations.

6. However, it was also obvious that even if we found chiropractic to be soundly based, it would not necessarily follow that chiropractic treatment should attract health benefits. There are other forms of health care, accepted without question, that do not attract health benefits. These matters had to be taken into account in determining whether chiropractic treatment ought to be included in the benefits system.

OSTEOPATHY

7. At an early stage of our inquiry we received a request from certain osteopathy organisations that we should interpret our terms of appointment to include an investigation of osteopathy. Osteopathy has features that are similar to those of chiropractic, and while both developed as separate disciplines it appears that the differences have diminished in the course of time.

8. While it might have been possible to regard osteopathy as a subject we might usefully examine, we finally decided that it was unnecessary for us to do so. An investigation into osteopathy of the kind the osteopathic organisations appeared to want would have substantially protracted this inquiry. Furthermore it appeared to us that if we limited the inquiry strictly to chiropractic, our findings would certainly be relevant to any study of osteopathy in a similar context which might become necessary in the future. At that stage, if the osteopaths then wished to pursue the matter, we considered that it would not be unduly difficult for them to show that they should be treated similarly to chiropractors or alternatively that they should be distinguished from chiropractors.

9. In any event we have not considered osteopathy at all in this inquiry.

PREVIOUS INQUIRIES IN NEW ZEALAND

10. There have been two earlier investigations by commissions of inquiry in this country into whether health benefits should be available for chiropractic treatment. The Royal Commission on Compensation for Personal Injury (the Woodhouse Commission) found itself unable to reach any settled conclusion in an issue of this kind without a prolonged examination of a great deal of medical and scientific evidence. It went on to say that the basic issue was the validity of chiropractic treatment, and that it made no recommendation because it was unable to judge the validity of such treatment. The later Royal Commission on Social Security took a similar view.

11. It is fair to say that both these commissions had access to only limited evidence on the nature and theory of chiropractic treatment. We have read the transcripts of the submissions and evidence made available to both these commissions. The "prolonged examination of a great deal of medical and scientific evidence" which the Woodhouse Commission felt it had not been placed in a position to undertake was of course assigned to us by our terms of reference. As a glance at our bibliography will demonstrate, we have had referred to us almost everything that has, or could be, said on the topic. And the submissions we received, together with the evidence called at our public and private sittings, left hardly any aspect of any topic within our terms of reference uncovered.

12. From the outset we made it plain to the interested organisations that we would gain more assistance from positive and concrete factual

evidence than from generalised assertions. The Commission is grateful to the principal parties for assisting it by recognising that emphasis in the submissions and evidence they tendered.

OUR APPROACH TO THIS INQUIRY

13. As we have said, we approached this inquiry in almost complete ignorance about chiropractic. None of us had any personal experience of it. This has, we think, turned out to be a major advantage. We were able to come to our investigation without any strongly preconceived ideas.

14. But as we prepared ourselves for this inquiry it became very clear that the forces of organised medicine were vigorously opposed to chiropractic in general, and in particular any notion that health or accident compensation benefits should subsidise chiropractic treatment. We are glad to take the earliest opportunity to report that although in the course of the inquiry we could not avoid noticing a major degree of underlying bitterness and animosity between organised medicine on the one hand and organised chiropractors on the other, those parties conducted themselves during the inquiry with moderation, good sense, dignity, and fairness.

15. It also became quite clear to us that the situation called for all interested parties to be given the widest opportunity to make submissions, call evidence, and cross-examine.

16. Accordingly, at its inaugural public sitting on 15 March 1978 the Commission, as then constituted, made it known that the most suitable way to conduct this inquiry was to give everyone interested the fullest opportunity to provide the Commission at its public sittings with the evidence and information that could assist it. We made it clear that we intended to rely on those interested in the inquiry to provide us with the evidence and the material which would thoroughly inform us on the matters we had to inquire into.

17. And on the question of cross-examination we said:

... in this Inquiry we think that cross-examination should be generously allowed, provided of course that it is conducted in a proper manner and is not unduly repetitive. We will however retain the right to control the extent and the nature of cross-examination at all times.

18. We thought it best to conduct our inquiry in public wherever possible

... so that all interested parties can hear what is said and are able to cross-examine and, at the proper time, provide their own comments or answers to any assertions they may wish to take issue with. We would prefer to hear evidence in private only as an exceptional course and only where there are plainly good reasons for doing so.

19. We followed those policies throughout the inquiry, with at least one important consequence. By being present at the public sittings and by listening to each other's points of view being put forward at length and subjected to very intensive cross-examination, the medical and chiropractic organisations have at least had the opportunity to acquire some understanding of each other's positions. That seems to have been conspicuously lacking in the past. Now that we have completed our inquiry it seems obvious to the Commission that a good deal of the mistrust of chiropractic demonstrated by organised medicine has arisen from ignorance of chiropractic and lack of communication with chiropractors.

THE PRINCIPAL PARTIES

20. This inquiry had no "parties" in the technical legal sense. However, it is no exaggeration to say that the inquiry took the form of a confrontation between chiropractors on the one hand and the medical profession on the other as to the efficacy and the scientific basis of chiropractic treatment.

21. The principal weight of the inquiry was therefore borne by the New Zealand Chiropractors' Association, the New Zealand Medical Association, representing the medical profession and a number of specialist medical organisations, and the New Zealand Society of Physiotherapists, representing generally paramedical services whose interest lay in musculo-skeletal treatment. All were represented by counsel who appeared throughout the major part of the inquiry, and who actively and extensively cross-examined the principal witnesses.

22. The Department of Health also appeared by counsel and cross-examined, though not to such an extent. A number of its officers were present throughout most of the inquiry's public sittings. The department saw itself in an independent role. The Commission is grateful for its assistance in a variety of ways.

23. Because the need arose to have some aspects of the evidence examined independently of the principal parties for the purpose of the hearings, Mr J. A. L. Gibson, an experienced Wellington barrister, was appointed as counsel to assist the Commission. Mr Gibson's attendance was required only as occasion demanded, and we desire to acknowledge the considerable value of the contribution he was able to make.

24. We wish to say that the factor of possibly the greatest assistance to the Commission in this inquiry came from the intensive cross-examination by counsel representing the parties principally concerned. If ever any convincing demonstration were needed of the value of cross-examination by experienced lawyers, it came in this inquiry. Weaknesses in the principal submissions were brought into the open as was the often unconscious bias or prejudice of some of the witnesses.

25. Of considerable value to us was the evidence of individuals who came to our sittings to speak of their experience of chiropractic treatment. While there are natural and obvious limits to the weight that can be given to such anecdotal material in an inquiry of this kind, these witnesses were able to convey to us very vividly, sometimes with unaffected emotion, the difference that chiropractic treatment had made to their lives. Nearly all these witnesses were available for cross-examination by counsel, and many were cross-examined. We were thus placed in the best possible position to evaluate chiropractic treatment as it appeared to those who had undergone it.

26. The Commission made it known that, although it was best for as much evidence as possible to be heard in public, there could be occasions when people would want to make submissions to the Commission privately and in confidence. By far the greater proportion of evidence was received in public sittings but we did hear some evidence in private as an exceptional course. In receiving and weighing that evidence we bore in mind that we were being deprived of the opportunity of having that evidence tested by cross-examination.

WITNESSES ON OATH

27. All witnesses giving formal evidence testified on oath.

OVERSEAS INQUIRIES

28. We were of course aware of formal inquiries into chiropractic conducted in Australia, Canada, South Africa, and the United States. While we found the reports of those inquiries most informative, we felt ourselves obliged to remember throughout this present inquiry that we were dealing with New Zealand chiropractors in a New Zealand context and with New Zealand health services in mind. In addition we had no way of knowing precisely what submissions or evidence those other inquiries had received or considered. In the end we felt the only proper course was to rely on our own judgment formed after considering all the submissions, evidence, and other material to which we had access.

DEMONSTRATIONS OF TECHNIQUES

29. From time to time in the course of the inquiry and more particularly as it was drawing to its close, we arranged to attend a number of demonstrations by chiropractors and physiotherapists. These proved of real value. Seeing these treatments actually performed; watching and hearing the patient's reaction, and listening to the explanations of what was sought to be achieved as the treatment was being carried out, gave vivid substance to what we had read and heard from the witnesses at our public sessions.

30. We attended these demonstrations in the chiropractors' and physiotherapists' own rooms, in each case with the patients' consent, and felt free to speak informally with both the patient and the practitioner concerned.

31. We have been careful not to place undue weight on what we saw and heard during these demonstrations because the very fact that we were present meant that the atmosphere could not be that of a normal consultation or treatment session. And because the demonstrations were necessarily held in private we were deprived of the benefit of having the comments of counsel.

TECHNICAL ADVISERS

32. At one stage while this Commission of Inquiry was being set up it was suggested that technical advisers, representing the medical profession on the one hand and chiropractors on the other, be appointed to the Commission's staff to advise it on technical matters as the hearings progressed. The Commission decided against this. We thought it would be better if, as a general rule, any information which came to us on technical matters were supplied at public sittings by expert witnesses so that everyone interested could know exactly what the information was. They would then be in a position to comment on it and take issue with it if necessary.

33. In the result we found no real difficulty in coping with any technical matters put to us. We wish to record our gratitude to the expert witnesses who went to considerable pains to explain technical matters clearly to us.

REPLACEMENT OF MEMBER OF COMMISSION

34. The Commission was set up on 24 January 1978. It held its inaugural public sitting on 15 March 1978 at which its terms of reference were explained and the procedure which it proposed to follow outlined.

35. The Commission was reconstituted on 22 May 1978, owing to the retirement of Dr T. A. Rafter to take up other duties overseas. Dr B. R.

Penfold, Professor of Chemistry in the University of Canterbury, was appointed to take his place.

SUBMISSIONS

36. Advertisements inviting submissions were placed in metropolitan and provincial newspapers in February 1978. Further advertisements were placed in local newspapers in Auckland, Rotorua, Christchurch, Timaru, and Oamaru as the Commission was about to move into those centres for formal hearings.

37. A total of 136 formal submissions was received. From the time of their receipt they were made available for public inspection, and the organisations particularly concerned in the inquiry were provided with copies.

38. The formal submissions comprised more than 2300 pages. Thirty-seven submissions were from organisations, and 99 were from private individuals. The representatives of 16 of the organisations appeared at formal public sittings of the Commission to present submissions. Some of the organisations presenting submissions also represented other organisations with a common interest. For example, the New Zealand Medical Association represented no less than 13 other medical organisations. Seventy-six private individuals presented their submissions in person.

PRIVATE SUBMISSIONS

39. Some people approached the Commission expressing a wish to give evidence but requesting that it be heard by the Commission in private and kept confidential to the Commission. In some cases, from the nature of the evidence that was to be presented, the Commission took the view that the evidence should be heard either at a sitting to which the general public should not be admitted but which counsel might attend if they chose, or at a wholly private sitting. The number of witnesses giving evidence before the Commission on a confidential basis or at a sitting to which the public were not admitted was 16.

40. In a few instances, where evidence was given at a public sitting, the Commission made an order prohibiting publication of the whole, or particular parts, of the evidence. Apart from the instances mentioned in this section the whole of the evidence before the Commission was presented in public.

THOSE WHO APPEARED

41. The following organisations appeared and presented their submissions at the Commission's public sittings:

- Accident Compensation Commission.
- Consumer Council.
- Crown Law Office.
- General Practitioner Society.
- Health, Department of.
- Janacia Child Care.
- N.Z. Association of Naturopaths and Osteopaths Inc.
- N.Z. Association of Social Workers Inc.
- N.Z. Chiropractic Board.
- N.Z. Chiropractors' Association Inc.
- N.Z. Medical Association.

N.Z. Nurses Association Inc.
 N.Z. Physiotherapy Board.
 N.Z. Society of Physiotherapists Inc.
 Patients Association for Chiropractic Education (PACE).
 Social Welfare, Department of.

42. The following private individuals appeared and presented their submissions at the Commission's public sittings:

Bailey, Mr E. W.
 Barnes, Mr P. E.
 Barrell, Mr G. W. L.
 Blanchard, Mr T. R.
 Cheeseman, Mr R. W.
 Clark, Mrs P. M., and Newton, Mrs I.
 Columb, Mr P. F.
 Deane, Mrs E. M.
 Doyle, Mr M. J.
 Driscoll, Mrs M.
 Dry, Mr D. S.
 Dryburgh, Mr and Mrs A.
 Glading, Mr S. G.
 Gower, Mr D. H.
 Griffin, Rev. P.
 Harvey, Mr T. G.
 Hilder, Mr C. B.
 Hoadley, Mrs W. N.
 Hope, Mr A. C.
 Howarth, Mrs M.
 Howe, Mr R. H.
 Innes, Mr J. J.
 Jarman, Mr A. E.
 Johnson-Foote, Mrs D.
 Kinsella, Hon. A. E.
 Langridge, Mr A. F.
 Lister, Mr R. W.
 Lovell, Mr V.
 Luke, Mr and Mrs T. D.
 Maclaren, Mr R. L.
 Martin, Mrs D.
 Marshall, Mrs D. P.
 McCully, Mr R. B.
 McLay, Mr H. S.
 McPhail, Mrs B.
 Meldrum, Mr D. W.
 Michie, Mr C. W. B.
 Money, Mrs T.
 Mowbray, Mrs J. R.
 Mulligan, Mr B. R.
 Nagle, Mrs V. A.
 Nixon, Mr J. E.
 Nolan, Mr J.
 O'Hagan, Mr D. O.
 Perry, Mr N. W.
 Peters, Mr R.
 Pirie, Mr W.

Pomeroy, Miss M. S.
 Radford, Mrs N.
 Raskin, Mr O.
 Rhodes, Mrs E. E.
 Rickard, Mrs J. C.
 Robinson, Mr R. G.
 Robinson, Mr W. J.
 Roscoe, Mr J. P.
 Savory, Lady
 Scott, Mr A. R.
 Seagar, Mr B. S.
 Sharland, Mr G. E.
 Sheehy, Mr P.
 Sinclair, Mrs F. E.
 Slade, Mr F. J.
 Smith, Mrs A.
 Snodgrass, Mr K. J.
 Snow, Mr J. H. D.
 Spring, Mr W. J.
 Stanton, Mrs V. C.
 Steele, Mr K. B.
 Thornton, Mrs K. C.
 Timmins, Mr T. V.
 Trotter, Mr W. B.
 Wade, Mr S. J.
 Walker, Mr G. P.
 Winter, Mr J. H.

43. The following witnesses gave evidence on behalf of the four main parties at the Commission's public sittings:

Department of Health

Andrews, Dr D. A.
 Hiddleston, Dr H. J. H.
 McKinlay, Professor J. B.

New Zealand Chiropractors' Association

Blackbourn, Dr L. C.
 Haldeman, Dr S.
 Kleynhans, Dr A. M.
 Mudgway, Dr L. C.
 Pallister, Dr S. J.
 Ross, Dr C. M.
 Thompson, Dr H. R.
 Turney, Mr G. A.
 Wells, Dr. P. D.
 Yochum, Dr T. R.

New Zealand Medical Association

Boyd-Wilson, Dr J. S.
 Cole, Professor D. S.
 Elliott, Sir Randal
 Eyre, Dr K. E. D.
 Hubbard, Professor J. I.
 Modde, Dr P. J.

Nicholson, Mr O. R.
Parker, Dr G. B.

New Zealand Society of Physiotherapists

Ingram, Mrs B. C.
Jarvis, Dr W. T.
Katz, Dr M. S.
Lamont, Mr M. K.
McKenzie, Mr D. M.
McKenzie, Mr R. A.
Mulligan, Mr B. R.
Neame, Mr A. A.
Searle, Mr I. E.
Wood, Mrs P. G.

44. The following witnesses gave evidence at sittings which were open to counsel but from which the general public was excluded:

Boyd-Wilson, Dr J. S.
Burt, Mr and Mrs B. R., and Andrew Burt.
Isdale, Dr I. C.
Lewis, Dr B. J.
Moody, Dr W. P. C.
Todd, Dr R. J.

45. The following made submissions but did not appear before the Commission. Their submissions were read into the evidence.

Andersen, Miss K.
Anderson, Mr S. R.
Andrews, Mr A. W.
Australasian Council on Chiropractic Education Ltd.
Bell, Mrs H. J.
Caddell, Mr A.
Chatfield, Mr P.
Cottrill, Dr C. E.
Creasy, Mr E. W.
Finlay, Mr B. J.
Furby, Mr B. S.
George, Mr W.
Ingram, Mr H. G.
Jackson, Mr A. N.
Jelicich, Mrs D. C.
Kenton, Mr B. J.
King, Mr R. H.
McInnes, Mrs D. C.
N.Z. Carpenters and Related Trades Industrial Union of Workers,
Wanganui Sub-branch.
N.Z. Federation of Labour.
N.Z. Institute of Driving Schools Inc.
N.Z. Register of Osteopaths Inc.
Tayler, Mr D.
Thomas, Mr A. F.
Turner, Mr A.
Turnovsky, Mr F.
Wallace, Mrs M.
Wegrzyn, Father B.

THE EVIDENCE

46. The oral evidence (apart from the actual content of the submissions, and apart from oral evidence presented at sittings held in private) was transcribed verbatim from shorthand notes. This consisted mainly of cross-examination by counsel and questioning by commissioners and amounted in all to 3638 pages of typescript, or approximately 1 637 000 words. Copies of the transcript were made available to the principal interested organisations during the progress of the sittings. The Commission received no less than 264 exhibits produced to it in evidence.

SITTINGS

47. The Commission sat in public for a total of 78 days, extending over a period from 15 March 1978 to 19 April 1979. The Commission sat in closed session or heard confidential submissions or evidence on 15 days.

VISITS TO INSTITUTIONS IN NEW ZEALAND

48. The Commission visited the medical schools at Otago and Auckland universities. We inspected the facilities and had discussions with members of the faculties.

49. The Commission also visited the two Schools of Physiotherapy in Auckland and Dunedin. Again we inspected the facilities, watched classes in progress, and met members of the staff.

50. We discuss these visits in more detail elsewhere in this report. We would like to express our appreciation of the efforts made at all these institutions to ensure that our visits were profitable and that we saw everything we wished to see.

51. We wish, however, to express our particular appreciation of the efforts of the Dean (Dr G. L. Brinkman) and Faculty of the University of Otago Medical School who went to some trouble in preparing a special programme for us. We had become aware that certain members of the faculty had been engaged in research which was likely to be of interest to us, particularly in the light of the evidence which had then been given by Dr Scott Haldeman, an overseas witness (see chapter 35). We sent copies of the relevant parts of Dr Haldeman's evidence in advance of our visit and asked for comment on it. The dean kindly arranged for us to meet and have discussions with those members of the faculty who were available and who might be able to help us, and we later received most helpful correspondence from a member of the faculty who had not been available at the time of our visit. Special slides and films were shown to us demonstrating some aspects of relevant current research activity and findings.

52. We found our visit to the Otago Medical School of great interest and value, not least because of the atmosphere of detached scientific interest and curiosity about the subject-matter of our inquiry. We wish to record that we noticed no attempt in anything that was said to us in the course of our visit to influence us one way or the other: the approach was one of neutral scientific inquiry in the best sense.

53. In saying what we have about the help that was willingly offered to us by the Otago Medical School we do not intend it to be thought that we are offering any comparison adverse to the Auckland Medical School. We visited the latter after our Otago visit, and by that time we were concerned principally to familiarise ourselves with the facilities of a modern medical school so that we would have proper standards by which to judge the

facilities of the overseas chiropractic colleges which we were shortly to visit. We were warmly and helpfully received by the Auckland Medical School Faculty.

OVERSEAS INVESTIGATIONS

54. The Commission travelled overseas in April and May 1979, extending its inquiry to Australia, the United Kingdom, Canada, and the United States. We felt it necessary to visit, and assess for ourselves, a selection of chiropractic colleges, in various ways to seek out and assess the most recent developments in the relationship between chiropractors and other health professionals in various countries, and to see what benefits were paid for chiropractic services and under what conditions by both government and private organisations in the countries visited.

55. The Commission spent altogether 17 days in meeting and interviewing officers of various organisations and inspecting chiropractic colleges.

56. The following chiropractic colleges were visited and inspected:

International College of Chiropractic, Preston Institute of Technology, Bundoora, Australia.

Anglo-European College of Chiropractic, Bournemouth, England.

Canadian Memorial Chiropractic College, Toronto, Canada.

National College of Chiropractic, Lombard, Illinois, United States.

Palmer College of Chiropractic, Davenport, Iowa, United States.

Los Angeles College of Chiropractic, Glendale, California, United States.

57. Officers of the following organisations, and the following individuals, were interviewed by the Commission:

Australia

Mr J. M. J. Jens, F.R.C.S., F.R.A.C.S., F.A.C.S. (Consulting Orthopaedic Surgeon).

Australian Medical Association (Victoria Branch).

Australian Chiropractors' Association.

Preston Institute of Technology.

Chiropractors and Osteopaths Registration Board (Victoria).

Professor Edwin C. Webb (Vice Chancellor of Macquarie University, Sydney, and Chairman of the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy and Naturopathy).

United Kingdom

British Chiropractors' Association.

British Medical Association.

Central Ethical Committee of General Medical Council.

St. Thomas' Hospital.

Council for Professions Supplementary to Medicine.

Ministry of Health and Social Security.

Canada

Workmen's Compensation Board, Ontario.

Ontario Ministry of Health.

College of Physicians and Surgeons of Ontario.

Canadian Chiropractic Association.

Ontario Chiropractic Association.

Workers' Compensation Board of British Columbia.

British Columbia Ministry of Health.
British Columbia Medical Association.
British Columbia College of Physicians and Surgeons.
British Columbia Chiropractic Association.

United States

American Medical Association.
American Chiropractic Association.
Council on Chiropractic Education.
Foundation for Chiropractic Education and Research.
Blue Cross and Blue Shield of Iowa.
Dr C. H. Suh (University of Colorado), Professor.
Dr M. W. Luttgies (University of Colorado), Associate Professor.
Dr J. D. Grostic (on leave from Palmer College at University of Colorado).

58. We wish to acknowledge the assistance that was willingly offered to us by all those we met in the overseas sector of our inquiry.

Chapter 3. EXISTING HEALTH SUBSIDIES IN NEW ZEALAND

INTRODUCTORY

1. In this inquiry we are concerned only with health and accident compensation subsidies for chiropractic treatment. We are not concerned with private insurance schemes, but we pause to mention one such scheme which once offered chiropractic cover and discontinued it as a result of direct representations made to its board of directors by Dr J. S. Boyd-Wilson, who presented the principal submissions for the Medical Association in our inquiry (see Transcript, p. 1845). We have no doubt that Dr Boyd-Wilson acted with the best motives, but we express the hope that the organisations offering private health insurance schemes will take note of what we say in this report about the value of chiropractic treatment.

HEALTH BENEFITS

2. The health benefits with which we are concerned are those available pursuant to Part II of the Social Security Act 1964. This part of the Act is administered by the Department of Health. The relevant benefits are the benefits for general medical services (sections 93-96), specialist medical services (section 97), and physiotherapy and radiology services (pursuant to regulations made under section 116).

3. The general scheme of Part II of the Act is that patients attending a medical practitioner are in normal circumstances entitled to a fixed and specified benefit which is intended to meet part of the fee payable to the practitioner. The practitioner may either collect the benefit himself as part payment of his fee and charge the patient the balance, or may charge the patient the whole fee, leaving it to the patient to claim the benefit payment from the department.

4. There is no provision in the Act or regulations for any benefit in respect of treatment by a chiropractor.

ACCIDENT COMPENSATION

5. The Accident Compensation Commission, subject to certain qualifications which are not important for the purposes of this report, is entitled to pay the cost of medical or paramedical treatment incurred as the result of the patient having suffered personal injury by accident in respect of which he has cover under the Accident Compensation Act 1972 (see section 111).

6. It is informative to set out the relevant parts of section 111 as follows:

(1) Subject to any regulations made under this Act, where a person suffers personal injury by accident, in respect of which he has cover under this Act, if as a result of the personal injury he requires to obtain a medical certificate for the purposes of this Act, or requires any treatment to which this subsection applies, the Commission shall pay the cost thereof so far as—

- (a) That person is not entitled to any benefit under Part II of the Social Security Act 1964 in respect thereof; and
- (b) The Commission considers that the amount to be paid by it is reasonable by New Zealand standards taking into account any contribution made by the Commission under subsection (3) of this section.

(2) Subsection (1) of this section shall apply to any of the following treatments in New Zealand (not being treatment in respect of damage to natural teeth to which paragraph (a) of subsection (2) of section 110 of this Act applies), whether or not the person requiring the treatment is a person entitled to claim the benefits provided by Part II of the Social Security Act 1964:

- (a) Treatment of the person as a patient in any hospital as defined in section 88 of the Social Security Act 1964;
- (b) Treatment of the person as a patient in any hospital as defined in section 2 of the Mental Health Act 1969;
- (c) Treatment of the person by a registered medical practitioner;
- (d) Treatment by the provision of any pharmaceutical requirement which is specified in any Drug Tariff for the time being in force under section 99 of the Social Security Act 1964 and which is prescribed for the person by a registered medical practitioner;
- (e) Treatment by the provision of any service, treatment, or assistance for the person for which a supplementary benefit is provided under section 116 of the Social Security Act 1964;
- (f) Treatment by the provision of any artificial limb or aid or prosthetic appliance which is prescribed for the person by a registered medical practitioner and of its normal repair or renewal so far as the cost thereof is payable by the person and is not a cost in respect of treatment to which paragraph (e) of this subsection applies . . .

(5) Subject to any regulations made under this Act, upon receipt by the Commission of a statement by a registered medical practitioner in New Zealand, given in a form approved by the Commission,—

- (a) Certifying as to any services afforded by that practitioner to any person and the amount claimed in respect thereof; and
- (b) Certifying that he considers that the services were required as a result of personal injury by accident; and
- (c) Containing the name and address of that person and such other information as may be required by that form to be furnished,—

the Commission, may, if it thinks fit, notwithstanding anything to the contrary in this Act, pay the amount so claimed for the services or so much thereof as it considers it is reasonable for it to pay by New Zealand standards without further inquiry as to whether the services were required as a result of personal injury by accident in respect of which the person had cover under this Act and without further inquiry as to whether he was entitled to compensation under this Act.

(6) Subject to any regulations made under this Act, upon receipt by the Commission of a statement by a person in New Zealand duly qualified to provide radiological or physiotherapy services or other paramedical services, given in a form approved by the Commission—

- (a) Certifying as to any such services (being services which he was duly qualified to provide) afforded by him personally or by or under the direct supervision of himself or another person duly qualified to provide the services, and the amount claimed in respect thereof; and
- (b) Certifying that the person to whom the services were afforded was referred by a registered medical practitioner as a case of personal injury by accident; and
- (c) Containing the name and address of that person and such other information as may be required by that form to be furnished—

the Commission may, if it thinks fit, notwithstanding anything to the contrary in this Act, pay the amount so claimed for the services or so much thereof as it considers it is reasonable for it to pay by New Zealand standards without further inquiry as to whether the services were required as a result of personal injury by accident in respect of which the person to whom the services were afforded had cover under this Act and without further inquiry as to whether he was entitled to compensation under this Act. . . .

7. The Accident Compensation Commission has taken the view, in a technical information circular dated 31 October 1974, that although there is no “direct provision” in the Act for the payment of chiropractic fees in cases to which the Act applies, the Commission may nevertheless pay the cost of chiropractic treatment

only if there is *clear written evidence* that a medical practitioner has referred the injured person to the chiropractor for the purpose of obtaining the treatment for which the claim is made. . . . If the patient has on his own initiative obtained chiropractic treatment and has subsequently sought approval for it from his doctor, payment is to be refused.

That is the current ruling.

8. It is not entirely clear to us on what legal basis this ruling was formulated. Presumably it was made in reliance on section 111 (6) which, as we have seen, provides that "paramedical services" other than radiological or physiotherapy services may be paid for on the certificate of the person who gave them that (*inter alia*)

the person to whom the services were afforded was referred by a registered medical practitioner as a case of personal injury by accident. . . .

9. We are not entirely sure whether it is right to regard chiropractic as a "paramedical service", but in any event it is clear that the Accident Compensation Commission will not pay out for chiropractic treatment unless the patient was "referred" for that treatment by a registered medical practitioner.

10. In practice this means that very few chiropractic patients indeed can get accident compensation coverage for the cost of chiropractic treatment. The great majority of doctors in New Zealand will not refer patients for chiropractic treatment. Indeed they are expressly forbidden to do so by an ethical ruling of the Medical Association. That ruling was formulated in correspondence by the Medical Association in 1974 (see Transcript, p. 1768). It was approximately contemporaneous with the Accident Compensation Commission's own ruling to which we have referred, and it is possible to infer that it was a response to what was known to be the Accident Compensation Commission's attitude. We shall have a good deal more to say about the Medical Association's ethical rulings at a later stage.

SUMMARY

11. The position therefore is that, as the law stands, no health benefit is obtainable for chiropractic treatment under the Social Security Act 1964. In terms of the Accident Compensation Act 1972 and the practice under that Act, a person who has suffered an accident covered by the Act can recover the cost of chiropractic treatment only if he has been "referred" for that treatment by a medical practitioner, and because doctors are forbidden by ethical rulings to refer patients to chiropractors hardly any chiropractic patients recover the cost of chiropractic treatment.

12. On the other hand the cost of spinal manual therapy administered by a medical practitioner or, on referral, by a physiotherapist, is subsidised under either scheme.

Chapter 4. HEALTH SUBSIDIES FOR CHIROPRACTIC TREATMENT OVERSEAS

INTRODUCTORY

1. In considering overseas health subsidies for chiropractic treatment we have concerned ourselves principally with what might be helpful in New Zealand conditions. While overseas we discussed the practical workings of health subsidy schemes with the people involved in their administration. We were anxious to discover what problems had been found to exist.

2. We paid particular attention to the schemes in operation in Ontario and British Columbia for two reasons: in each province the respective schemes, and chiropractic involvement in them, have been of relatively long standing; and secondly because the social and cultural patterns in those provinces are not dissimilar to our own. So there was a background of administrative experience which we felt could be a very useful guide to us in our inquiry and to those in New Zealand who may be charged in the future with incorporating chiropractic treatment into our own health and accident compensation schemes.

UNITED STATES

3. For a variety of reasons we do not find the United States experience of welfare subsidies for chiropractic treatment particularly helpful. There are substantial differences between the various individual state statutes governing chiropractic which make it difficult to find a general pattern. In some states and in some areas chiropractors came to be accepted virtually as general physicians, mainly because of a lack of qualified medical personnel in those particular areas. This traditional status has in many places remained, so there are in that respect different cultural patterns in a number of parts of the United States.

4. The chiropractic benefit under the Medicare scheme, introduced in 1974, represents something of a compromise. It is provided that

Payment may be made only for the chiropractor's manual manipulation of the spine to correct a subluxation (demonstrated by X-ray to exist) which has resulted in a neuromusculoskeletal condition for which such manipulation is appropriate treatment. No reimbursement may be made for X-rays or other diagnostic or therapeutic services.

(See Federal Register, Vol. 39, No. 155, p. 28624). For reasons discussed later we do not consider this an appropriate formula for New Zealand conditions. The health insurance policies of most major United States insurance companies and most state worker's compensation schemes include chiropractic treatment.

AUSTRALIA

5. Western Australia has recognised and registered chiropractors since 1964, but no other Australian state regulated the practice of chiropractic until 1978. Of the three states which have since brought down legislation (Victoria, New South Wales, South Australia) only Victoria's registration system was in full operation at the time of writing this report. Because this has been a relatively recent development, the experience in Victoria might be thought of as providing a particularly interesting illustration of what

might be expected to happen in New Zealand in the short term if health and accident compensation benefits became payable for chiropractic treatment.

6. In this respect we have been greatly helped by the Health Benefits Council of Victoria. The council represents 21 health insurance funds within the state. For many years it firmly resisted any suggestion that there should be any form of benefit for chiropractic treatment. Its grounds were, first, that chiropractic was not a recognised branch of medicine; and secondly that chiropractic tended to over-generate service.

7. In 1975 the Australian Federal Government introduced its Medibank universal health insurance scheme, thus depriving the independent health insurers of the greater proportion of the medical benefits business. At that stage some insurers introduced a chiropractic benefit for the first time.

8. Then the report on the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy, and Naturopathy (the Webb report) appeared, and the state parliaments started preparing legislation for the registration of chiropractors. When it became clear that chiropractors must be registered in order to practise, and also because of the recommendations in the Webb report, a chiropractic benefit was introduced by most of the remaining insurers. An example in the public sector is the Medibank Private Scheme, operated by the Health Insurance Commission of Victoria, which has formulated its "extras" cover to provide benefits for chiropractic treatment at the rate of \$10 per X-ray (one a year) and \$5 per attendance for spinal manipulation, with a \$60 per annum limit.

9. The Health Benefits Council informs us that everyone now seems quite happy with the situation; and it adds:

... it is pleasing to note that the fears of over-generation of service have not been realised, and, in fact, there is less evidence of over-generation by chiropractors than in the fields of general medicine.

10. We found a similar reaction in regard to payment of chiropractic benefits under the health insurance and workers' compensation schemes in Ontario and British Columbia, in both of which Canadian provinces chiropractic benefits have been available for many years.

CANADA

11. Chiropractors are licensed in every province in Canada except Newfoundland. Workers' compensation benefits are available for chiropractic treatment in most provinces, without referral by a medical practitioner. Most medical benefit schemes in Canada include chiropractic services.

12. As we have said, we paid particular attention to the schemes operating in Ontario and British Columbia not only because they are of long standing, but because the social and cultural patterns in those provinces are similar to our own.

13. There is, however, one distinguishing factor. There is no medical ethical ruling prohibiting a medical practitioner from referring patients to a chiropractor. That is not to say that there is no medical opposition to chiropractic. But it is the case that organised medicine in Canada has not gone to the length of stating its opposition in the form of an express ethical ruling as is the position in New Zealand.

Ontario

14. In the course of our visit to Toronto we had discussions with the director and senior officers of the Workmen's Compensation Board and senior officers of the Ontario Ministry of Health. We particularly wish to acknowledge their helpfulness and courtesy in speaking to us at considerable length and in providing us with a great deal of material, all of which we have found of great assistance.

(1) *Workmen's Compensation Chiropractic Benefits*

15. The Ontario workmen's compensation scheme is analogous to our accident compensation scheme, although ours is of course substantially broader. Workmen's compensation payments for chiropractic treatment have been made in Ontario since 1937, so there is over 40 years' practical working experience in this respect.

16. We were told, on the basis of the board's experience, that an advantage of having a chiropractic benefit was that chiropractors generally, in contrast to other practitioners, seemed to be able to get patients with certain back problems back to work much more quickly, even though chiropractic treatment might have to be continued after the patient's return to work. We gathered that the form of treatment offered by other health services for many back problems tended to involve long periods of analgesic drugs and/or extended physiotherapy treatment. There is no requirement that chiropractic treatment be on medical referral: a patient under the workmen's compensation scheme is entitled to consult a chiropractor direct, and many do so.

17. We were told that the board was satisfied with the way in which chiropractors dealt with workmen's compensation cases. There were a few who had tended to abuse the system, but the board had been impressed by the vigorous disciplinary measures the Ontario Chiropractic Association had taken against offending chiropractors. We were told about one case where the board had suspended an errant chiropractor from its list of approved chiropractors for 3 months; on learning of this the Chiropractic Association had promptly held a disciplinary hearing and had suspended him altogether from practice for 6 months. It is not surprising that incidents such as this had impressed the Compensation Board with the chiropractors' good faith in participating in the scheme.

18. So the chiropractors in Ontario obviously worked well with the board; indeed the board's director told us of his proposal to mount a research study on the efficacy of spinal manual therapy for back injuries suffered in the course of employment. We did not understand this proposal to arise from any doubts about the efficacy of chiropractic treatment, but rather to be prompted by a desire to have concrete data on which future policy could be based.

19. We were provided with a copy of the board's *Policy and Procedure Manual*, issued in December 1978, relating to treatment control in chiropractic claims. This detailed manual of office procedure is an example of the board's impressive efficiency in protecting public funds. We reproduce the manual as appendix 7. We should add that, as is the case in the other schemes we investigated in Canada, any case—medical or chiropractic—which is in some way out of the ordinary, is quickly drawn to the attention of the board through the data processing procedures in use. Such procedures might usefully be followed here.

20. It will be seen that the office procedure manual provides means by

which chiropractic treatment can be periodically checked, monitored, and evaluated. We gather that the same kind of procedure applies to medical treatment.

21. We add that the extent of the chiropractic benefit under the scheme has been progressively liberalised by the board over the years. The position now is that if chiropractic treatment under the scheme extends beyond 6 weeks (regardless of how many treatments occur within that time) it automatically comes up for review and possible investigation: any treatment beyond that period will need to be justified. We heard no complaints from the officers of the Ontario Chiropractic Association with whom we discussed the system; nor did the officers of the College of Physicians and Surgeons of Ontario, with whom we had extended talks, complain about it. In short the workmen's compensation scheme in Ontario, with its payments for chiropractic treatment, seems to be working smoothly to the satisfaction of all parties.

(2) Health Insurance and Chiropractic Benefits

22. At the time of our visit the Ontario Ministry of Health was in the process of drawing up, in response to initiatives by the Ontario Chiropractic Association, new provisions for the regulation of the chiropractic profession. These are to be an amendment to the Ontario Health Disciplines Act 1974 and supporting statutory regulations, and the ministry was good enough to supply us not only with a copy of the drafts but also with copies of the comments and submissions of interested parties. The latter contained nothing that was new to us, but we wish to comment on the moderate attitude of the medical profession in Ontario.

23. The draft amendments to the Health Disciplines Act 1974 and the draft supporting regulations are of considerable importance, and we include them as appendices 5 and 6 respectively. They may well be found to provide very useful models for any amendments to the Chiropractors Act 1960 which may be felt necessary in the light of this report.

24. We pass now to the payment of chiropractic benefits under the Health Insurance Act 1972 (Ontario). This is a provincial health insurance scheme which can be equated roughly with our social security scheme. Patients covered by it may receive subsidised chiropractic treatment up to a limit of \$125 in each year, which figure includes X-ray costs up to a maximum of \$25. There is no requirement for medical referral.

25. Figures taken out by the ministry showed that during the previous financial year 785 chiropractors had delivered 3 644 900 services under the scheme to 416 000 patients at an average cost for each patient of \$56. So there is no evidence of over-generation by chiropractors of treatments under the scheme. Again we heard no complaints about the way the scheme operated, except in one respect which we will mention later.

British Columbia

(1) Workers' Compensation Chiropractic Benefits

26. The Workers' Compensation Board of British Columbia administers the Workers' Compensation Act 1968. In terms of the Act chiropractors are "qualified practitioners", and employees covered by the Act are free to select their own "qualified practitioner", whether chiropractic or medical.

27. Chiropractic treatment under the Act is limited by the board to 8 weeks, although that time may be extended in cases where extended treatment is clearly shown to be necessary. The executive director of medical services (who is a medical practitioner) told the Commission that there was no more abuse of the statutory procedures by chiropractors than there was by medical practitioners; that the chiropractors created no real problems, they accepted the board's rulings, and were willing to join in discussion of any matters the board wished to raise with them. We were told that as far as the board was concerned the chiropractors policed themselves very well and were certainly prepared to co-operate with the board. It appeared that the workers' compensation scheme was working smoothly as far as chiropractors were concerned.

(2) *Health Insurance and Chiropractic Benefits*

28. The Commission visited Dr D. M. Bolton, who is Medical Adviser to the Medical Services Plan of British Columbia. This is a health scheme administered by the Provincial Ministry of Health under the Medical Services Act 1967, and benefits for chiropractic treatment are included at the maximum rates of \$75 per patient per annum under 65 years of age and \$100 per patient per annum over 65 years. No benefit is paid for X-rays.

29. Dr Bolton, who is a medical practitioner, pointed out that there were two difficulties in the scheme. The fact that no benefit was paid for X-rays meant that local chiropractors were trying to induce local radiologists to take X-rays, on their behalf, of patients covered by the scheme. As we learned later when we met officers of the British Columbia Medical Association and the British Columbia College of Physicians and Surgeons there was considerable opposition to this. We are unable to predict how this problem might be resolved unless by following Ontario's example and increasing the benefit to cover chiropractic X-ray costs, a course which in the circumstances would be eminently sensible.

30. Secondly, as Dr Bolton told us, the statutory limits on the benefit, which are inflexible, work some hardship on patients whose condition is such that they need extended courses of chiropractic care. Nevertheless, for administrative reasons, it was felt best to draw the line at the existing limits. He told us, however, that in fact many patients did not reach the prescribed limit.

31. The ministry deals with approximately \$1.5 million in claims under the scheme per month. In 1978 approximately \$330 million was paid to physicians under the scheme and \$9 million to chiropractors, there being 4000 medical practitioners and 200 chiropractors in British Columbia.

32. The general impression is that patients who have consulted chiropractors for certain back ailments get back to work more quickly; and that chiropractors appeared to be much more expert at spinal manipulation than any medical practitioner. Chiropractors had not caused any administrative headaches, and in fact the British Columbia Chiropractic Association (to which any chiropractor participating in the scheme must belong) took prompt and effective disciplinary action in the event of any complaint about abuse of the scheme.

33. We wish to record our gratitude to the officers of the British Columbia Workers' Compensation Board and the Ministry of Health who went out of their way to assist us.

THE UNITED KINGDOM

34. Although there are less than two chiropractors per million of population in Britain, the British Chiropractors' Association has made some impact. But, from our interviews with the officers of the Chiropractors' Association, senior officials of the Ministry of Health, the Registrar of the Council for Professions Supplementary to Medicine, and officers of the British Medical Association, it appears that the system of health benefits in the United Kingdom, and possible future chiropractic participation in the system, is so different from the system operating in New Zealand that no useful parallels could be drawn.

CONCLUSIONS

35. It is quite clear that in Victoria, Ontario, and British Columbia, where the social context is close to our own, no insurmountable problems have been found in including chiropractic treatment in health benefit schemes. There is negligible over-generation of treatment, and in the two Canadian provinces the ability of chiropractors to co-operate and to discipline themselves has been found to be entirely satisfactory. The experience in Victoria has hardly been long enough to enable anyone to form an adequate judgment, but there seems to be every indication that the experience will be at the same satisfactory level as in Ontario and British Columbia.

36. We record that in all three of these areas individual chiropractors seem to have established good working relationships with individual medical practitioners. In Ontario in particular the official medical attitude seemed moderate and realistic; in Victoria we detected some degree of mistrust although at the same time a willingness to co-operate to ensure that the new registration system worked. In British Columbia the official medical attitude was less co-operative.

37. We draw particular attention to the draft Ontario legislation (appendices 5 and 6) because of its possible importance as a model for New Zealand purposes.

PART II: THE ESSENCE OF CHIROPRACTIC

Chapter 5. THE NATURE OF CHIROPRACTIC AND THE ISSUES INVOLVED

INTRODUCTORY

1. In outlining in a preliminary way the nature of chiropractic we will attempt to describe in uncomplicated language what is in fact a highly technical topic.

2. Chiropractors treat specific segments of the spine by hand. They call this "adjustment". Most people think of chiropractic in very simple terms. In the New Zealand context a chiropractor tends to be a person consulted as a last resort when the doctors and physiotherapists have failed to cure a bad back. On the evidence the Commission has received, that is the general pattern. So the chiropractor, in the mind of most people, is a kind of modern spinal bonesetter: it is a matter of his finding the joint that is out, and putting it back in.

3. If chiropractors had limited their practices solely to cases of backache, and if some of them had not gone beyond the limits of reasonable professional conduct, it is unlikely that they would have antagonised the organised medical profession to the degree that became evident as the Commission's hearings proceeded. In fact some chiropractors claim that their treatment is capable of relieving a great variety of conditions apart from backache: asthma, deafness, diabetes, high blood pressure, and bedwetting are only a few examples of the wide range of disorders for which chiropractic is claimed to be of at least potential benefit. Some chiropractors go further and try to persuade their patients to consult them first, rather than a doctor, for any ailment or disorder.

4. Now the relief of backache by manual therapy of the joints of the spine is something that is easy for people to grasp. If a spinal joint is not functioning properly, it is easy to see that the likely result is pain. If the malfunction is corrected the pain is likely to be relieved. That is logical. But, people might ask, how can putting right a malfunction of a spinal joint possibly affect other conditions such as asthma or diabetes? At first sight the proposition seems ludicrous. That is what most members of the medical profession in fact think.

5. The position is made worse, in medical eyes, by the fact that anyone can consult and be treated by a chiropractor without prior medical consultation. The implications are obvious. For if people come to believe that chiropractors are capable of relieving a wide range of disorders by a simple spinal adjustment the risk is that they will go to a chiropractor instead of their doctor. Some chiropractors actually encourage this idea. The patients may thus delay getting appropriate medical treatment. And, says the medical profession, they will be getting a form of treatment which does not relieve their condition, and which may actually be harmful; for it is said that a chiropractor, though trained in manual therapy has no general training which would adequately equip him to recognise disorders which a fully trained doctor can readily identify.

6. Moreover, the medical profession says, chiropractors are tied to a theory of disease which science does not and cannot recognise. Chiropractic is therefore a cult, and chiropractors are quacks.

7. How do chiropractors justify their belief that putting right the maladjustment of a spinal joint can affect disorders such as asthma or diabetes? A number of theories have been put forward in an effort to explain how this could happen, but in the last resort chiropractors rely simply on their results. They may not know exactly how the improvement in the patient's condition is brought about; but they do know that some of their asthmatic patients, for example, in whose spinal joints they diagnosed a malfunction have either lost their asthma altogether or have noticeably improved once the malfunction has been corrected.

8. This of course adds another dimension to the problem which the Commission has had to face. For in regard to the type of disorder we have been discussing no-one has ever been able to demonstrate in any scientifically satisfactory way the precise means by which the patient's condition is cured or relieved. Chiropractors believe from their experience that if they adjust malfunctioning spinal segments the patient's condition may be improved, and we are satisfied that in some cases it is. But what is the link between the treatment and the result? No-one knows. Scientific research into this question has begun only recently. We deal with this in chapter 37.

9. We pause at this point. Chiropractors have for years been claiming that chiropractic treatment may be and in some cases is beneficial for the type of disorder we have mentioned. Yet it is astonishing to find that little if any constructive effort has been made by the medical profession to investigate these claims. In the face of that neglect it would appear unreasonable that organised medicine should be so bitterly and adamantly opposed to chiropractic. The approach of organised medicine to chiropractic is not one of detached scientific interest and curiosity about a form of treatment that appears to have helped a large number of patients. That is an approach which might have been expected; but instead it has been one of remorseless and unrelenting opposition.

10. We deal later with the apparent reason for this quality of medical opposition to chiropractic. It is sufficient at this stage to say that in the Commission's opinion the opposition is based on three main factors: first, the history of chiropractic; secondly ignorance, coupled with misinformation, about modern chiropractic theory and practice; and thirdly what many medical practitioners regard as unprofessional conduct by some New Zealand chiropractors.

11. The history of chiropractic is also dealt with separately. But at least some aspects of ignorance and misunderstanding about chiropractic can conveniently be dealt with now.

“CHIROPRACTIC”

12. The name “chiropractic” in itself suggests something separate and apart from the mainstream of ordinary health care: a separate and specific art or technique; a different system of health care. That is a misleading impression.

13. It is true that chiropractic has developed without recognition from the mainstream of medicine. If you are cut off from professional contacts with medical practitioners, and denied access to medical research and diagnostic facilities, you have to develop separately or not at all. What has

kept chiropractors going is their belief in the efficacy of the treatment they give, and the increasing following they have been able to attract.

14. What they have done has been to develop the art of spinal functional analysis and “adjustment” to a degree with which the medical profession as a whole cannot compete. They have developed a range of techniques and skills which few in New Zealand outside the chiropractic profession have been able to master.

15. But apart from these specialised skills and the specialised background of clinical experience which has resulted from their use, chiropractic techniques are not very different from those of others who specialise in manual or manipulative therapy. So it would be wrong—except in one respect, which the Commission on reflection cannot regard as of great significance—to treat chiropractic as a healing art separate and distinct from that practised by orthodox medical or paramedical personnel. It is a branch, or perhaps an extension, of it.

16. The one respect in which chiropractors may be said to differ from orthodox medicine is their belief that spinal “adjustment”, apart from benefiting obvious disorders such as back pain, will generally and sometimes specifically improve a patient’s health. It is this belief, expressed in a number of ways in the chiropractic literature and publicity material, which leads medical practitioners to the view that chiropractors place a quite unreal degree of importance on the integrity of the spinal column. This factor has caused the Commission a good deal of concern. We will explain it further.

17. One modern statement of the chiropractic position may be extracted from the Palmer College of Chiropractic Bulletin for 1978–1979. A large proportion of New Zealand chiropractors trained there. The Bulletin has this to say (p. 25):

Chiropractic is that science and art which utilises the inherent recuperative powers of the body, and deals with the relationship between the nervous system and the spinal column, including its immediate articulations, and the role of this relationship in the restoration and maintenance of health.

The Bulletin goes on (pp. 28–9) to expand on that somewhat Delphic pronouncement:

Each organ within the body has some function in the maintenance of life and health of the entire organism, and it must be co-ordinated with the needs and demands of the moment. Body organs are arranged in systems, so that they may carry out their mission. Thus, the body is an organization of these systems.

The state or organization found among the body organs and systems is maintained through the nervous system, and indicates the presence of an intellectual guiding entity—an inborn or innate intelligence . . .

The innate intelligence of the human body uses the brain and nervous system as a means of communication. An organ cannot function normally unless it receives a normal transmission of nerve impulses from the brain.

The vertebrae (or segments) of the spine give support for the trunk and protection to the spinal cord and nerves as they pass from the brain. They are held in location by ligaments and moved about by paired spinal muscles. Normal spinal movements, such as bending and twisting, are regulated by the nerve supply into the spinal muscles.

If a vertebra loses its normal range of movement, and is misaligned far enough to cause distortion of the spine, it may result in a disturbance with the normal transmission of the vital nerve supply from the brain, not only into the muscles the nerve may contact, but also into some other organ or system of organs in the body. The condition is referred to as vertebral subluxation . . .

A subluxated vertebra, disturbing the normal nerve supply of an organ, brings about functional disease which may be followed by pathological disease.

18. The purpose of the chiropractor’s “adjustment” of the “subluxation” is to restore “normal nerve supply . . . to the organ or system of organs”, and thus “their normal function may be re-established”. Allowing for the fact that this is no doubt an explanation in laymen’s

terms of a concept on which much highly technical chiropractic literature has been written, it is of course a statement which lends itself to having neurophysiological holes punched in it. One medical practitioner from overseas with chiropractic training (Dr Scott Haldeman) told us that such a statement was "not representative of the profession" (Transcript, p. 3350); but we do not entirely accept that in regard to the New Zealand profession. We do accept, however, that in the chiropractic world such a view of the purpose of spinal "adjustment" is rapidly becoming outmoded. The observed effects of spinal "adjustment" are now being tentatively explained on more scientifically tenable bases. That is because very considerable advances in neurophysiological knowledge within the last 10 years have compelled some chiropractic reappraisal. We discuss these topics in greater detail in a later chapter. It is sufficient to say at this point that the reappraisal which has already taken place does not seem to the Commission to affect the rationality of the chiropractor's belief that by putting spinal defects right he can not only relieve back pain and other obvious symptoms but may, in some cases, restore the body generally to normal functioning or at least enhance its functioning.

19. We do not think it is right to call a belief of this kind a "philosophy". If a doctor tries a new form of treatment and has unexpected results which are repeated in a number of cases, his belief that his treatment may bring about those results is hardly a "philosophy". It is more a hypothesis. So simply because medical practitioners do not share the chiropractors' belief that "adjusting" the spinal column may enhance the body's general functioning, that is not a difference in philosophy: it is a disagreement over a hypothesis, or, to put it more positively, a disagreement about the efficacy of a particular form of treatment. And there has been disagreement within the medical profession for years over the efficacy of spinal manual therapy even for treatment of simple back pain.

TERMINOLOGY

20. The terminology in this area of practice is confusing. The layman might describe what is done as "manipulation", but that creates difficulty with the physiotherapists, who use the expression "manipulation" to describe the shifting of a joint outside its normal range of voluntary motion: they use the expression "mobilisation" to describe the shifting of a joint within its normal range of voluntary motion. To add to the confusion they give both procedures the global title of "manual therapy". Chiropractors use both procedures, but many call both "adjustment" or "manipulation". We will use the term "manual therapy" to describe the process, by either means, of restoring an abnormally functioning joint and its associated elements to normal.

PRACTITIONERS OF SPINAL MANUAL THERAPY

21. Spinal manual therapy in that sense is practised by some medical practitioners, some physiotherapists, and all chiropractors. To provide a proper context for our further discussion of chiropractic we deal with each group in turn.

Medical Practitioners

22. The attitude of the medical profession towards spinal manual therapy is ambivalent. That is probably because this form of therapy is

not taught in the New Zealand medical schools. One medical practitioner (Dr J. S. Boyd-Wilson) expressed the matter in this way (Transcript, pp. 1776-7):

I must tell you that I am not a believer in manipulative therapy in general, whether it is medical or chiropractic, and many thoughtful friends of mine take the same view . . . I believe that the great majority of medical practitioners in this country share the view which I have expressed.

And later:

My position is this: that spinal manipulative therapy, if it has a place at all, has a very small place for a limited number of musculo-skeletal disorders, but even in this limited area its efficacy has yet to be proved, and until such time as that proof is available I believe the bulk of thoughtful medical practitioners will have doubts about it.

23. There are however some medical practitioners who have been sufficiently impressed with the efficacy of spinal manual therapy either to attempt it themselves or to refer patients with spinal problems to physiotherapists or (usually by indirect means) to chiropractors.

24. We have received very little evidence concerning medical practitioners in New Zealand who carry out spinal manual therapy themselves. What evidence we have received is largely that of patients whose experience of attempts at manual therapy by their own doctor drove them to a chiropractor. That evidence, though slight, suggests that some medical practitioners try spinal manual therapy with only a crude idea of how to perform it. We have heard no evidence that suggests that any New Zealand medical practitioners have attended on a long-term basis any of the courses on spinal manual therapy available in this country. There are some others apart from orthopaedic surgeons who have taken more than a passing interest in spinal manual therapy, but the New Zealand Medical Association apparently felt under no necessity to mention them to us or to call them as witnesses.

25. One such medical practitioner is Dr J. W. Fisk of Hamilton. We were referred at a late stage of our public sittings by a witness to Dr Fisk's writings in the *New Zealand Medical Journal*. Having read them we made further inquiries about Dr Fisk. He is the first medical practitioner to have gone on the specialists' register because of his work on spinal manual therapy. His book, *The Painful Neck and Back* (Springfield, Illinois, 1977), is a stimulating and witty practical guide to the management of neck and back problems, their diagnosis, manipulation and prevention. It contains a valuable section on exercises.

26. Dr Fisk has gone further than that. Recently he was awarded the degree of Doctor of Medicine of the University of Edinburgh for his dissertation, "The Significance of Disordered Muscle Activity in the Perpetuation and Treatment of Low Back Pain, with Particular Reference to the Effect of Manipulation". That provides a measure of the importance and interest of Dr Fisk's work. As might be inferred from the title, Dr Fisk's principal thesis is that cases of neck and back pain which are likely to respond to manual therapy are caused by disordered muscle activity which manual therapy can help.

27. We were unfortunately unable to watch Dr Fisk in action. However that lack is compensated for by the excellent and specific photographs and explanations in his book. Judging from that it does not seem to us that his techniques of spinal manual therapy are significantly different from those used by chiropractors. We sought Dr Fisk out and had a most helpful discussion with him. We will be referring to his work later in this report. It is interesting that his work was brought to our attention by a chiropractic witness.

Physiotherapists

28. Spinal manual therapy is said by the New Zealand Society of Physiotherapists (Submission 75, p. 285) to be a “specialty of physiotherapy”. The society and its witnesses produced powerful arguments for its encouragement, but under the aegis of physiotherapy. We consider those arguments later.

29. The physiotherapist has (*ibid.*, 307):

... a broad undergraduate training in general medical principles, including hospital experience; a specific training in the application of physical treatment techniques requiring skilled handling of patients and development of tactile dexterity; an established liaison with other health services when appropriate for the patient.

But it appears to be accepted that qualification as a physiotherapist alone is not sufficient to enable a physiotherapist safely to undertake spinal manual therapy.

30. Recognising this, the New Zealand Society of Physiotherapists set up the New Zealand Manipulative Therapists’ Association. Since 1971 that association has conducted three-year “post-graduate” courses in manipulative therapy. They are not full-time throughout the period, but involve the periodic attendance of candidates. The courses are open to qualified physiotherapists who have had at least two years of “post-graduate” experience. A reasonably high standard is set.

31. The use of the word “post-graduate” and our reference to the standard of the courses needs explanation. Physiotherapists do not graduate from a university. They graduate from schools of physiotherapy which are attached to the technical education system and are under the aegis of the Department of Education. It was obvious from the comments made during their evidence by witnesses supporting the society of Physiotherapists that their lack of university training was a sore point. We sympathise with their misgivings, and discuss the matter in more detail later.

32. The standards of the manipulative therapy courses are reasonably high: surprisingly so, since they were established and are continued only by the dedicated efforts of a handful of enthusiasts, some of whom have won international recognition in their field. The courses are financed by the candidates themselves, the instructors working for a nominal fee. Financial help for the courses is conspicuously lacking. In these circumstances their future must necessarily be insecure.

33. We heard submissions and evidence from Mr R. A. McKenzie, a physiotherapist and a prominent figure in the Manipulative Therapists’ Association. He has developed a system of spinal manual therapy that has attracted attention. He concentrates on lower back pain and has developed exercises by which some patients can keep themselves substantially free of back pain. We asked to see the proofs of a book he has written on the subject, and we have also seen the manuscript of a further book in which he sets out the technical aspects of his mode of therapy. We saw him treating some of his patients. It is no denigration of his ability to say that he is largely self-taught in the field of spinal manual therapy, and on any view of the matter he is a successful and dedicated practitioner. Like nearly all other physiotherapists in New Zealand he accepts patients only on medical referral.

34. Another physiotherapist who gave evidence and whom we saw in action was Mr B. R. Mulligan. He too has been a leading figure in the Manipulative Therapists’ Association.

35. In our opinion the following factors emerged as significant features of their practice: first, their patients were at least partially screened because they had initially been examined by a medical practitioner. Secondly, they both appeared to limit themselves to areas that were plainly causing discomfort to the patient: indeed Mr McKenzie told us that he would not use manual therapy on any section of the spinal column that was not giving rise to pain. Even if vertebrae were not properly functional, if pain was not present he would leave them alone. Thirdly, both had available to them the physiotherapists' armamentarium, heat, ultrasound, and so on. Apart from those features, the processes they used in the act of manual therapy were not substantially different from those used by chiropractors.

Chiropractors

36. We are left in no doubt that chiropractors are specialised and skilled spinal therapists. Their specialisation and skill is not surprising, since their four-years' full-time course at a chiropractic college lays particular emphasis on the biomechanics and neurology of the spine, and on techniques of manual therapy. There can be no doubt that their basic education in these areas is manifestly more thorough than that of any New Zealand medical practitioner, physiotherapist, or manipulative therapist. At the same time we have no doubt that a New Zealand-qualified manipulative therapist can by experience acquire the same degree of technical expertise. The chiropractor's training and experience, however, make him, in the Commission's view, potentially a more skilled diagnostician of spinal disorders of an apparently mechanical origin.

SUMMARY

37. The dimensions of the problems which the Commission has had to face now become clearer, and the issues are explored in greater detail in the following chapters.

38. Of central importance is whether chiropractors are effective in helping their patients and administer their therapy safely. There is also the subsidiary question whether what has in our view wrongly been called the chiropractic "philosophy" can be regarded as a serious factor in evaluating the work of spinal manual therapy as practised by chiropractors.

39. Furthermore the reasons for the medical profession's opposition to chiropractors need to be examined, particularly because they stem in large measure from the chiropractors' wide claims for the therapeutic value of spinal manual therapy.

40. Having outlined the basic problems facing the Commission, we must now explain in greater detail what the evidence disclosed as to chiropractic theory and practice. But to put this in context we will need to trace the history of the development of chiropractic.

Chapter 6. THE SPINE

1. As the accompanying diagram (Fig. 6.1) shows, the spine is made up of bony segments called vertebrae. For ease of identification they are classified by area and numbered. Reading from the top, the first area comprises the cervical vertebrae, marked C1-7 on the diagram. Then come the thoracic vertebrae (chiropractors call them the dorsal vertebrae), marked T1-12. Finally there are the lumbar vertebrae, marked L1-5, and below them as part of the spinal column, the sacrum and the coccyx.

2. The spine's flexibility is achieved by the mobility of each segment, or vertebra, in relation to its upper or lower neighbour. All these segments are held in position by various ligaments and muscles. If it were not for those we could not keep our spines upright. And it is those ligaments and muscles which enable us to adjust the position of our spinal column, or particular parts of it, to suit particular activities.

3. Down the inside (the spinal canal) of the vertebrae passes the spinal cord. It is like a main trunk telephone cable. Branching from the spinal cord at numerous points down the spinal column are nerves which control, not only the muscles and ligaments which hold the spine in position and enable us to adjust its position, but also muscular functions in various other parts of the body. So if we compare the spinal cord with a main trunk telephone cable, the various nerves which branch from it are like individual telephone lines leading to individual areas.

4. Some parts of the body are however controlled basically by their own circuit of nerves: the heart and parts of the digestive tract are good examples. But these circuits, which seem capable of independent operation, are linked at various points to the main nervous system. It is rather as if those independent circuits were telephone sub-exchanges, capable of operating semi-independently within their own area, but nevertheless always capable of receiving and delivering responses from or to the main exchange.

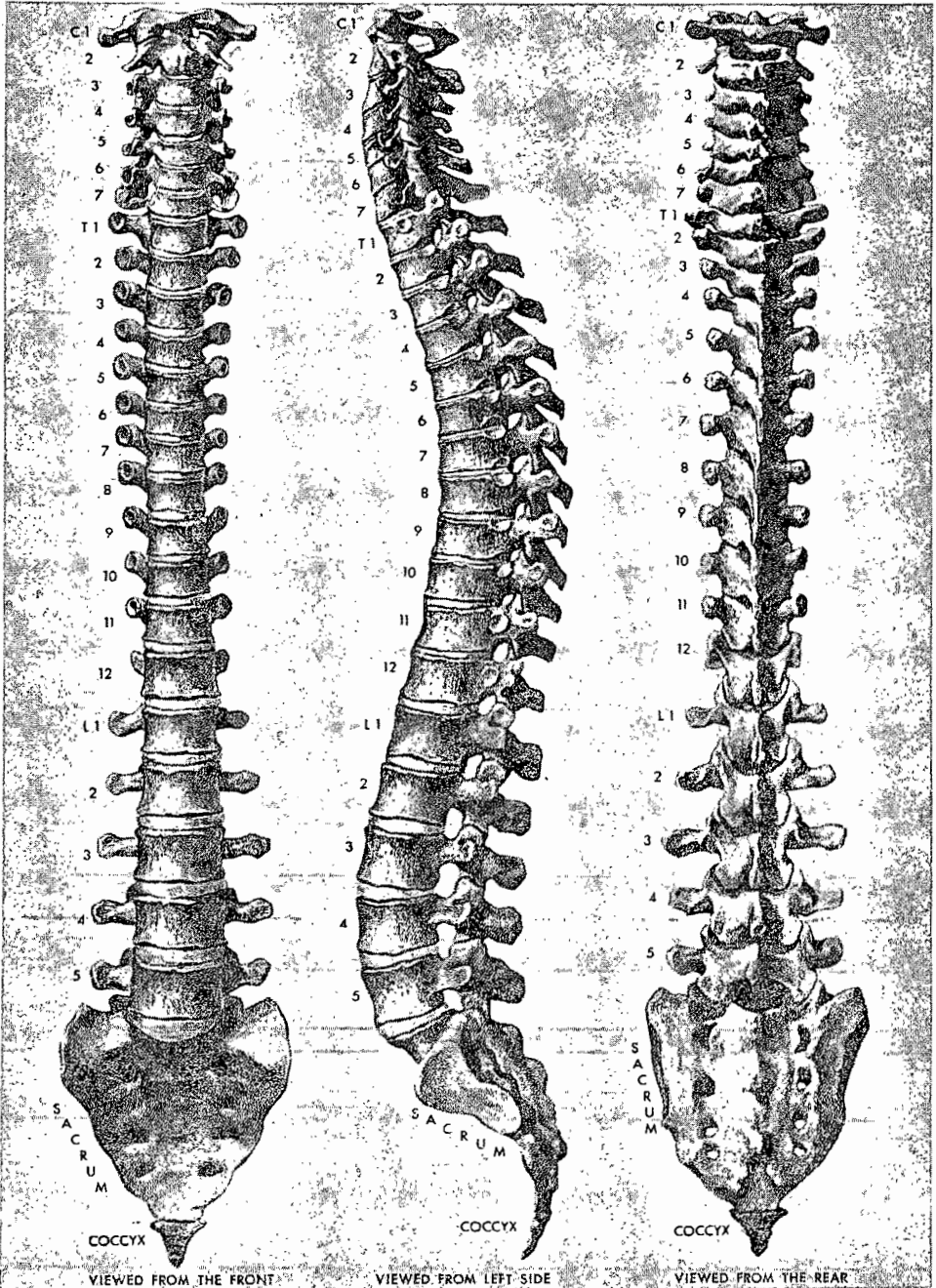
5. The spinal cord passes down the spinal column through the spinal canal. It is like a string of beads, the spinal cord being the string, the vertebrae the beads, and the spinal canal made up of the holes in the beads—although of course the spinal cord does not, as string does with beads, hold the vertebrae together. The ligaments and muscles adjoining the spinal column do that.

6. The nerves branching out from the spinal cord naturally have to pass through the gaps between one vertebra and the neighbouring vertebra. They do this along defined channels in the vertebrae, the intervertebral foramina.

7. Now the muscles and ligaments which hold the spinal column upright and allow it to assume various positions are controlled by nerves. The nerves convey impulses which are in effect coded instructions requiring the muscles and ligaments to work in particular ways. So if we want to straighten our backs, an extremely complex chain of action is set up through our nervous system and to the necessary muscles and ligaments. "Extremely complex" is perhaps an understatement. There are several *billion* neurons (nerve cells) in the human body.

Figure 6.1

THE GENERAL CONFIGURATION OF THE ARTICULATED SPINE
(Source: NZMA Submission 114)



8. The spinal canal contains not only the spinal cord, but also a vascular system (blood supply) and cerebro-spinal fluid. The cerebro-spinal fluid, like the spinal cord, provides a direct pathway to the brain. The spine's vascular system again has a direct connection with the brain. It is not too fanciful to picture the brain, not as a semi-isolated unit enclosed by the skull, but as a unit, whose major part is located in the skull, but which also extends down the inside of the spinal column.

9. We emphasise that the picture we are sketching is necessarily crude, over-generalised, and incomplete, but it is essential to have at least some understanding of these matters in order to appreciate the way chiropractors work.

Chapter 7. THE BACKGROUND OF CHIROPRACTIC

INTRODUCTION

1. The history of chiropractic provides a fascinating example of a method of healing which has gained wide public acceptance in spite of its unpromising beginnings. As we shall see, it belongs to a branch of health care which organised medicine in the English-speaking world has traditionally never taken seriously.

2. The chiropractors are descended from the bonesetters, although their field of practice is concerned primarily with the spine. Who were the bonesetters? We include them as an introduction to chiropractic history, not only because that is their proper historical place, but also because the attitude of the New Zealand medical profession towards chiropractors in this inquiry parallels in many significant respects the attitude of the English medical profession earlier this century towards Sir Herbert Barker, whose distinction as a bonesetter was unquestioned in the English community of his time, and who was respected and revered by the few doctors who had made themselves familiar with the work he did. Indeed, on a number of occasions during this inquiry, as we considered and assessed the medical profession's opposition to chiropractic, it seemed to us that history was repeating itself.

3. So we will start our review of the development of chiropractic by briefly examining the work of the bonesetters. This will lead to a deeper understanding of the attitude of the medical profession as demonstrated in this inquiry.

THE BONESETTERS AND SIR HERBERT BARKER

4. One of the earliest forms of medical practice was bonesetting—what would now be described by the medical profession as manipulation. There always seem to have been people who have had a natural and instinctive knack of putting strains, sprains, and dislocations to rights: this craft was often handed down in families from generation to generation. While many of these people carried on their trades or jobs and carried out bonesetting only as and when called on, some took up bonesetting as a full-time occupation and acquired fashionable practices. Mrs Sarah Mapp was a notorious full-time bonesetter in the early eighteenth century. She learned the art from her father. Her success encouraged others to set up in full-time practice. Naturally their success depended on the results they were able to achieve, and it is quite clear that a good bonesetter was able to give significant relief in cases which had defeated the efforts of the orthodox medical profession.

5. But for present purposes the most illuminating case is that of Sir Herbert Barker. In the early years of the present century he was as well-known in England as any doctor of the day. He was clearly the leading bonesetter of his time.

6. He learned the craft of bonesetting from his cousin, and after a period of experience in the provinces he set up practice in London. Like most other bonesetters he had no formal medical training and no medical qualifications. His autobiography, *Leaves from My Life* (London 1927),

provides a fascinating account of his work, and it is also of major significance because it presents us with a fully documented account of the attitude of organised medicine.

7. Barker's work was characterised by success after success, many of them dramatic. It might have been expected that the medical profession would have been eager to encourage him and to learn from his methods, and indeed a small number of leading individual physicians and surgeons strongly supported him. But the forces of organised medicine fought him relentlessly, solely on the ground of his lack of formal medical training. His efforts to offer his services and demonstrate his techniques were rebuffed and it was not until nearly the end of his life that he was called from retirement to demonstrate his techniques to an audience of over one hundred orthopaedic surgeons at St. Thomas' Hospital in London in July 1936. The report in the *British Medical Journal* (1936, August, p. 255) gave him great credit, stating: "He displayed in some cases remarkable dexterity . . . and the warm thanks of the meeting for a most interesting demonstration were conveyed . . .", but in spite of that there was no general attempt to give manipulation a recognised clinical status.

8. It is clear that Barker was a man of integrity and outstanding in his field. His knighthood was awarded as a recognition of his services to public health. But two factors were fatal to his acceptance by organised medicine.

9. In the first place, as we have said, he had no formal medical qualification. That meant that as an "unorthodox" practitioner he could not possibly be recognised by the medical establishment.

10. In the second place he was unable to explain his methods, and in particular the precise way in which he carried out his manipulations. In 1922, in a letter to *The Times*, he said that he had considered writing a book to describe the techniques he used, but was "convinced that it is impossible adequately to describe them in print".

11. So it is easy to see how difficult it was for the medical establishment, trained in scientific methods, to bring itself towards any sort of formal recognition of Barker's work. For one thing, there was the perfectly reasonable scepticism of the scientist for a technique which the manipulator could carry out but not explain. But more than that, there was the fact that if Barker had been recognised, the medical profession would not have been in a strong position to resist recognition of the claims of anyone else who might say that he had discovered a miracle cure by using a technique that could not adequately be explained: the typical equipment of the quack.

12. That is the kind of dilemma that must attract the sympathy and understanding of reasonable people. It is a real difficulty. For if Barker had, for instance, been allowed into the hospitals he might well have accomplished a great deal of good—that is suggested by his successful treatment, on an unofficial and unpaid basis, of hundreds of servicemen who suffered disability in war service.

13. The most vivid illustration of the official medical attitude to Barker is found in its treatment of Dr Frederick Axham. Dr Axham observed Barker in operation, and was so impressed with Barker's methods and his successes that he offered to act as Barker's anaesthetist. His offer was accepted.

14. The medical profession had an alternative. Either it could turn a blind eye, reserving any action for a case of assisting obvious quackery, or it could act. In 1911 it chose to act. Dr Axham was charged with

“infamous conduct”. In the course of the disciplinary hearing before the Medical Council it appears that Dr Axham was invited to resolve what must have been a difficult situation by giving his undertaking not to aid Barker in the future. On conscientious grounds, stated by Axham in a letter to *The Times* (4 December, 1911), he refused to give such an undertaking. He was thereupon struck off the medical register.

15. Years later, when Dr Axham was in advanced old age and on his death bed, a campaign was mounted to get his name restored to the register. For a variety of technical reasons the Medical Council found itself unable to do so. Delay resolved the problem, and Axham died. It was not the most distinguished episode in medical history.

16. We mention this incident, not because it is to be assumed that the medical profession of today would necessarily act in the same way in a similar case, but to demonstrate the obvious depth of feeling by organised medicine against health practitioners outside the medical establishment on grounds which are, in principle, understandable. We believe that the Barker episode goes some distance towards explaining the attitude of New Zealand organised medicine towards chiropractic as it was demonstrated during our inquiry. For reasons which appear later in this report there is in many respects a clear parallel.

THE BIRTH AND DEVELOPMENT OF CHIROPRACTIC

17. Contemporaneously with the development of Barker's career, two separate schools of manual therapy were developing in the United States. Both went far beyond the therapy itself. One was osteopathy. Andrew Taylor Still, a country doctor from Virginia, became convinced that the body cannot function properly unless it is structurally sound: if the structure is made sound the body's natural recuperative powers (or, as Still called it, the life force) will take over to restore health. He concentrated largely on the spine, believing that the treatment of structural and mechanical spinal derangements (“lesions”) could, by liberating and purifying the blood-stream, restore normal body function. Still set up a school of osteopathy at Kirksville, Missouri, in 1892, and osteopathy developed and flourished.

18. The second school of manipulation to emerge, less than 200 miles away in the neighbouring mid-western State of Iowa, was chiropractic. Three years after Still had founded his school of osteopathy Daniel David Palmer reported that he had cured his janitor of deafness. (D. D. Palmer, *The Science, Art and Philosophy of Chiropractic*, 1910 Edition.)

19. Palmer was medically unqualified. It appears that he may have dabbled in various forms of unorthodox healing techniques. It is not at all improbable that, like Barker, Palmer had a natural knack for healing and considerable intellectual powers. Palmer tells us that his janitor had put his back out seventeen years before, since which time he had been almost stone deaf. Palmer examined him, found a vertebra out of alignment, adjusted it, and the janitor immediately recovered his hearing.

20. This recovery is said to have been verified by the janitor's own doctor; but the general local medical attitude was predictable. It was scientifically impossible, they said, for the vertebral realignment to have cured the janitor's deafness. But as far as Palmer was concerned it was no accident. For shortly afterwards he came across another case. It was a case of heart trouble which did not seem to be improving under orthodox medical care. He examined the patient's spine and, in his own words, “found a displaced vertebra pressing against the nerves which innervate

the heart". He adjusted the vertebra and found that this treatment gave immediate relief. In Palmer's own words again: "Then I began to reason, if two diseases, so dissimilar as deafness and heart trouble came from impingement, a pressure on nerves, were not other disease due to a similar cause?"

21. The attitude of the local medical profession to Palmer's cures did not discourage him: indeed he seems to have taken it as a challenge. He set to work to study what medical knowledge there was at that time of the structure and function of the spine. He studied the nervous system. From that he developed the therapeutic technique, whose fundamentals we have already described, with an evangelical fervour typical of his country in that particular period.

22. There are two things to be said at this stage. First, while chiropractic might be seen superficially to owe something to an osteopathic blueprint, there were in fact from the outset significant differences in theory and major differences in technique. Osteopathy is not within our terms of reference and because we are obliged to concentrate exclusively on chiropractic there is no useful purpose in examining those differences further: we merely note them, noting at the same time that the differences in theory and practice seem to have diminished with the years. Secondly, both chiropractors and osteopaths appear to be descendants of the bonesetters, but with this notable distinction: that the art has been developed and refined and can be taught to students who have an aptitude.

23. In any event Palmer set up what finally, under the aegis of his grandson David Daniel Palmer, became known as the Palmer College of Chiropractic, which is still one of the leading chiropractic educational institutions. The great majority of New Zealand chiropractors has been trained at it.

24. Palmer's method of treatment and his philosophy spread. While his original "cures" had been treated by local doctors with what must have seemed to Palmer to be patronising indifference, it is not overstating the position to say that his teaching, and the chiropractors who had completed his training, were later opposed by the orthodox medical profession in the United States with virulence. Palmer was himself convicted and jailed on a charge of practising medicine without a licence. Many other practising chiropractors were dealt with in the same way, largely through the use by the medical profession of *agents provocateurs*. It seems likely that opposition of this quality merely gave wings to the evangelical and fundamentalist fervour of the early chiropractors.

25. The attitude of the medical profession in the United States can be understood, although it is clear that at that time the general standards and ethics of medical practice in the United States were themselves far from beyond criticism. But chiropractors did not improve their own image among orthodox medical practitioners. First, they drew in patients. Secondly, they claimed cures which orthodox doctors considered impossible. Thirdly they tended to advertise their treatment and its results to a degree which must have acted as a severe irritant.

26. The chiropractic attitude of the time is cogently illustrated by Palmer's own view of his position as the founder of chiropractic. He wrote:

I am the originator, the Fountain Head of the essential principle that disease is the result of too much or not enough functioning. I created the art of adjusting vertebrae, using the spinous and transverse processes as levers, and named the mental act of accumulating knowledge, the cumulative function, corresponding to the physical vegetative function—growth of intellectual and physical—together, with the science, art

and philosophy—Chiropractic. . . . It was I who combined the science and art and developed the principles thereof. I have answered the time-worn question—what is life?

There is no touch of modesty or deference to science in that claim.

27. There is no need for us to dwell on the colourful and entertaining history of the Palmer family: Daniel David Palmer, his son Bartlett Joshua Palmer, or his grandson David Daniel Palmer and their foundation of chiropractic education. Reference may be made to the Report of the Australian Committee of Inquiry into Chiropractic, Osteopathy, Homoeopathy and Naturopathy (The Webb Committee) (1977), pp. 34–5, for a succinct account of the Palmers' activities; although it must be added that the Webb Committee relies to some extent on Ralph Lee Smith's journalistic survey of chiropractic, *At Your Own Risk*, as its source for information about the Palmers, a source which the present Commission declines to regard as either objective or reliable (see chapter 21). In any event the Webb Committee took the view (at pp. 36, 138–140) that by 1977 chiropractic education had become much more soundly based than the descriptions of the early Palmer influence would suggest. We concur with this view. In 1979 it is even more soundly based.

28. A further item of chiropractic history which is of significance is the extension of what we might describe as the pure chiropractic doctrine by William Carver, an Oklahoma lawyer. He established a chiropractic school in Oklahoma City. He believed that chiropractors should supplement chiropractic adjustment with other kinds of treatment, such as massage, heat therapy, diet regulation, and so on. What happened was a division between those who followed Carver's views (known as the "mixers") and those who adhered to the view that chiropractic adjustment was the only permissible therapy (the "straights").

29. This division between mixers and straights is significant mainly for the reason that a good deal was made of it in the course of our inquiry; but whatever the position may be in other countries, we do not consider the distinction of any particular relevance in the New Zealand context. For in New Zealand it appears to us that chiropractors regard manual therapy as the only real item in their armamentarium. We have not heard it suggested that New Zealand chiropractors as a whole make any extensive use of other aids, although some may do so.

30. We have dealt with the early development of chiropractic, but it is in truth now only of academic interest. The Commission is satisfied that modern chiropractic education has achieved respectable standards. Indeed we made a point of hearing a number of recently qualified chiropractors both in our public sessions and privately. We were on the whole favourably impressed both with the standard of education they had received from a variety of chiropractic colleges, with their manner, and with their sense of professional responsibility. We deal with the question of current chiropractic education later in this report.

Chapter 8. THE PRACTICE AND THEORY OF CHIROPRACTORS

INTRODUCTION

1. We have already seen that on the basis of their clinical experience chiropractors believe that after manual therapy aimed at restoring proper biomechanical function to a malfunctioning spinal column, local pain said to be caused by that malfunction will in most cases be relieved. They also believe that other disorders not normally associated with the spinal column are sometimes relieved following similar treatment.

PRELIMINARY POINTS

2. At the outset three preliminary points must be stated. They are in the Commission's view central to a true understanding of modern chiropractic in New Zealand.

(a) *Advances in Chiropractic*

3. In the first place the Commission is left in no doubt that since its first formulation in the United States some 80 years ago chiropractic has developed greatly. Anyone who attempts to judge modern chiropractors by what was written or taught about chiropractic in the early 1900s will obtain a wholly misleading picture of what chiropractic is today. While there remains a lack of serious scientific study of the basis of chiropractic treatment, nevertheless it is clear to the Commission that chiropractic today should not be judged by what any modern scientific mind would see as its unpromising beginning.

(b) *Chiropractic not a Panacea*

4. The second point is this. Perhaps the strongest criticism directed against modern chiropractic is that it claims to be a cure for ills and disorders of almost every kind. That is what its critics say; but the Commission does not understand the majority of New Zealand chiropractors to claim that chiropractic is a panacea. The majority limit their claims to asserting that spinal manual therapy can possibly be beneficial in a wide range of disorders not normally thought of as associated with a malfunctioning of spinal joints. In this assertion they may be more optimistic than the clinical evidence would warrant. This is a matter we will discuss at some length at a later stage in this report. But the point is that while a few chiropractors release publicity matter which makes exaggerated claims (see chapter 18), we do not understand New Zealand chiropractors as a whole to make the claim that chiropractic can cure everything. Such a claim would, indeed, be ridiculous.

(c) *Distinct Types of Disorder (Type M and Type O)*

5. The final preliminary point which needs to be emphasised is the confusion that can result from failure to recognise that chiropractic spinal manual therapy is spoken of in relation to two distinct types of disorder.

6. First there is the type of disorder whose symptoms are mainly local

pain either in the spine itself (e.g., simple backache), or in closely associated areas (e.g., headache or sciatica). These may all be classified as musculo-skeletal disorders, involving essentially mechanical dysfunction.

7. The second category comprises organic or visceral disorders. High blood pressure, peptic ulcer, diabetes, and so on, come into this category, which we will call *Type O* disorders.

8. It is the chiropractors' claims of success in treatment of the *Type O* category which principally strains the credulity of medical practitioners, and in their minds invalidates the whole chiropractic system.

9. We are indebted to an overseas witness, Dr W. T. Jarvis, for this method of classification. We discuss Dr Jarvis's evidence at a later point.

CHIROPRACTIC THEORY SUMMARISED

10. The essential practical element in chiropractic is what chiropractors refer to as an "adjustment" of specific segments of the spinal column by hand or what is described by medical and allied practitioners as manipulation or mobilisation. The purpose of the adjustment is to correct what is thought to be a mechanical malfunctioning of the spinal column and thus to relieve pain or disability directly or indirectly resulting from that malfunction. On any view of the matter both the identification of the malfunction and its adjustment call for specialised knowledge of spinal biomechanics and an adequate working knowledge of neurology and physiology. It is clear to the Commission that chiropractic as practised today cannot lightly be dismissed as a cult or as a practice requiring a degree of skill but little education.

11. A general theory of chiropractic is not easy to distil from the evidence we received. That may be, as the Commission suspects, because chiropractors on the whole have been primarily interested in clinical results. Their views on the neurophysiological processes by which those results follow from the spinal therapy often have been scientifically naive. However it needs to be understood that the area of spinal mechanics and its implications in neurophysiology has not been explored by orthodox medical science. In the Commission's view chiropractic theories have only just begun to evolve on a scientific basis both with the advent of new discoveries in neurophysiology and with the increasing number of trained scientists interested in the field (see chapter 37).

12. These factors possibly account for the somewhat cautious approach to a definition of the practice and theory of chiropractic in the formal submissions of the New Zealand Chiropractors' Association. We venture in the following paraphrase to extract what appear to be the central points of chiropractic theory as they appear at pages 20 and 26 of the association's submission (No. 19).

The practice of chiropractic has as its central therapeutic goal the restoration of normal function to the neuromusculoskeletal structures of the spine in order to advance the general welfare of the patient. Its focal point of concern is the integrity of the nervous system. The modern theory of chiropractic is no longer simple and direct nerve pressure, but is as complicated as the nervous system itself, with recognition of the fact that the last word cannot be said in explanation for the success of chiropractic technique until the last words have been said in explanation of the complexities of the human nervous system.

Chiropractors do not contend that subluxation, (see chapter 9), however defined, is the most significant causal factor in disease. They do claim that subluxations of different orders and types are a factor in the production of symptoms and that the adjustment of these subluxations brings about a return to more normal physiological functioning.

13. The Chiropractors' Association therefore states chiropractic theory in terms which embrace both *Type M* and *Type O* disorders without distinguishing between them. The association also speaks in terms only of

the integrity of the nervous system. Both these points need further explanation.

14. The chiropractors' failure to distinguish between *Type M* and *Type O* disorders in expressing this theory appears to be consistent with clinical experience. But it means that chiropractors themselves put their whole theory of physical disorder and its treatment on a much wider base than would be justified solely by their generally acknowledged skill in spinal therapy for the relief of backache and similar disorders. It is of course a weakness readily perceived by those who oppose chiropractic: pointing to *Type O* claims, they say that no practitioner accepting that kind of theory can possibly deserve consideration for membership of a general health team. It is however in the Commission's view significant that no chiropractor sought to assert before us that treatment for *Type O* complaints on the one hand, and *Type M* complaints on the other hand, was to be distinguished on any theoretical basis; that would have been a simple way of avoiding the main force of any attack against *Type M* treatment on theoretical or philosophical grounds.

15. We have mentioned the chiropractors' clinical experience. Cases were cited to us of patients who went to a chiropractor solely to find relief from a *Type M* complaint; to their surprise they found that a *Type O* disorder was relieved at the same time.

16. In speaking solely in terms of chiropractic treatment being directed to preserving the integrity of the nervous system, the Chiropractors' Association may be a little behind the current thinking of some modern academic chiropractors. It is true that historically chiropractors have concentrated on the nervous system, but in their search for an explanation of their results which will be consistent with discoveries in medical science, some chiropractors go further than the nervous system. As Dr T. R. Yochum put it in his evidence (Transcript, p. 3188):

One would have to have an intense understanding of the mechanism of the movement of the spinal column; how the nervous system and even the vascular supply would relate to that movement, because it is all integrated. One cannot separate the bones from the nerves, or the nerves from the blood supply.

That is a far cry indeed from the "pinched nerve" theory which appears to be no longer a part of generally-accepted modern chiropractic thought.

17. But in any event, today's chiropractors appear hesitant to commit themselves to any single theory. Perhaps that demonstrates wisdom rather than, as was hinted at one stage of our inquiry, evasiveness. For the fact remains that the various chiropractic theories which have been advanced since chiropractic was first developed are properly to be regarded as no more than attempts to explain how chiropractic gets the results it does. The fact that a particular chiropractic theory is discredited by a later advance in scientific knowledge does not mean that the results of a chiropractor's treatment have not happened. It simply means that the explanation provided by the discredited theory was not correct: so there must be another explanation. Indeed it is probably true to say that chiropractic is a form of treatment still in search of an explanation for its effectiveness. The medical profession, with its massive research resources, has made no serious attempt to seek such an explanation and certainly has not found one. Nor has organised medicine been able to prove that chiropractic does not work.

18. The question of chiropractic "philosophy" became of some importance in this inquiry because it was stressed to us repeatedly that it was a basic point of the medical profession's opposition to chiropractic. If, as the Commission accepts, chiropractic theories are no more than

attempts to explain results, chiropractic philosophy becomes a red herring. On the evidence discussed in detail later in this report the Commission is unable to ignore the fact that, whatever theories may have attracted them from time to time, chiropractors have developed a specialised technique of treatment which is effective in a limited but important range of cases (*Type M*), and which can at times apparently be effective in a wider range of cases (*Type O*). Moreover, as practised in New Zealand, chiropractic is safe.

19. On that basis the efficacy of the treatment becomes the important issue in the inquiry, rather than the adequacy or inadequacy of the explanations so far advanced in an attempt to account for its apparent successes.

THE "RETURN TO MORE NORMAL PHYSIOLOGICAL FUNCTIONING" THEORY

20. There is one aspect of the approach to modern chiropractic practice which requires special mention. It is part of the chiropractic theory as expressed by the Chiropractors' Association in its formal submissions that although mechanical malfunction of the spinal column is not claimed to be the most significant causal factor in disease, it is claimed to be a factor in the production of symptoms and that its correction brings about a return to more normal physiological functioning.

21. This is of course a generalised and unspecific way of rationalising the relief of *Type O* disorders which can sometimes be achieved by a chiropractor's treatment. But it carries important implications. For if a spinal mechanical malfunction is found to exist in any particular case, then its correction must, at the very least, according to the chiropractor, remove an impediment to the natural working of the bodily system, thus enabling the body's natural defence mechanism against disorder and disease to operate more effectively and without that impediment. That naturally does not exclude the possibility that chiropractic treatment can work in a more direct manner, but in a way that cannot for the present be scientifically explained, to relieve some cases of *Type O* disorder.

22. The more general hypothesis—that an impediment to the full operation of the body's natural healing powers has been removed—means, however, that there can be no limits to the nature of the disorders on which chiropractic may operate, provided of course that the particular patient is found to have a mechanical malfunction in his spinal column. Even if a particular disorder has become irreversible, chiropractic treatment of a spinal malfunction could conceivably enable the patient better to cope with the disorder. There is only one exception: where the condition of the spinal column is such as to preclude chiropractic treatment, as in the case of cancer or tuberculosis.

23. So the implications open up. The chiropractor's belief that chiropractic correction of a spinal malfunction is going to remove an impediment in the patient's body's natural ability to cope with a *Type O* disorder means that the prospect of chiropractic therapy may appeal to the patient more than the orthodox medical alternatives of drugs or surgery.

24. While there is no reason in principle why a particular patient should not have both forms of treatment concurrently—the allopathic doctor fighting the disorder from one direction, and the chiropractor attempting to remove an impediment to the body's natural powers to cope with the disorder—this course is seldom adopted in practice, largely because the

organised medical profession refuses to acknowledge any merit or validity in chiropractic treatment. It is not hard to see why. It is a case of people, not medically qualified according to the standards of organised medicine, venturing to suggest that their single modality of treatment may be as beneficial or helpful as treatment backed by all the resources of medical skill and science. One unfortunate result is that the innocent patient can be left at the mercy of the over-zealous chiropractor when in fact he should be getting orthodox medical attention.

25. We feel we should add that there was no evidence before the Commission which could lead to the conclusion that the sort of danger mentioned in the last paragraph arises in New Zealand practice any more than very infrequently. That is probably because New Zealand chiropractors are well aware that any suggestion of harm to a patient as a result of delay in his receiving obviously necessary medical attention would work most unfavourably towards chiropractic as a whole. At all events the Commission's impression is that most New Zealand chiropractors are careful about strongly advising their patients to seek medical advice instead of or in addition to chiropractic treatment if there is anything in the patient's condition suggesting that such advice might be necessary.

26. Without wishing in any way to seem to doubt the good faith of most chiropractors in New Zealand, the Commission sees some risk that the present careful attitude might change once chiropractic moves towards wider acceptance in this country. It is one thing to be careful when it is known that any slip is likely to be faithfully recorded in a situation where a profession is under siege and is seeking advantages which it does not at present have. It is another thing to maintain the same standard of care once the siege conditions have been effectively lifted. To say that does not suggest any lack of good faith: it is simply an understandable and predictable facet of human nature. We will later suggest measures which might be taken which would have the effect of neutralising this risk.

“PREVENTATIVE CHIROPRACTIC”

27. Another aspect of chiropractic which we need to mention in order to dispose of it is what may be described as “preventative chiropractic”. This is chiropractic directed at maintaining a healthy spine in a healthy condition: to stop malfunctions from developing, or to catch them before they have got to the stage of producing noticeable symptoms. It is the same kind of concept as that of servicing a car: there may be nothing apparently amiss, but the whole point of having a car regularly serviced is to ensure that it is kept in good running order and to rectify faults before they make their presence felt.

28. “Preventative chiropractic” is of course a logical extension of the main concepts of chiropractic. There is no material distinction at this level between regular chiropractic, medical, or dental check-ups. The real distinction lies in this: medical or dental check-ups may produce evidence of identifiable disorders whose results can be predicted with a reasonable degree of certainty. The Commission does not consider that the same can be said of chiropractic “preventative” check-ups, at least in the present state of scientific knowledge. That is because the result of a malfunctioning of spinal joints is by no means predictable. No symptoms may show up at all. It is quite a different matter when a patient goes to a chiropractor with a specific symptom. Then the chiropractor knows that there is something he may be able to work on.

29. The Commission has mentioned "preventative chiropractic" at this point so that it can be noted and disposed of. In the present state of scientific knowledge the Commission sees no basis for recommending that any health benefit be payable in respect of "preventative chiropractic".

EXTREMITIES AND SOFT TISSUES

30. In the course of the inquiry it was suggested that chiropractors are unduly limited in the therapy they can offer, first, because the Chiropractors Act defines "chiropractic" for the purposes of the Act as the examination and adjustment by hand of the segments of the human spinal column and thus confines chiropractors to the spine, and, secondly, because they confine themselves to a particular technique of manual therapy, the chiropractic "dynamic thrust". Physiotherapists, it was said, are in contrast able to offer a far wider range of treatment and therapy, including soft-tissue massage and stretching, and graded rhythmic, passive joint movements, not only to the spine but to the extremities as well.

31. We do not accept that chiropractors are restricted, or necessarily restrict themselves, in the ways described. Their range of therapy is by no means limited to a "dynamic thrust": we have ourselves seen them use a variety of techniques, and there is no ground for saying that the physiotherapists' variety of manual therapy is wider, or for that matter generally more gentle, than that of the chiropractors. Nor do chiropractors limit their manual therapy to the spine. Some regularly perform manual therapy on the extremities, either in conjunction with or independently of spinal manual therapy in any particular case. This is not contrary to the Chiropractors Act: there is nothing in law to prevent chiropractors carrying out extremity work (see chapter 14, para. 8). As we discuss in chapter 38, they are adequately trained to do so.

REFERRED PAIN

32. One complicating factor in any study of chiropractic is the phenomenon of referred pain. In simple terms this is pain which develops at a site remote from its actual cause. To take a straightforward case, a patient may develop a dysfunction in or around particular vertebral joints which directly involves the adjacent nerves. The result is pain; but the pain appears not at the site of the vertebral dysfunction, but in the patient's chest, indistinguishable from the pain normally associated with angina. This is a well-recognised medical phenomenon. It is an inconvenient way the nervous system has of playing tricks on the diagnostician.

33. Now of course in a case like that the chiropractor will be likely to find the vertebral dysfunction. If he is successful in correcting it, the pain will be relieved because it was the dysfunction which was causing the pain. If the chiropractor is honest he will explain to the patient that this was a simple case of referred pain; but in the absence of any such explanation the patient may well go away believing that the chiropractor has been able to cure him of a heart condition which his own doctor was unable to relieve.

34. The illustration we have given is a simple one. The phenomenon of referred pain can however appear in many other ways. In the above instance the pain was caused by a vertebral disorder: in medical terms it was vertebrogenic. But it can also work in reverse. An organic disorder, of

the digestive system for instance, can make its presence felt as a pain in the back: that is viscerogenic pain. Or a disorder in one part of the spinal column can show up as pain in an entirely different part of the spinal column. It is quite clear, as scientific fact, that reflex sensory input can originate from somatic or visceral sources to produce somatic and visceral effects. Sensory input from visceral sources can produce both visceral and somatic responses and somatic input may produce combined visceral and somatic responses.

35. It is also true that defined portions of the soma and viscera share common spinal cord segments. That is because of the metameric segmental development of the body. This sharing by portions of the soma and viscera of neural spinal segments permits the irradiation of sensory and motor responses from somatic to visceral structures and vice versa, and from one part of the soma to another having the same segmental innervation. It is quite clear that this phenomenon, in cases where it exists, can complicate the precise identification of cause and effect.

36. So referred pain can be very deceptive to the layman. Medical practitioners and chiropractors understand the phenomenon: it is something they are used to coping with. The point is, however, that where apparent visceral pain is in fact referred pain which is vertebrogenic—where it has its true origin in a vertebral disorder—and where the chiropractor is able to relieve the pain by adjusting the vertebrae, the disorder must be classified as *Type M*—musculo-skeletal; not as *Type O*—organic or visceral.

37. The phenomenon of referred pain raises another important point. When it is vertebrogenic it can easily lead the medical practitioner into a mistaken diagnosis. For it is at this stage that his lack of training in spinal biomechanics becomes a liability. The main emphasis throughout the chiropractor's 4 or 5 years of academic training is on the structure and function of the spine and its biomechanical and neurophysiological features. The doctor has no such intensive training. So what the doctor is faced with in a case of vertebrogenic referred pain is something he may find great difficulty in dealing with. Because the pain does not result from any identifiable organic or visceral disorder, and because he will not be able readily to identify the kind of vertebral disorder which forms part of the chiropractor's daily commonplace work, the cause of the patient's discomfort may be a mystery to him. That illustrates a number of points, perhaps the most important of which is the necessity for professional co-operation between medical practitioners and chiropractors.

38. But what is this subtle vertebral disorder which chiropractors alone seem to be trained to identify and correct? Chiropractors call it a "subluxation". Medical practitioners are sceptical about its existence. We now discuss it.

Chapter 9. THE "CHIROPRACTIC SUBLUXATION"

INTRODUCTORY

1. The concept of the "vertebral subluxation" is central to chiropractic. It postulates the existence of a class of spinal abnormalities which the chiropractor believes contributes to pain and other bodily disturbances. He seeks to identify such an abnormality and will direct his manual therapy towards attempting to correct it. He regards such an abnormality as causing various kinds of interference within the nervous system. That interference in his view can cause local pain; or it may be a factor in producing other disorders.

2. But exactly what is the "chiropractic subluxation"? Chiropractors say that only they, with their specialised training, are able to identify and treat it. Yet they differ in their views on its essential nature. Dr Scott Haldeman, perhaps the leading chiropractic academic, told us that he preferred not to use the term "chiropractic subluxation" at all. He said that it was not possible to give a precise but all-embracing definition to the condition which chiropractors say they treat. He preferred to use the term "manipulatable lesion". By that he was in a sense not only side-stepping the issue but also begging the question.

3. In this inquiry the Medical Association took a direct view of the matter. It was argued that "chiropractic subluxations" exist only in the chiropractor's imagination. In making this assertion the Medical Association relied on two main propositions. As we understood them they may be summarised in this way: first, chiropractors have never established by any acceptable scientific means exactly what a "chiropractic subluxation" is, or how it could have the effects chiropractors claim for it; and, secondly, that the existence of a "chiropractic subluxation" cannot be verified by any orthodox means, particularly by X-ray.

4. We must explain the second proposition. The chiropractor will almost invariably take an X-ray of his patient's spine. The medical practitioner experienced in interpreting radiographs will examine such an X-ray and find no abnormality. He will look at a sequence of X-rays: some taken before chiropractic treatment, others taken after such treatment. The medical practitioner will say that no difference before and after treatment is demonstrable from the radiographs. The chiropractor will nevertheless declare that he has corrected the abnormality, the "subluxation". How can this be? If there were any spinal abnormality in the first place it should have shown up on the X-rays. It did not show up, therefore it cannot have existed.

5. The chiropractors answer this argument by saying that medical practitioners do not understand the essential character of a "chiropractic subluxation". To appreciate the point we must explain what the chiropractors see as the difference between structural and functional deficiencies in a joint.

“STRUCTURAL” AND “FUNCTIONAL”

6. As we shall see, much confusion is caused by the use of the term “subluxation”. When a medical practitioner uses the term he means that two elements of a joint have become displaced, but to a degree less than actual dislocation. That, according to the chiropractors, is a structural joint defect. The alignment of the elements of the joint is not as it should be having regard to the natural structure of that joint. It is a condition demonstrable by X-ray.

7. When the chiropractor uses the term “subluxation”, however, he is referring principally to a functional defect in a joint. The joint may look normal on an X-ray plate. There may be no perceptible misalignment or structural abnormality. But when the joint is examined as it is put through its ranges of motion, it may be found that there is either an abnormal limitation of movement (“fixation”), or an abnormal excess of movement (“hypermobility”), or some other functional abnormality. These abnormalities in joint action may be apparent when the joint is put through one particular arc of movement, but not when it is put through another. The possibilities are wide.

8. So the chiropractor on the one hand and the medical practitioner on the other have different emphases. In examining a suspect joint, by palpation, radiography, or other means the chiropractor is looking primarily for some abnormality in function. He will not necessarily expect to find a structural component, because a functional abnormality need not involve structural abnormality. By the same token a structurally abnormal joint may function perfectly well, although it is common sense to suppose that a structural fault will in most cases be accompanied by some functional deficiency. The point is that structural and functional deficiencies need not necessarily run in harness.

9. It is therefore understandable why medical practitioners and chiropractors get their wires crossed. The practitioner trained in orthodox medicine cannot understand why a chiropractor cannot point out on an X-ray the actual defect which he says he is correcting. He cannot understand why “before and after” X-rays often reveal no perceptible differences. He assumes that the deficiency which the chiropractor claims to have remedied was imaginary. He does not appreciate that the chiropractor’s first emphasis has been on function rather than structure.

WHAT THE “CHIROPRACTIC SUBLUXATION” IS SAID TO BE

10. It will be helpful at this stage if we refer to some of the evidence we received concerning the nature of the “chiropractic subluxation”. Dr T. R. Yochum, a chiropractor who is the Head of the Department of Roentgenology at the International College of Chiropractic in Melbourne gave us the following explanation (Transcript, p. 3181). The Medical Association elected not to cross-examine him.

Q: [Professor Penfold] ... Could you, for a start, indicate what your personal definition is ... of the chiropractic subluxation?

A: My definition of a chiropractic subluxation personally is one of a complex bio-mechanical neurophysiological disrelationship as it affects predominantly the spinal column. This mechanism may be functional and it might not, in many cases, be demonstrable in a radiograph.

Q: [The Chairman] In many cases?

A: Yes.

Q: Do you mean a static radiograph?

A: Yes, a static radiograph.

And later (Transcript, pp. 3187-8):

Q: [The Chairman] I think one of the things that might have . . . [caused confusion] at the outset is the notion of the medical subluxation, being some kind of demonstrable displacement falling short of dislocation. What is your view? Is it possible to have a displacement of that kind to a small degree which nevertheless is not a chiropractic subluxation?

A: That is correct.

Q: Is that because the subluxation in the medical sense may have no functional impact?

A: That is exactly right. It is purely structural.

Q: Whereas a chiropractic subluxation is —?

A: Dynamic and functional.

Q: But not structural?

A: In some cases structural but predominantly dynamic and functional.

Q: Is that why we also hear of the word 'fixation' being used, because that has a functional impact?

A: That is right. A locking.

Q: Whereas in other cases one can have perhaps too great a degree of movement?

A: Hypermobile, that is right.

Q: To understand what the chiropractic subluxation is, one has to have a very refined appreciation of the actual process of articulation of that particular joint?

A: That is right.

Q: Would there be any more than that?

A: One would have to have an intense understanding of the mechanism of the movement of the spinal column; how the nervous system, and even the vascular supply would relate to that movement, because it is all integrated. One can not separate the bones from the nerves, or the nerves from the blood supply.

Q: We are almost getting into osteopathy with the vascular system?

A: That is right.

Q: When you speak of a chiropractic subluxation do you really mean the biomechanical and physiological functioning of a particular joint with all these other elements included?

A: That is a very good way to explain it.

Q: It makes sense to you?

A: Yes.

11. It is clear from this why the chiropractic subluxation is difficult to describe precisely. It is because it is an omnibus term used by chiropractors not only to describe what they regard as a variety of inter-related conditions in regard to a particular joint, but also to describe their view of the consequences of those conditions. It describes a malfunction in the motion of a particular joint, the related osseous, muscular, tissue, and nerve function, and the consequences in terms of nerve and muscle activity and vascular effects. So it is not at all a simple or straightforward concept. It is much broader than the medical concept of subluxation.

12. Dr Yochum was also able to explain clearly to us what the technique of chiropractic adjustment involved in terms of movement. He told us (Transcript, p. 3191):

The movements of vertebra in my opinion are millimetric in nature—very small degree of actual movement of a segment. I do not know if I can document that. It is a matter of my expertise, and training, and experience as a chiropractor and as specialist in xray. I believe even though the movement is millimetric in nature it is of centimeters in significance in that it does not take more than a few millimeters of derangement to affect the whole neurological complex of a motor unit in the spine. That is what creates the clinical phenomena that we treat.

13. We have already referred briefly to the evidence of Dr Haldeman, who is both a chiropractor and a qualified medical practitioner, who preferred to call the "chiropractic subluxation" a "manipulatable lesion". Under cross-examination he said this (Transcript, p. 3339):

Q: [Mr Eichelbaum] . . . First of all I like your term . . . "manipulatable lesion", an expressive term. Would you just clarify this. Do you put that forward in a notional sense? Do you use that as a notional expression or as a clinical fact. I wasn't clear about that.

A: I think it is a clinical fact. Yes, I think when I find something I want to manipulate it is there and it is a diagnosis I made on that patient.

Q: And is it fair to add to the statement you have just made, "but in the present state of research I cannot be certain what it is"?

A: I know what it is: I know the characteristics of it. I know for example that there is an abnormal or an unusual amount of muscle spasm in the area, there is usually an abnormal and unusual amount of tenderness. There is usually a decreased mobility of the joint or an increased mobility of the joint. The one I usually manipulate is usually the decreased mobility of the joint which I feel I can help. There may be associated symptoms such as pain, referred pain. If one wished to expand that—a functional visceral problem which could be related—may perhaps be related on the segmental level or chain level to it and on X-ray there is possibly a confirmation of this and a direction of manipulation.

Q: Yes. So to sum it up tell me if this is fair—you believe it exists as a fact. In the present state of research one cannot be certain as to the process that has led to it and the third point is again in the present state of research one cannot be sure of the process whereby manipulation alleviates the condition?

A: The manipulatable lesion goes away when you manipulate it and the manipulation we know does a few things. We know it moves the joint. If one found joint restriction—after the manipulation the joint restriction has gone . . . I don't think there is any reason to doubt what you did is move the joint. If there is muscle spasm before and there is no muscle spasm after I don't think there is any reason to doubt that you released that muscle spasm. If there is pain before and no pain after it is likely that you reduced the lesion which was causing the pain.

Q: I don't think there is any difference between us really. You are saying you are satisfied as to the cause and effect?

A: That is right.

14. It is clear that the general concept of the "chiropractic subluxation" is not accepted by medical practitioners. They do not consider it of any significance or importance, and appear to have dismissed it out of hand.

15. The problem is that the chiropractic concept of the subluxation is essentially hypothesis. In the meantime chiropractors are effective in diagnosing and remedying back complaints of a type that can respond to spinal manual therapy. We conclude that chiropractors are not unreasonable in explaining their methods and results in terms of joint dysfunction and its effects.

THE DETECTION OF THE "CHIROPRACTIC SUBLUXATION"

16. Three basic aids are used by chiropractors in detecting the "chiropractic subluxation": X-ray, palpation, and (by some) a piece of equipment called the neurocalometer or neurocalograph.

(a) X-ray

17. The way chiropractors use X-rays has clearly led to a considerable degree of scepticism on the part of the medical profession. It is therefore right that we should explain what the evidence disclosed about the purpose of this aid. We deal later and more generally with chiropractic X-rays and their use: see chapter 17.

18. An X-ray plate will not necessarily picture a "chiropractic subluxation" unless, of course, it includes a structural displacement of the units of a joint. If it is visible on an X-ray plate it will of course amount to a subluxation in the medical sense.

19. But an X-ray plate may show other things to the experienced chiropractor. It may reveal a general postural problem which may indicate a subluxation in a particular vertebral region. And by positioning the patient in a specific way, he may be able to detect the existence of a functional, as distinct from structural, anomaly in a vertebral joint.

20. If the chiropractor is satisfied that the existence of a chiropractic subluxation is likely, he may be guided by the X-ray plate in determining the direction and force of adjustment he will need to use.

21. Also, an X-ray plate may indicate that a condition exists which precludes chiropractic treatment, or which makes it necessary to warn the patient that he should obtain medical advice.

22. The general issue of the use of X-ray in the detection of chiropractic subluxations in indicating contra-indications to spinal manual therapy, and indicating the precise mode of adjustment, was cogently expressed by Dr Yochum in his evidence. In answer to questions by Professor Penfold he said (Transcript, pp. 3181-2):

Q: But is there any way of knowing in advance, from other examinations, that it will not be demonstrable on a radiograph?

A: Well, there are certain static and motion palpation procedures that could be performed by the chiropractor, along with orthopaedic testing, ranges of motion, and certain neurological tests that are very, very highly indicative of the presence of a subluxation. Indeed, they may predicate at an even greater level whether there is the presence of a subluxation or not, in comparison with X-rays.

Q: So, supposing that by such examinations you have overwhelming evidence of a subluxation, what then would be the purpose of the X-ray?

A: The purpose of the X-ray is two-fold. Since the chiropractic approach to the patient is by the physical force of manipulation one must ascertain whether the osseous structures that we would manipulate can maintain that thrust or whether there are any pathological disorders or any congenital abnormalities of the spinal column that could make manipulation unsafe. The X-ray is also used to give postural indications where there may be areas of primary concern—maybe not specific levels, but more a generalised evaluation. So it is used two-fold—on a postural basis and on a pathological basis. I examine X-rays on that basis daily—posturally and pathologically.

Q: Would the X-ray in any way serve any function by indicating how you were going to treat the patient?

A: Yes, it would. The existence of a congenital abnormality of the spinal column is great. A professor who trained me in radiology once said, “God has yet to make the symmetric spine”—and from my experience in radiology that is true. There is a great deal of asymmetry and congenital variance as to the planes of articulation of the movable segments of the spine. If they are present that can indeed alter the specific type of technique—of adjusting technique—that the chiropractor may elect to use on his patient. So, on that basis, it is very important.

And Dr Yochum expanded this (Transcript, pp. 3189-90) when he said:

... My environment in the past six years has been in the field of radiology and I would say that the patient must be X-rayed because, even though there may not be a symptom there, there may be an underlying anomaly that might alter the chiropractic approach to manipulating that segment. That anomaly may be asymptomatic at that point. I would like to feel that opinion was an objective one, and not from a specific radiological point of view.

Q: [The Chairman] Your radiograph then would be from the point of view of safety?

A: Yes.

23. We consider these explanations reasonable. As we have said, the Medical Association elected not to challenge Dr Yochum’s evidence in cross-examination.

(b) *The Neurocalometer*

24. The neurocalometer, and its cousin the neurocalograph, are devices designed to measure the temperature differences between two points on the body. The neurocalometer shows the result on a dial; the neurocalograph plots the result as a graph on a strip of paper, thus providing a permanent record. Two thermocouples, mounted at a fixed distance from one another, are passed down the patient’s spinal column in contact with the skin on either side and at a uniform pressure. The output is said to indicate the possible site or sites of what the chiropractors call “neural involvement”.

25. Our understanding is that these pieces of equipment are not claimed to provide anything more than a rough and ready guide and many chiropractors do not use them at all. Repeated neurocalograph plots

are, however, said by some to provide a useful pattern. We are for our part inclined to be sceptical. We are not satisfied that the neurocalometer or neurocalograph is a reliable clinical device.

(c) *Palpation*

26. Palpation is, however, the fundamental aid for a chiropractor in any case. It involves a refined tactile exploration with particular reference to the biomechanical action of joints, and any muscular abnormality.

27. It is obvious that the detection of joint dysfunction is a specialised art. Indeed, it is a medical practitioner who has provided perhaps the best description of the expertise involved. Dr J. F. Bourdillon, a most experienced orthopaedic surgeon, points to the need for intensive training in recognising joint abnormalities (*Spinal Manipulation*, 2nd ed., rev. (London, 1975), p. 38):

The necessity for this training is not always appreciated and its neglect may well lead to the impression among non-manipulators that the manipulator is imagining the abnormality and that he spends his time treating something that does not exist. This difficulty can perhaps be compared to that of a novice trying to read Braille. Distinguishing the pattern of the raised dots is easy for those who have had sufficient practice. However, it is quite impossible for those like myself who have not, and, to the beginner, the idea that it might be possible seems unbelievable.

HOW A CHIROPRACTOR TREATS "SUBLUXATIONS"

28. A commonly held view of a chiropractor's technique is that he thumps a misaligned joint back into place. That is not what happens. In the first place he is not necessarily correcting a "misalignment". His aim is to restore the proper functioning of the joint.

29. Secondly, it is clear that many techniques of "adjustment" are used. Some of the chiropractors we saw in action had much more subtle and varied techniques than others. That is only to be expected. The best chiropractors plainly took a great deal of care to calculate with some precision the direction and the amount of force which was needed. We saw techniques ranging from the very gentle oscillation of a joint to the forceful but carefully controlled pushing (not thumping) of a joint. We saw only one patient demonstrate any sign of discomfort, but he had arrived in the chiropractor's rooms in some considerable pain and the particular chiropractor appeared to use rather forceful techniques.

30. Chiropractors clearly take a great deal of trouble to position a patient so that the manipulation can be carried out effectively. In particular, most chiropractors use a special table with a number of adjustable features: parts of it can be raised, lowered, tilted, or sprung at various tensions, independently of other portions of the surface, and the whole can be tilted so that the patient can be "adjusted" in an upright, semi-upright, or a prone position.

31. Bearing in mind that the chiropractors we saw in action covered a fair range of competence, we were nevertheless on the whole impressed with the precision of their techniques and the care with which they were administered. Some chiropractors were very impressive indeed.

SUMMARY

32. We now summarise our understanding of the "chiropractic subluxation". We do so by reference to the final submissions of leading counsel for the Chiropractors' Association (Mr R. J. Craddock), who

drew all the strands together for us. We cannot do better than simply repeat what he said (Submission 136, pp. 24–7):

The concept of the subluxation, which is central to Chiropractic theory and practice, is not inherently a complicated one, and the essential elements are clear . . .

- (a) Abnormal function in a spinal joint.
- (b) Neurological involvement.
- (c) Perhaps, but not necessarily, displacement of a vertebra.

The problem is a functional not a structural one. . . . The abnormal function of the spine may produce a vascular involvement as well as the neurological one, and this vascular involvement, originally emphasized in osteopathy, is now accepted by Chiropractors generally.

. . . The medical profession simply fails to see the direction and subtlety of the Chiropractic approach towards spinal dysfunction. Because the Chiropractor uses X-ray extensively the medical practitioner thinks he is looking for a gross bony change, and when the medical practitioner cannot see this on the X-ray the Chiropractor is using he immediately becomes sceptical. He might as well expect to see a limp, or a headache or any other functional problem on an X-ray.

33. We refer also to the closing submissions of Mr J. T. Eichelbaum, Q.C., leading counsel for the Medical Association, who dealt with the chiropractic subluxation in this way (Submission 135, p. 50):

The detection of the subluxation is a skill possessed only by the chiropractor. He will palpate the spinal column in order to detect areas of tenderness, abnormal function, or spinal deviation. But palpation alone will not determine the presence of a subluxation: The chiropractor will also evaluate the posture of the patient and take a case history. He will take an X-ray, not for the purpose of diagnosing the subluxation, but in order to exclude pathologies and contra-indications to manipulation. It is a combination of these factors which enables the chiropractor to say that a subluxation is present.

34. It would be wrong to let it be thought that in this summary Mr Eichelbaum was conceding that chiropractic subluxations have any reality, but the above passage conveys, in simple terms, the chiropractor's approach.

35. Having weighed up all the evidence, we accept that chiropractors are not unreasonable in believing that through their specialised training and skill they are capable of identifying and treating functional defects in the vertebral column which others without that training or skill would not regard as significant. We consider that to deny that such functional defects can exist, and can impinge on the nervous and/or vascular systems, is, in the present state of knowledge, an unreasonable and unscientific stance. The exact nature of such defects has not yet been demonstrated; nor has the mechanism by which its apparent effects are produced. Undoubtedly chiropractors believe that there is such a condition as a chiropractic subluxation. They do so because when they apply manual therapy, supposedly to correct the subluxation, the patient's condition in many cases improves. The fact that there is not yet any conclusive explanation of exactly what happens means nothing more than that the chiropractors' hypothesis is so far unproven. It does not mean it is invalid. We accept, for the purposes of this inquiry, that a chiropractor is equipped by his training and skill to locate and relieve a condition which for want of a better term he calls a subluxation, and that the result of his therapy can provide relief from, at least, back pain.

Chapter 10. CHIROPRACTORS AND ORGANIC OR VISCERAL DISORDERS

INTRODUCTORY

1. We have already made it clear in chapter 1 of this report that we do not recommend that health or accident compensation benefits be paid for a chiropractor's treatment which is related to the possible relief of Type O (organic or visceral) disorders unless the chiropractor's treatment is given on medical referral.

2. That being so, it may be wondered why we trouble to discuss the effect of chiropractic treatment on Type O disorders at any length at all. We are however obliged to do so because the main attack on chiropractic was directed at the chiropractors' claims to influence the course of Type O disorders. In its essentials the argument was that the claims made by chiropractors in this respect were scientifically unsound: that being the case the whole practice of chiropractic was built upon a base that could not be sustained, and therefore chiropractors could not possibly be admitted as partners in any orthodox health care system.

3. It must already be plain that the Commission rejects that argument. It is clear that chiropractors by their specialised training have techniques and skills that put them in a strong position to diagnose and treat musculo-skeletal (Type M) spinal complaints of a type that will respond to manual therapy. They are better qualified in that respect than most medical practitioners and physiotherapists, including those who practise "orthodox" manipulative therapy. The Commission finds that as a fact. Type M cases constitute the bulk of a New Zealand chiropractor's practice. It is plain that whatever the basic theory of chiropractic may be, in the Type M cases chiropractors produce results which are as consistent as could be expected from any form of therapy. So it does not make sense to suggest that because a minor part of their practices extends into Type O cases, there is something basically and fundamentally wrong with the way they deal with Type M cases. The Commission therefore has no hesitation in finding that the chiropractor's treatment of Type M cases qualifies him as a useful member of the general health team.

4. This way of looking at the matter does not however get rid of the objections to the chiropractor's way of dealing with the Type O situation. We now turn to this general topic.

WHAT THE CHIROPRACTORS CLAIM

5. Much chiropractic publicity material (see chapter 18) gives the impression that spinal manual therapy will influence certain Type O disorders. However the chiropractors who gave evidence before us or whom we interviewed made no such claim. Some did claim that they had had cases where the patient's Type O disorder had been relieved or had disappeared following spinal adjustment. We give examples later. In some instances the results have been dramatic. But some admitted quite frankly that such results tended to be unpredictable, and that their approach to spinal adjustment in such cases was to give the treatment in the hope that the patient might benefit from it.

6. That approach was confirmed by patients who had suffered from medically diagnosed Type O disorders and who gave evidence before us describing how the chiropractor's treatment had significantly relieved their disorders. Apart from one or two instances the most that the chiropractor had said was that relief was possible.

7. That is entirely consistent with the view held by many New Zealand chiropractors of the aim and purpose of spinal manual therapy where a subluxation is found. We have mentioned it before and there is no harm in repeating it. The chiropractor does not set out to cure or relieve a particular ailment. What he sets out to do is to ensure that the spinal column is functioning normally. If a particular ailment clears up or is relieved following the therapy, so much the better. If it does not, then at least the patient, now with no spinal impediment to the working of his nervous system, ought to be in a generally better condition and better able to cope with the ailment.

8. Critics of chiropractors might say that such a view of the matter is in reality a convenient way either of rationalising the unpredictability of results in Type O cases or of evading the difficulties inherent in any suggestion that chiropractors in fact treat Type O disorders as such by spinal manual therapy. Such a criticism, while it has its point, is however not altogether fair. If a patient with diabetes, but no Type M symptoms, consults a chiropractor, the chiropractor will not assume that because the patient has diabetes he must have a subluxation of a vertebral joint which is causing or contributing to the diabetic condition. That is not the chiropractor's starting point.

9. As far as the Commission is able to judge, the chiropractor's approach will be to discover whether the patient has a vertebral subluxation. If he has not, that is the end of the matter. If he has, and there are no contra-indications, then the chiropractor will attempt to adjust it. He may consider the possibility that the adjustment of the subluxation may, among other things, have as a result relief or alleviation of the patient's diabetic condition. He will consider that possibility because his own clinical experience, coupled with the accumulated clinical experience of other chiropractors, suggests to him that such a result may follow. He will not be disappointed if the patient's diabetic condition does not improve, but by the same token he will not be surprised if it does. The main purpose of the exercise will however have been to correct a vertebral defect, and the result of the treatment if successful, will be, at least, that the patient will now not have it.

THE CHIROPRACTORS' RESULTS

10. On the basis of their clinical experience chiropractors claim that by restoring proper mechanical function to a malfunctioning vertebral joint by means of manual therapy a wide variety of Type O disorders will sometimes be relieved. The Commission is satisfied on the evidence that this may in fact happen, though it seems impossible to predict on the basis of any presently available scientific knowledge when and why such a consequence will follow and in what types of case.

11. A number of medical experts told the Commission that the results chiropractors and their patients claimed in Type O cases were unlikely to be the results of spinal manual therapy. They gave a number of reasons for reaching this conclusion, and we intend to examine those reasons in detail at a later stage. However at the same time no medical expert was prepared to say that such results were impossible, simply because

knowledge of neurophysiology had not advanced to a point where the possibility of such results from spinal manual therapy—however remote he might think they were—could positively be excluded.

12. We note in passing that one very experienced physiotherapist who gave evidence before us, and who specialises in spinal manual therapy, told us that his own patients, sent to him on medical referral, not infrequently attributed to his treatment an improvement in or relief from Type O disorders: speaking of chiropractors, he said (Transcript, p. 3473):

When they cure somebody of a gall bladder I would say to my patients they didn't have a gall bladder, it was a misdiagnosis. Q: An original medical misdiagnosis? A: Because I have people claim that I do this sort of thing. Q: What do they claim you have cured, just by way of example? A: Everything from abdominal disorders to head disorders, balance—some of these things are involved from the spine but some of them obviously were misdiagnosed in the first place. . . . It must follow if you spend a day manipulating they are going to give you credit for all sorts of things.

13. This physiotherapist was, of course, not prepared to admit that the treatment he gave had the results the patients claimed for it except where the spinal malfunction had been wrongly diagnosed as a visceral complaint: but in the end it depends, we think, on how such matters are looked at. The physiotherapist will tend to consider such claims unfounded because they run counter to the teachings of orthodox medicine within the context of which he has received his training. And a doctor will naturally not refer a Type O disorder to a physiotherapist for treatment by spinal manual therapy; so this kind of case normally lies outside the physiotherapist's experience. The chiropractor on the other hand will approach such matters with a very much more open mind. Some medical practitioners would say that the chiropractor has a dangerously open mind.

14. The commission considers that four points emerge:

- (1) A patient with a Type O disorder should not be encouraged to resort to chiropractic treatment in the hope of securing relief from that disorder unless he is at the same time under medical care. It is important that any patient suffering from an organic or visceral disorder should be medically monitored on a continuing basis.
- (2) If a patient with a Type O disorder wishes to consult a chiropractor in the hope that some relief can be obtained, there is no reason why he should not do so, provided there are no contra-indications to spinal manual therapy, and provided he is encouraged to remain under medical care.
- (3) Chiropractors should be careful to avoid giving any impression that spinal manual therapy will necessarily be beneficial to a patient with a Type O disorder. In particular chiropractors should in such cases do nothing which discourages a patient from remaining under medical care. Ideally the chiropractor should regularly consult the patient's own doctor, although present medical attitudes may rule that out as a realistic possibility.
- (4) The Commission regards the effectiveness of chiropractic treatment of patients with Type O disorders as too unpredictable to warrant subsidy under the Social Welfare and Accident Compensation Acts in cases where the patient consults the chiropractor direct and as his only health practitioner. However the Commission recognises that there could be cases where the patient's own doctor might wish to refer the patient to a

chiropractor in the hope that the patient might respond, and in such an instance we see no reason why the cost of the chiropractic treatment should not be subsidised.

A MEDICAL PRACTITIONER'S ASSESSMENT OF TYPE O RESULTS

15. The Commission found its views on Type O cases reinforced by an unexpected medical witness. An experienced medical practitioner saw the Commission in private.

16. His reasons for doing so were understandable. He took the view that his patients were entitled to the treatment which was most appropriate for their condition—including treatment by a chiropractor—as long as it was safe for the particular patient. Thus he was in breach of the spirit, if not the letter, of the current medical ethical ruling which we discuss later.

17. An hour's conversation with him left the Commission in no doubt that he was highly intelligent and open-minded. He was clearly a dedicated healer and his outlook was nothing if not refreshing. He had seen for himself what he believed to be the benefits of chiropractic treatment both to his own family and to his patients. He had developed a good working relationship with local chiropractors whose methods he felt he could trust, and he told us of the fruitful interchanges of views he had had with them in regard to the diagnosis and treatment of particular patients.

18. On the basis of this experience he was able to confirm his belief that chiropractic treatment could be very successful in cases of back and neck pain and headache. However he went further than that. He told the Commission of some remarkable cases in which he believed that chiropractic treatment had successfully cured, or significantly relieved, asthma, deafness, narcolepsy (a condition characterised by sudden attacks of an uncontrollable desire to sleep), chorea (St Vitus dance) and eczema. He asserted the effectiveness of chiropractic treatment in some cases of diabetes, not as a cure, but as a means of enabling certain patients significantly to lower their insulin intake.

19. Because we heard this evidence in private there was naturally no opportunity for it to be tested by cross-examination. Notwithstanding that limitation the Commission found the evidence convincing and helpful. It was a case where the chiropractic treatment of a number of patients suffering from Type M and a number of Type O conditions had been monitored by a qualified and experienced medical practitioner who was prepared to tell us that the patient had plainly benefited. As an example of what can be achieved by full co-operation between medical practitioners and chiropractors for the benefit of the patient the evidence was most valuable.

20. Other accounts of treatment for Type O disorders were given in the evidence of chiropractors and patients who testified before us, and were questioned, regarding Type O disorders. We deal with some of that evidence later.

Chapter 11. ACCESS TO CHIROPRACTORS

INTRODUCTION

1. We have already seen that a patient may consult a chiropractor direct. There is no legal or ethical requirement that a chiropractor may not treat a patient unless a medical practitioner has seen the patient first and has expressly referred the patient to a chiropractor for treatment.

2. Under the accident compensation scheme a patient is entitled to recover the cost of his chiropractic treatment if that treatment has been authorised by a doctor. But if the patient's own doctor will not refer him (and most doctors will not) there is nothing at all to prevent the patient from consulting a chiropractor on his own initiative. In such a case the patient must himself meet the whole cost of chiropractic treatment.

3. The medical profession has its own ethical rules which prohibit a doctor from referring a patient to a chiropractor. We deal later with those ethical rules and with our reasons for recommending that they be abolished; but the present situation is that if a patient wants to consult a chiropractor for anything he is perfectly free to do so as long as he does not expect a formal referral from his doctor.

4. As matters stand, relatively few people will consult a chiropractor without having first had medical attention. Most people have had their first contact with a chiropractor only because they have not been satisfied with their medical treatment. They go to a chiropractor as a last resort. So in practice the position is that most chiropractic patients have been under medical care before they consult the chiropractor. In the present situation, therefore, the medical profession is in practice the first portal of entry to the health care system for most people.

5. But it need not be. Therein lies a real problem. For although we see no reason why a patient with a bad back or another kind of Type M disorder should not consult a chiropractor direct, consulting a chiropractor direct as the first port of call for a Type O disorder is a very different matter. There is also the problem of the patient who suspects he has a Type M disorder but in fact has a Type O disorder. Because of the phenomenon of referred pain, this is an easy enough mistake to make.

THE CHIROPRACTOR'S APPROACH

6. The attraction of chiropractic for a number of faithful chiropractic patients is that it holds out the possibility of relief of Type O disorders by simple and painless spinal therapy and without resort to drugs or surgery. It is easy to understand the attraction. It is also easy to understand that chiropractors are tempted to capitalise on it.

7. We say at once that many New Zealand chiropractors, faced with a new patient who has not been to a doctor and who complains of symptoms which indicate a Type O disorder, will immediately ensure that the patient receives medical advice, whether or not he is also offered chiropractic treatment. That is a proper approach. If the patient is placed under proper medical care, we see no reason why he should not have chiropractic treatment as well if he wants it: there is at least the possibility that it may help him.

8. But it is quite another thing actively to suggest to people that they should make the chiropractor their first port of call for any ailment. There is evidence that some chiropractors do this. We discuss the evidence in a later chapter. No doubt it is done because it is believed that sick people should at least have the opportunity to experience a method of treatment which could help them without drugs or surgery. The motive is understandable. But because we are not convinced of the general effectiveness of chiropractic treatment in Type O cases we could not accept such an approach as proper or desirable in the public interest.

THE MEDICAL PROFESSION'S VIEW

9. It is easy to understand the medical profession's concern at any suggestion that people complaining of Type O symptoms should see a chiropractor before seeing a medical practitioner. For it means that the chiropractor is imposing himself on the patient as the judge of whether medical attention is needed. That is an obvious danger. And it was, we think, the central point of concern of the witnesses called on behalf of the Medical Association who expressed their opposition to chiropractic on the basis that chiropractic was holding itself out as an independent health care system when in fact it could not be anything of the kind.

10. We accept that reasoning. For if chiropractors encourage patients to come to them rather than the medical profession in the first instance, for consultation about Type O symptoms, they are setting themselves up as qualified to decide whether or not the patient should have medical care. They are setting themselves up, not only as a portal to health care but as a patient-screening system, with the right to direct patients into either the medical system or their own system.

11. The danger of this needs no emphasis. For reasons which we develop later we consider that chiropractors are qualified by their training to identify cases which should be referred immediately for medical diagnosis. But we also accept without question that the only person qualified to carry out a proper differential diagnosis is a medical practitioner. We are satisfied that most chiropractors in New Zealand can be relied upon to act responsibly and to refer the patient at once if there is any suggestion of a medical problem. The danger lies with the maverick chiropractors who set out to encourage patients to rely on them, and them alone, to decide whether medical care is appropriate. We have had evidence about the activities of some of them. Such chiropractors in their enthusiasm to promote chiropractic have overplayed their hands and have lost sight of their proper responsibilities.

12. There is a great difference between the chiropractor who holds himself out as no more than a practitioner who may be able to help people for whom chiropractic care is appropriate, on the one hand, and the chiropractor who sets out to attract patients on the basis that the patient should consult him, rather than a doctor, as a first measure. In the first case, the patient has an open choice. If he consults a chiropractor in the first instance rather than a doctor he does so on his own responsibility. In the second case the patient is intended not to have an open choice: it is the chiropractor who will decide whether the patient should see a doctor. And the danger is that a chiropractor who is unwise enough to suggest that he is the better portal to health care may also have questionable judgment about whether the patient should have medical advice, and may have questionable judgment about the value of chiropractic care.

13. By the same token, however, most medical practitioners, because of

their limited knowledge of the nature of spinal manual therapy and its possible benefits, are not the best judges of whether a patient should have chiropractic treatment. The few doctors who do appreciate the benefits of spinal manual therapy are restrained by the present medical ethical rules from referring patients to a chiropractor in any formal way. Chiropractors cannot therefore be blamed for trying to let people know what the benefits of chiropractic are: if they do not tell people, no-one else is going to.

14. But it is one thing to publish information about chiropractic that fairly states what chiropractic can claim to do. It is altogether another thing to try to persuade people that chiropractors are the first practitioners to turn to when a health problem arises. It is unfortunate that a few chiropractors, through their over-enthusiasm, tend to bring chiropractors generally into disrepute. But chiropractors have only themselves to blame. The remedy is in their own hands. They must tighten the discipline in their profession. Specific rules must be laid down which will be enforced. We later suggest means of tightening chiropractic discipline.

SHOULD CHIROPRACTORS REMAIN A PORTAL TO HEALTH CARE?

15. It is obvious that there are arguments against chiropractors retaining their present right to accept patients direct. We have expressed them already. But we are unable to recommend that the right of chiropractors to accept patients off the street be limited. The unwise actions of a few chiropractors cannot be allowed to obscure the valuable contribution made by most to health care in this country. And we are conscious of the fact that if, for instance, we were to recommend that chiropractors should be allowed to accept patients only on medical referral, the adoption of that recommendation would in present circumstances effectively destroy the chiropractic profession in this country.

16. The solution to the problem lies, as we have said, in a tightening of discipline within the chiropractic profession. Our detailed findings on the question of professional discipline appear in a later chapter, but it is convenient to anticipate what we say at a later stage by stating now that two points emerge:

- (1) That it should be accepted as unethical for a chiropractor to publish any material designed to induce any person to believe that a chiropractor should be consulted with a view to determining whether a patient requires medical care;
- (2) That it should be accepted as unethical for a chiropractor to display or distribute any general publicity material or any notice or sign that is not expressly approved by the appropriate authority.

17. In chapter 43 we make specific recommendations on how such ethical principles should be formulated and enforced.

Chapter 12. IS CHIROPRACTIC A SEPARATE AND DISTINCT HEALING ART?

INTRODUCTION

1. The question whether chiropractic is a separate and distinct healing art is one which our terms of reference require us to answer. We have already done so in chapter 5 by holding that chiropractors cannot be regarded as practising a separate and distinct healing art. They practise in a specialised branch of general health care. The branch in which they practise is no more a separate and distinct healing art than dentistry, psychiatry, physiotherapy, or any other specialty.

2. It is, of course, clear that in its very early stages in the United States chiropractic was seen as a viable alternative to orthodox medicine as it was at that time. Indeed "orthodox medicine" is hardly an apt term to describe the practice of a great many United States medical practitioners, bearing in mind the virtual absence of any standards in medical education in the pre-Flexner era when mail-order medical degrees were commonplace. It is possibly because of that atmosphere and tradition that the Chiropractors' Association still regards chiropractic as a separate and distinct healing art (Submission 19, p. 6). In the Commission's judgment the day is long past for that view to remain tenable.

DISTINGUISHING FEATURES

3. But chiropractic does have distinguishing features in its approach to treatment. The evidence we received enables us to summarise them in the following way.

Diagnosis

4. The purpose of the chiropractor's diagnosis is different from the purpose of a medical practitioner's diagnosis. The medical practitioner's diagnosis is directed to discovering as accurately as possible what is wrong with the patient so that the appropriate mode of treatment may be selected. The medical practitioner's diagnosis will also include a process of elimination: the patient's symptoms may indicate the presence of more than one disorder, in which case the medical practitioner will have to attempt to distinguish them. That in simple terms is the process known as differential diagnosis. The patient's symptoms of which he complains may indicate either heart disease or indigestion. The medical practitioner by differential diagnosis aims to find out which it is and to prescribe treatment accordingly.

5. The chiropractor's approach is different. It is no part of his function to select a particular treatment to cope with a particular disorder, because he has only one form of treatment at his disposal: that of manual therapy. Nevertheless he will carry out a form of differential diagnosis, but for entirely limited purposes: first, in order to satisfy himself that there are no contra-indications to spinal manual therapy; and secondly to be able if necessary to advise or urge the patient that he should seek medical advice. Of course many patients, as we assess the situation in New Zealand, will already have taken medical advice and will already have been under

medical care by the time they consult a chiropractor. In such a case the chiropractor will have the benefit of the medical practitioner's diagnosis and prescribed treatment, as reported to him by the patient.

6. We must pause at this point to elaborate the last statement. The practice generally is for a chiropractor to accept what a patient reports to him about the patient's medical diagnosis, subject of course to the chiropractor's own assessment and diagnosis. On only rare occasions will the chiropractor feel free to check with the medical practitioner concerned. That is an alarming situation, but the Commission has no hesitation in finding that the medical profession is itself to blame for it. Medical ethical rules in New Zealand (see chapter 41) are designed to prevent collaboration on any professional basis between medical practitioners and chiropractors. A medical practitioner who discusses a patient's condition with a chiropractor therefore runs a grave risk, and any suggestion of their working in harness in regard to a particular patient is in general, in the present situation, out of the question. The Commission cannot avoid seeing this as an attempt by organised medicine to cut off the patient's nose to spite the chiropractor's face, and we have some firm recommendations on this topic which appear later in this report.

7. But until this unhappy situation is remedied, as we believe it must be, the chiropractor is in most cases compelled to rely on the patient's account of the medical practitioner's diagnosis—an account which may often be garbled—supplemented by his own diagnosis. If the chiropractor is the patient's first port of call, then the differential diagnosis naturally becomes the chiropractor's sole responsibility.

8. It will be seen that the chiropractor's differential diagnosis is not aimed at identifying the patient's disorder so that a specific treatment for that disorder may be prescribed, but is instead aimed at determining whether spinal manual therapy should be undertaken at all and whether the patient should be encouraged to take medical advice.

9. That is the first stage of the chiropractor's diagnosis. The second stage is to decide whether the patient suffers from a spinal malfunction. If he does not, then chiropractic cannot help him. If he does, then the purpose of the chiropractor's treatment will be to correct or ameliorate that malfunction. At that point the precise disorder of which the patient complains becomes irrelevant, because the chiropractor is concerned only with whatever malfunction he may have located in the functioning of the patient's spine. By treating that malfunction he expects the patient's general condition to improve, and the specific condition of which the patient complained may be relieved. This, the chiropractor will say, is either because the malfunction which he has corrected was the direct or indirect cause of the condition, or because by correcting the malfunction he has removed an impediment to the body's natural healing powers.

10. So it is seen that the process of diagnosis and the selection of treatment clearly distinguish chiropractic from medical practice. The chiropractor's specific diagnosis, as distinct from his more general and what may be more correctly described as his exclusionary differential diagnosis, is for an extremely limited purpose. It is not related to any disorder other than a mechanical functional disorder of the vertebral column.

Nature of Treatment

11. Some attempt was made during our hearings to persuade the Commission that chiropractic treatment was no more than a form of

spinal manual therapy already provided by other paramedical personnel. That view of the matter is superficially attractive, for physiotherapists who are also manipulative therapists are frequently involved in medical referrals in cases of backache and other disorders normally regarded as directly associated with the spinal column. Physiotherapists make extensive use of soft tissue techniques, which chiropractors also include within their total range of treatment; but the physiotherapists (along with medical practitioners) have exclusive access to ultrasonic devices. Physiotherapists do not of course limit themselves to the vertebral column.

12. So it was said that physiotherapists, at the times when they do work on the vertebral column, carry out the same function as chiropractors. The suggestion was that chiropractic treatment was a superfluous part of the general health care picture, because the physiotherapists in fact include chiropractic work—or work which is to all intents and purposes indistinguishable from chiropractic work—as part of the much wider range of treatment they offer.

13. At the early stages of our hearings we might have been disposed to accept this view. But as the hearings progressed and as the Commission gained a greater insight into the functions of these two branches of health care, it became clear that this view was over-simplified.

14. The Commission is satisfied that chiropractors are specialists in biomechanics of the vertebral column. They are also specialists in techniques of manipulation and mobilisation of the segments of the vertebral column. Some individual physiotherapists, because of a special interest in the matter, may have acquired the chiropractor's specialist skill, but the Commission is satisfied that physiotherapists in general are less well equipped by training and experience to administer spinal manual therapy.

15. The Commission has been impressed with the subtlety and refinement of chiropractic treatments, both in terms of what we were told and what we saw in various demonstrations. It is not a simple matter of thumping a vertebra back into place by brute force as some witnesses seemed to believe. The Commission's finding is that as a therapist the chiropractor occupies a unique position as a spinal specialist.

The Purpose of the Treatment

16. In most cases the purpose of the treatment is obvious. It is to relieve back pain. In the minority of cases the treatment is not to cure or relieve any particular disability but to correct a spinal malfunction so that the body's own recuperative forces can work unimpeded to relieve any disorder there may be. While this is an over-simplification it will serve in the meantime.

17. Medical or physiotherapeutic treatment is directed at the immediate source of the particular disorder or, if the source cannot positively be identified, at relieving the symptoms. It is not generally accepted by the medical profession that the chiropractic concept of a malfunction of the spinal column can be a source of any disorder which is not immediately associated with a spinal deficiency that the medical practitioner or physiotherapist can recognise.

18. Essentially the difference is between the hypotheses that the chiropractors on the one hand and the medical profession on the other are willing to accept. Even where a layman would see a measure of common ground, as in the average *Type M* case, the medical profession as a whole

is reluctant to accept that chiropractic treatment can be effective (Submission 26, p. 125). Certainly the medical profession will not acknowledge that a spinal malfunction, which usually only a chiropractor can pinpoint, could possibly be the cause of or a factor which could contribute to a disorder classified as *Type O*. But, as we have already said, that does not mean there is a philosophical difference. It is a difference of opinion whether a particular treatment can achieve a particular result.

Summary

19. It is therefore clear that in matters of diagnosis, the nature of the treatment offered, and (in a minority of cases) in the purpose of the treatment offered, chiropractic differs from orthodox medicine. It is an expert specialty in its own right. It is true to say that the attitude of organised medicine has compelled the development of chiropractic as a separate discipline, but in spite of that chiropractors are properly seen as practising in a specialised branch of the healing arts within the total health care frame work.

Chapter 13. CHIROPRACTIC AS A PROFESSION

1. In the whole field of health care chiropractic is a micro-specialty. It has developed separately for two main reasons: first, the initial belief that it provided an approach, alternative to medicine, to general health care; and secondly the neglect by the medical profession of spinal manual therapy. In much the same way, dentistry might now be a part of orthodox medical practice if the medical profession had chosen to accept the care of the teeth as part of its general health responsibilities.

2. Physiotherapists are in a different position. Rehabilitation of the patient is a major part of their work, and physiotherapy as a whole is to be regarded as an aspect of orthodox medical care, the medical practitioner having control of the treatment. That means that any division there is between medical practitioners on the one hand and physiotherapists on the other is essentially a division of labour: the medical practitioner prescribes the treatment and the physiotherapist carries it out, but given the time and the skill the doctor could legitimately carry it out himself.

3. So physiotherapists are essentially medical auxiliaries. Their present training is directed towards ensuring that they have the appropriate knowledge and skill to carry out the doctor's instructions without harming the patient. Even those physiotherapists who have trained as manipulative therapists still submit, if unwillingly, to that relationship.

4. The chiropractor, on the other hand, has never regarded himself, any more than a dentist does, as a medical auxiliary. Because of gaps in his general medical training he cannot be treated as a medical specialist. It is more correct to regard him as an independent practitioner in a specialised area of health care.

5. In that sense chiropractic must clearly be regarded as an independent profession, having its own educational and training system and having as its aim the provision of a particular kind of health care through a particular mode of treatment. That does not mean that chiropractic is a profession providing an alternative system of general health care, a notion that we have already rejected.

6. As we shall see when we discuss the Chiropractors Act 1960, one of the main purposes of the Act was to protect the public by ensuring that only properly qualified and licensed practitioners could practise. That is recognition of the fact that spinal manual therapy as administered by chiropractors involves refined techniques requiring specialist training. It is significant that chiropractors themselves promoted the 1960 Act, just as they promoted the earlier Chiropractors' Association Act 1955 which made it an offence for people who were not members of the New Zealand Chiropractors' Association to hold themselves out as members.

7. The New Zealand Chiropractors' Association is New Zealand's only professional organisation for chiropractors. Membership is not compulsory, but most practising chiropractors are members. The association has a statutory right to representation on the Chiropractic Board, and has a statutory right to oppose any application for registration as a chiropractor, the only basis upon which a chiropractor may practise in New Zealand. The association has its own Code of Ethics (see Appendix 4).

8. The Chiropractic Board, which is also a disciplinary body, lays down the educational standards a chiropractor must meet in order to be registered, and itself examines chiropractors to ensure that their training is appropriate for New Zealand conditions. We discuss these matters at a later stage.

9. In short, the chiropractors practising in New Zealand have a statutory professional structure and a professional association with statutory rights and a code of ethics. We are satisfied that chiropractors must be regarded as carrying on an independent profession.

10. It is, however, a profession which is still in search of a true professional reputation. Most chiropractors acquired their chiropractic education in the United States. It is clear to us that their views of professional behaviour are to some extent based on what is regarded as proper professional behaviour in the United States. That includes the view that it is acceptable for a professional practitioner actively to market his product. We discuss the problems associated with this and the solutions we recommend at a later stage.

Chapter 14. THE LEGAL STATUS OF CHIROPRACTORS

PRINCIPAL STATUTORY PROVISIONS

1. The only persons who may legally practise as chiropractors in this country are those who are registered as chiropractors under the Chiropractors Act 1960. A person may be registered as a chiropractor only if he has passed the University Entrance Examination or its equivalent, has obtained a certificate, diploma, degree or licence from a recognised institution which is recognised by the Chiropractic Board "as furnishing sufficient evidence of the possession . . . of the requisite knowledge and skill for the efficient practice of the profession of chiropractic", is of good character and reputation, has obtained a certificate of competency on examination conducted by the Board, and is over 24 years of age. If he is over 21 but under 24 he may be conditionally registered, but may practise chiropractic only in association with a chiropractor who is over 24: sections 9, 10.

2. The New Zealand Chiropractors' Association has a statutory right to be notified of any application for registration: section 11; and is entitled to object: section 13.

3. All applications for registration must be formally considered by the board: section 12.

4. Once a chiropractor has become registered, the only qualifications to his right to practise are, first, that he must hold an annual practising certificate (section 28), and that he must not have been struck off the Chiropractors' Register or suspended from practice. The latter are penalties which may be imposed by the board for a proved disciplinary offence: section 23.

5. Any person who is not a registered chiropractor, and either describes himself or otherwise holds himself out as a chiropractor or a chiropractic expert, or—

Uses or causes or permits to be used in connection with his business, profession, or calling any written words, titles, or initials, or any abbreviation of words, titles, or initials, intended or likely to cause any person to believe that he is registered under this Act or that he is engaged in the practice of chiropractic, within the meaning of this Act, or that he is qualified to practise chiropractic—

commits a criminal offence: section 26.

PURPOSES OF THE ACT

6. The Act has three predominant general purposes. In the first place, by limiting the practice of chiropractic to properly qualified registered chiropractors, the intent clearly was to protect the public by excluding unqualified or unsuitable people from practice. Secondly, the Act was designed to ensure minimum standards of education, training, and proficiency for chiropractors practising in New Zealand. Thirdly, by laying down a disciplinary structure binding on all registered chiropractors, the Act was intended to provide registered chiropractors with a great measure of control over their professional standards of conduct (as to discipline see chapter 43).

IMPLICATIONS OF THE ACT

7. Two important legal propositions are established by the Act:
- (1) Chiropractic, at New Zealand law, clearly has the status of an independent profession. It is not related, at law, to any other health profession.
 - (2) Registered chiropractors are clearly entitled, as a matter of law, to accept for chiropractic treatment, and to treat, patients who approach them direct, and without medical or other intervention.

8. The nature and extent of a chiropractor's practice is therefore, as a matter of law, very wide. Although the Act defines "chiropractic" as "the examination and adjustment by hand of the segments of the human spinal column and pelvis", the Act itself does not limit him to that. What the Act does is to limit chiropractic, in that special statutory sense, to registered chiropractors only. It does not say that a chiropractor cannot use other forms of treatment or examine and treat other parts of the body. If any limitation on what he can do is sought, it must be found elsewhere: he cannot do any act otherwise prohibited, such as perform surgery or prescribe drugs, nor must he hold himself out as qualified to practise medicine (Medical Practitioners Act 1969, section 69). But within those limits he is an independent professional practitioner accountable only to the Chiropractic Board.

9. A registered chiropractor is therefore not legally required to defer to the opinion of a medical practitioner. He need not accept a medical practitioner's diagnosis of his patient's disorder. He is not controlled by the medical profession. He is, in law, independent.

10. In case it is thought that the present statutory definition of chiropractic does not accurately describe what chiropractors do in practice, the following amended definition is suggested:

The examination and treatment by hand of the joints of the human spinal column, pelvis and extremities, including associated soft tissues.

We so **recommend**.

POINTS OF CRITICISM

11. Three main points emerge from the provisions of the Act as it stands. We deal with them separately.

Administration of the Act

12. In the first place, the Act is administered by the Department of Justice. That may seem surprising, and it is. When the Act, as a Bill, was progressing through Parliament, the Department of Health, as the Government agency obviously most suited to administer the Act, firmly resisted involvement. So for want of any better solution the Department of Justice was given the task of administering the Act.

13. We can now see that this was a mistake. It meant that the chiropractic profession was able to develop without the Department of Health having any way of being kept informed of what was happening. The Department of Justice has never really been interested. It has administered the Act and that is all. When we invited the Department of Justice to make submissions in this inquiry, its response was that it could not put forward anything likely to be helpful. We do not blame the Department of Justice. The Chiropractors Act is outside its normal field of operations.

14. We have no doubt whatever that the Act should now be brought under the administration of the Department of Health. It is not at all acceptable that the Department of Health should have no measure of control over a minor but important part of this country's health services. The Department of Health should not have been allowed in 1959 to evade its responsibilities. It should accept those responsibilities now.

15. We think that the involvement of the Department of Health in chiropractic affairs will have two very valuable results. In the first place, it will reduce the undesirable isolation in which chiropractors at present function: any prospect of chiropractors becoming part of the general health team will not be encouraged if their present isolation continues. Secondly, the direct involvement of the Department of Health will greatly strengthen the chiropractors' hands in helping them to impose proper professional discipline. A few of their members at present tend to bring chiropractic into disrepute with the medical and other health professions.

16. We therefore strongly **recommend** that the Chiropractors Act 1960 be brought under the administration of the Minister of Health and the Department of Health.

The Chiropractic Board

17. We have spoken of the isolation of the chiropractic profession from other health professions. That isolation tends to be perpetuated by the composition of the Chiropractic Board.

18. The board consists of a chairman (who must be a barrister of at least 7 years' standing), two chiropractors nominated by the New Zealand Chiropractors' Association, and two persons nominated by the Minister of Justice, one of whom must be a chiropractor.

19. It is interesting to contrast with this the composition of the Physiotherapy Board (Physiotherapy Act 1949, sections 4, 5). The Chairman is the Director-General of Health. The Registrar is the Advisory Physiotherapist in the Department of Health and is a member *ex officio*. The principals of the two schools of physiotherapy are members *ex officio*. Three registered and practising physiotherapists (of whom at least one must be in private practice and one employed in a public hospital) are nominated by the New Zealand Society of Physiotherapists and appointed on the recommendation of the Minister of Health. Two medical practitioners are appointed on the recommendation of the Minister after consultation with the New Zealand Medical Association and the Society of Physiotherapists.

20. It is also of interest to compare the composition of the Medical Council (Medical Practitioners Act 1968, section 3). It consists of the Director-General of Health, the Deans of the two medical schools and eight medical practitioners appointed so as to cover a range of medical activity and specialisation.

21. The Dental Council (Dental Act 1963, section 3) consists of the Director-General of Health, the Dean of the Faculty of Dentistry in the University of Otago, four dentists, and one medical practitioner.

22. It will be seen from these comparisons that two of these statutory bodies preserve professional isolation: they are the Medical Council and the Chiropractic Board. The others, the Dental Council and the Physiotherapy Board, have medical members, two in the case of the Dental Council, and three in the case of the Physiotherapy Board. It may be assumed that these variations of pattern arise either for historical reasons or because the particular provisions in each case are what the interested parties wanted.

23. Now the professions whose statutory boards we have considered are all health professions. The one permanent link between the medical, dental, and physiotherapy boards is the Director-General of Health. So the three professions, though separate by statute, have the Director-General of Health in common. The chiropractic profession has no link with the other three, and as matters stand there is no prospect of it unless the Minister of Justice were to choose to appoint the Director-General of Health as one of his nominees pursuant to section 3 (2) (c) of the Chiropractors Act 1960 (as inserted by the Chiropractors Amendment Act 1961). That is unlikely.

24. We consider this situation undesirable. The isolation of chiropractic should not be allowed to continue. It is not in the public interest, nor, ultimately, is it in the interests of chiropractors. People get wrong ideas and are misinformed about chiropractic simply because chiropractic is isolated. That is why we have had so much about chiropractic presented to us in this inquiry which is simply not correct. The Department of Health knows little about chiropractic that has not been told to it by the medical profession. If it had been represented on the Chiropractic Board it would have been able to learn something about chiropractic from the inside.

25. Quite apart from that, chiropractic is a health profession. As a health profession it should have health representatives other than chiropractors on its statutory governing board. We consider the department's reasons for not wishing to have a representative on the board (Submission 133, para. 32) simply evasive.

26. For those reasons, and for further reasons which we mention later, we consider that the Chiropractic Board must be expanded so as to include the Director-General of Health or his nominee, being a senior officer of his department, and a registered medical practitioner. We so **recommend**.

27. Three further points remain. The Chiropractic Board has disciplinary functions, and in appropriate cases it can strike a chiropractor from the register, thus depriving him of his livelihood. It is therefore highly desirable that the board should continue to be chaired by a lawyer.

28. Next, we have considered and dismissed the possibilities that the Director-General of Health may not wish to be represented on the Chiropractic Board and that it may not be possible to find a medical practitioner prepared to accept nomination. It is hard to take either possibility seriously. It is in the public interest that the Chiropractic Board be broadened and strengthened in this way, and there is a public duty to ensure that additional positions are filled.

29. Finally, we have considered the possibility that both chiropractic and physiotherapy might be placed under the one statutory board. Both involve manual therapy, and one statutory board instead of two at first sight makes sense in terms of both efficiency and economy. But at present such a possibility is unrealistic. The education and training of chiropractors are very different from those of physiotherapists.

Discipline

30. The disciplinary provisions of the Chiropractors Act (sections 22, 23) are in the Commission's view inadequate. They apply only to serious offences. The New Zealand Chiropractors' Association has a disciplinary procedure in its rules which applies to less serious offences, but that

procedure can be applied only in regard to members of the association. Membership of the association is not compulsory for registered chiropractors.

31. In these circumstances there cannot be adequate disciplinary control over registered chiropractors. Unless professional standards can be enforced there will always be some who will feel it safe to step over the borderline of what is proper. The situation needs to be remedied. We make recommendations on how this might be done in chapter 43.

THE AUSTRALIAN LEGAL POSITION

32. Apart from Western Australia, which has recognised and registered chiropractors since 1964 (Chiropractors Act 1964 (W.A.)), no Australian state regulated the practice of chiropractic until 1978. However, in that year, and since, there has been something of a flurry of legislative activity induced by the publication of the Webb report. At the time of writing the present report three other Australian states had passed legislation for the recognition and registration of chiropractors: Victoria (Chiropractors and Osteopaths Act 1978), New South Wales (Chiropractors Act 1978), and South Australia (Chiropractors Act 1979); but in only one of those states, Victoria, had the new legislation come into full effect.

33. The Webb report supplies full details of the situation in Australia as it existed prior to the passing of the 1978 and 1979 legislation, and it is clear that the situation (except in Western Australia) differed markedly from that in New Zealand. For one thing there were two groups of chiropractors: those educated in the United States, Canadian, and United Kingdom chiropractic colleges, who formed the principal membership of the Australian Chiropractors' Association, and those who had been educated in a variety of small Australian colleges, mainly in New South Wales. These Australian colleges had widely varying standards, and their products formed the principal membership of the United Chiropractors' Association of Australia. We mention these matters to explain how it is that the New South Wales Act (section 5) provides that the membership of the New South Wales registration board includes two persons nominated by the United Chiropractors' Association.

34. As we have said, at the time of writing this report, of the 1978 and 1979 Acts only the Victorian Act had come into effect. The Victorian registration board has been set up and is operating and has promulgated Statutory Rules (Chiropractors and Osteopaths Regulations 1978).

35. Of particular interest in the New Zealand context are, first, the composition of the board, and secondly the chiropractic qualifications recognised by the board as a prerequisite to registration.

Composition of the Board

36. The board is an independent statutory body, but works under the aegis of the Victorian Health Commission. Indeed, a common feature of all the Australian state Acts is that they come under the aegis of the respective state departments of health.

37. The Victorian board consists of:

Two registered chiropractors and one registered osteopath, elected by registered chiropractors and osteopaths;

An orthopaedic surgeon nominated by the Minister of Health from names submitted by the Victorian Faculty of the Royal Australasian College of Surgeons;

An independent person nominated by the Minister, who is to be chairman;

A teacher of medicine nominated by the Minister from names submitted by the University Faculties of Medicine;

A member of the Royal Australasian College of Physicians.

38. It is therefore seen that the board is equally divided between chiropractors and osteopaths on the one hand, and members of the medical profession on the other, the chairman not belonging to any of these professions. The Act, as we have said, is administered by the Victoria Health Commission.

39. In the course of our meetings in Melbourne with representatives of various organisations we found no evidence of any degree of major dissatisfaction at the way in which the board had been constituted. We met the board at one of its meetings, and it seems to be agreed by the interested organisations that the board is functioning well. We heard and saw nothing to indicate that there was any strong degree of tension between the medical and chiropractic members, and indeed the suggestion was that the chiropractic members had created a good impression by their insistence on proper educational attainments by those who were seeking registration under the new system.

40. It was obvious that the constitution of the board was a factor which was noticeably creating a much better understanding by the medical members of the way in which chiropractors worked. Having seen the Victorian system in operation and having spoken to those principally concerned with it, we are encouraged in our firm view that the New Zealand board ought to be reconstituted so that it has medical and Department of Health representation (see above, para. 26).

Prerequisites for Registration

41. It is not necessary for us to discuss the transitional provisions ("grandfather clauses" and the like) of the Victorian system. It is, however, significant that the board has approved the following degrees, diplomas, qualifications, and training for the purposes of qualification of chiropractors for registration (Rule 305):

(a) State of Victoria

(i) The Diploma of Applied Science (Human Biology) and the Diploma of Applied Science (Chiropractic) awarded by International College of Chiropractic/Preston Institute of Technology.

(ii) Diploma of Chiropractic awarded by the Chiropractic College of Australasia.

(iii) Fellowship Diploma awarded by the Victorian Branch of the Australian Chiropractors' Association prior to the first day of January, 1979. . . .

(b) Canada

Doctor of Chiropractic degree awarded by the Canadian Memorial Chiropractic College, Toronto, Ontario. . . .

(c) United States

(i) Doctor of Chiropractic degree awarded by colleges that are accredited by or that have "Recognized Candidate for Accreditation Status" with the Commission on Accreditation of the Council on Chiropractic Education which at 1 September 1978 were:

Cleveland Chiropractic College, Kansas City, Missouri; Logan College of Chiropractic, Chesterfield, Missouri; Los Angeles College of Chiropractic, Glendale, California; National College of Chiropractic, Lombard, Illinois; New York Chiropractic College, Old Brookville, New York; Northwestern College of Chiropractic, St Paul, Minnesota; Palmer College of Chiropractic, Davenport, Iowa; Texas Chiropractic College, Pasadena, Texas; Western States Chiropractic College, Portland, Oregon.

42. Two short comments are required. First, the only United Kingdom qualifications specified are those relating to osteopaths: the diploma of Doctor of Chiropractic awarded by the Anglo-European College of Chiropractic in Bournemouth is not mentioned. That is presumably because no chiropractor already practising in Victoria was educated there, and no students from Victoria are enrolled at the college.

43. Secondly, the Chiropractic College of Australasia is the principal institution associated with the United Chiropractors' Association of Australia. It is clear that this institution was included to meet local needs.

Discipline

44. Each Australian statute provides the respective registration boards with disciplinary powers: Victoria, sections 13-14; New South Wales, sections 18-23; South Australia, sections 26-32; Western Australia, Chiropractic Registration Board Rules 1966, Rules 11-14. We have taken account of these provisions in formulating the revised disciplinary procedure which we recommend for adoption in this country (see chapter 43).

Conclusions

45. For the purposes of the present inquiry the most important point to emerge from the recent Australian statutes, and particularly the Victorian experience, is the need to involve the medical profession in the operation of the board and the need to involve the Department of Health in the administration of the Chiropractors Act. The discussions we have had overseas have reinforced our view that such involvement is essential in the interests both of the chiropractic profession and of public health generally.

Chapter 15. THE SAFETY OF CHIROPRACTIC TREATMENT

INTRODUCTION

1. In the submissions of those opposed to chiropractic some emphasis was laid on the risks to the patient of chiropractic treatment. Two points were made, which we summarise.

2. In the first place it was said that there are inherent dangers in the physical nature of chiropractic treatment. We were told that the kind of manipulation practised by chiropractors, unless properly administered, can result in serious disability or death.

3. Secondly, we were told that because the chiropractors' training in differential diagnosis cannot compare with the standards of differential diagnosis required by the New Zealand Medical Council, a chiropractic patient is endangered in three respects. If the chiropractor cannot correctly identify the true nature of the patient's disorder, the patient's condition may be worsened by chiropractic treatment. Next, if the patient's disorder is not properly diagnosed, the patient may be lulled into a sense of false security and by accepting chiropractic treatment may delay far too long in obtaining medical treatment appropriate for the real disorder. Finally the chiropractor may correctly diagnose the disorder but may wrongly induce the patient to believe that chiropractic rather than medical treatment provides the better answer.

4. Those are in essence the risks of chiropractic treatment as we were led to understand them. But what is the position in practice?

DIFFERENTIAL DIAGNOSIS

5. We should first say a further word about differential diagnosis. It is clear that a particular symptom may indicate the presence of more than one disorder. That is common medical experience. The doctor's task in differential diagnosis is to decide which disorder is causing the symptom. Unless one is experienced in differential diagnosis the wrong disorder may be identified. If the symptom is back pain, that may indicate either a disorder of the spine which can respond to chiropractic manipulation, or it may indicate the presence of tuberculosis or cancer which will require medical treatment, or the pain may be referred to the back from another part of the body.

6. Now it is clear on any view of the matter that at least in theory the standards of differential diagnosis required by the New Zealand Medical Council are inappropriate in the case of chiropractors. There is one simple reason for saying this. A medical practitioner is required to use his diagnostic skills over the whole range of human symptoms and ailments. The chiropractor's position is different. All he is required to do by way of diagnosis is to be able to arrive at an informed conclusion on three points: first, whether spinal manual therapy is ruled out for a particular patient because the attendant risks are unacceptably high; secondly, whether the patient is in fact suffering from a condition which requires medical treatment which he is not getting—the chiropractor need not specify which condition; and thirdly whether the patient's condition is one which

is likely to respond to chiropractic treatment. All this can be reduced to its essentials by saying that the chiropractor needs to know whether it is safe for him to treat the patient and whether he should insist that the patient take medical advice. On this basis whether the chiropractor's training in differential diagnosis would meet the New Zealand Medical Council's standards is irrelevant.

7. That is the position in theory. But there is a difficulty in practice. Can a chiropractor be relied upon to identify a condition which calls for medical treatment? Moreover, can his confidence in the efficacy of chiropractic treatment distort his judgment so that he starts chiropractic treatment or persists in it when on any objective view of the matter some other form of treatment or management is indicated?

THE CHIROPRACTOR'S JUDGMENT

8. The question we have asked immediately above is, we think, a crucial one. What is the New Zealand experience?

9. A few cases of chiropractic over-enthusiasm were brought to our attention. They were mainly cases where chiropractic treatment was continued after the stage had been reached where it had become apparent that the treatment was ineffective.

10. But one case outside this class caused us concern. It was the case of a very young baby who was being treated for jaundice in hospital. The parents, who were both strong converts to chiropractic, were worried about the child's apparent lack of response. So, with the encouragement of their chiropractor, who had not then seen or examined the child, they insisted on removing the baby from hospital so that it could be given chiropractic treatment. They did this against the strong advice of the doctor in charge of the case. We are aware of the chiropractor's part in the matter, because a letter he wrote to the hospital, supporting the parents' position, was produced to us. Fortunately the child recovered, and naturally the parents and no doubt the chiropractor believed that their decision had been vindicated. We cannot see how chiropractic treatment could possibly have benefited the child; indeed we say that the removal of the child from specialist hospital care in the circumstances could have had very serious results, and we think that the chiropractor acted improperly in supporting the parents in their proposal to remove the child.

11. This was a case which in our view clearly creates no confidence in the judgment of the chiropractor concerned. Other chiropractors who gave evidence before us and who were asked what they would have done in such a case responded immediately that they would not have touched it.

12. Although this may have been an isolated case, we draw attention to it because it represents a situation which should never be allowed to arise. Chiropractors cannot be surprised if such a case tends to give all of them a bad name. This type of situation is capable of discouragement by disciplinary action.

CHIROPRACTIC SAFETY

13. We are satisfied that chiropractic treatment in New Zealand is remarkably safe. By the very nature of this inquiry, and bearing in mind who were the principal parties taking part in it, we find it reasonable to suppose that any known cases of harm caused by chiropractic treatment in this country would have been brought to our attention. We learned of

only three. One was outlined to us in a confidential submission and we interviewed the patient concerned in private. Another was brought to our notice by the Consumer Council: the patient had written to the council some years ago, but had since died. The third case was referred to in a letter by an Auckland surgeon which was produced to us. A fourth case was referred to in the evidence of one of the medical witnesses, but after further enquiries the witness frankly conceded that the details of the case were not as he had thought they were, and he very properly retracted his evidence.

14. Even if we were to assume that the three cases we have mentioned demonstrated inadequacy on the part of the chiropractors concerned—and we are not satisfied that this is necessarily so—these three incidents cannot possibly be regarded as sufficient evidence to warrant the conclusion that chiropractic treatment in general involves serious risks to the patient. One medical witness under cross-examination (Transcript, p. 1785) went to the length of saying—

It was better to have 1000 patients in this country putting up with their migraine without going through the process of cervical manipulation—rather than have one patient paraplegic, or close to it. . . . Q: Do you say that all spinal manipulative therapy should be stopped because of the risks to the patient that exist from the procedure? A: I must be frank with you. I could see no harm in following the course you suggest, none whatever. Q: Do you advocate it? A: Indeed I do.

We are unable to accept this as a realistic or reasonable view.

15. Tens of thousands of patients have gone through chiropractors' hands in this country. They have apparently suffered no ill effects. We have no doubt that every effort was made to locate verifiable cases of harm caused by chiropractors. The conspicuous lack of evidence that chiropractors cause harm or allow harm to occur through neglect of medical referral can be taken to mean only one thing: that chiropractors have on the whole an impressive safety record.

16. From this two points emerge. First, it seems clear that the New Zealand chiropractor's training in differential diagnosis is adequate for his purposes. He is not trained to the standards required by the New Zealand Medical Council, but he need not be.

17. Secondly, we are satisfied that the manual therapy offered by chiropractors is carried out with every effort at safety and in most cases with refined skill and judgment. We saw a number of demonstrations of chiropractic manual therapy techniques and were generally impressed with the obvious skill and control that were used. We have no doubt that the chiropractor's training adequately equips him to carry out his techniques without harm to the patient.

18. We are therefore satisfied that chiropractors in this country are generally careful and skilled. They are capable of carrying out their treatment with safety to the patient. There must of course always be the case where something goes wrong despite every reasonable precaution. That is a hazard of every technique or occupation. The medical profession itself does not claim to be immune from it. But with that reservation, our finding is that there is no unusual degree of risk to patients who undertake chiropractic treatment from a registered chiropractor in New Zealand.

Chapter 16. PATTERNS OF PRACTICE IN NEW ZEALAND

INTRODUCTORY

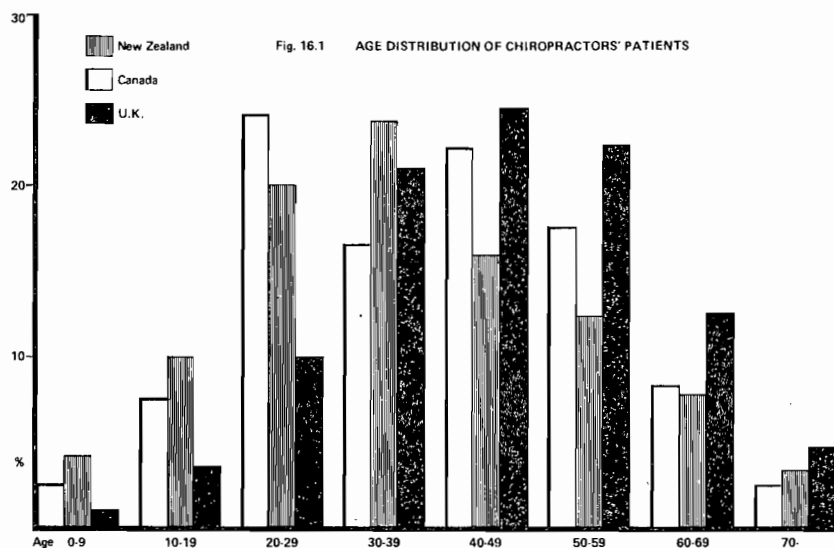
1. The New Zealand Chiropractors' Association conducted two surveys during the early part of 1978 and presented the results to the Commission. The first was a survey of new patients seen during a 3-month period. The second was of the chiropractors themselves. While both surveys were conducted at short notice and aspects of the design are open to criticism, the results nevertheless provide useful background information on New Zealand chiropractors and their patients. The Commission has no reason to doubt that the information provided by the chiropractors in both these surveys is correct.

THE NEW PATIENT SURVEY

2. The new patient survey covered all new patients seen by association members during the period 1 March 1978 to 31 May 1978. It was conducted by means of a standard questionnaire which the chiropractors were asked to complete for each patient whom they had seen *for the first time* during this period. Questionnaires were returned by 61 of the total 74 practising members of the association. The number of patients surveyed was 4609 out of a total of 5445 new patients who were actually seen by the participating chiropractors during this period. There is no way of knowing if the patients for whom no questionnaire was returned were selected in any way by the chiropractor concerned.

3. The association coded the information on the returned questionnaires after consultation with staff of the Applied Mathematics Division of the Department of Scientific and Industrial Research. The data were then processed. The more useful results are summarised below and, where appropriate, comparisons are made with the results of surveys of patients in Canada covering ten Toronto chiropractors (H. J. Vear, *J. Canadian Chiropractic Association*, 9-13 October 1972) and in the United Kingdom covering 24 chiropractors (A. C. Breen, *Rheumatol. Rehabil.*; 16: 46-53. 1977). The Commission arranged to have the data further analysed by the Applied Mathematics Division to bring out some points of detail.

4. Figure 16.1 shows the age distribution of the patients of New Zealand chiropractors in comparison with similar distributions among patients in Canada (Toronto) and the United Kingdom. The majority (>70 percent) of patients in all these studies were in the 20-60 age group but in the United Kingdom there are markedly fewer young patients. In the United Kingdom less than 5 percent of patients were under 20 (compare New Zealand 15 percent) and less than 15 percent were under 30 (New Zealand 35 percent.) (The nature of the children's complaints in comparison with the population at large is commented on below.) There are no notable differences in the age-group trends of Canadian and New Zealand patients.



5. The occupations of the patients in eight broad categories are listed in table 16.1. While no precise analysis of this distribution was attempted, it is clear from comparative figures for the total working population that the patients treated by chiropractors are a reasonable cross section of the New Zealand community. This observation is in accord with studies made in the United States (R. Kane *et al.*, *The Lancet*; 29 June, 1333-6, 1974) and in Australia (G. Parker, *Medical J. Australia*, 4 September 373-8, 1976) which showed that there are no marked differences in the socio-economic class distributions of those seeking chiropractic services and those seeking medical services:

Table 16.1

OCCUPATIONS OF CHIROPRACTIC PATIENTS

Comparison with occupational percentage in total work force

Occupation*	Percentage of Patients	Percentage Total Work Force†
Production	27.6	36.5
Agriculture	15.8	10.2
Professional	13.2	14.4
Clerical... ..	11.1	16.2
Sales	10.7	10.0
Service	7.8	7.2
Administration	3.2	3.4
Other	10.6	2.1

*Eleven percent of patients were in the "prework" category. The percentages by occupation therefore refer to only 89 percent of all patients treated.

†These figures obtained from statistics given in *New Zealand Official Year Book* 1978, p. 776.

6. The locations of the major areas of presenting complaints are listed in table 16.2. These are compared with corresponding figures from the Breen (United Kingdom) survey although the comparisons are subject to some uncertainty because the areas of complaint were not described in quite the

same way in both surveys—the descriptions given are those of the New Zealand survey. It should also be noted that most of the United Kingdom patients and about half the New Zealand patients presented with more than one problem area and the percentages in table 16.2 are for the totals.

Table 16.2

LOCATION OF MAJOR AREAS OF PRESENTING COMPLAINT

(The descriptions are those used in the NZCA survey)

Area of Complaint	Percentages	
	N.Z.	U.K.
Lower back... ..	30	29
Neck	18	11
Head	15	7
Lower extremity	10	24
Shoulder and arm	10	15
Thorax	6	5
Pelvis	3	6
General well-being	4	3
Other	4	

7. The table indicates that extremity joint problems figure much more prominently in the United Kingdom than in New Zealand, while head and neck complaints are correspondingly more emphasised in New Zealand. Of the New Zealand patients 41 percent went to the chiropractor as the result of accidental injury.

8. A closer analysis of the areas of complaint shows an interesting age dependence. While the category “general well-being” accounts for less than 4 percent of the total new patient visits nearly 50 percent of patients under the age of 15 attend for that purpose. It was explained to us that these treatments would generally be for preventative maintenance.

9. It is unfortunate that the Commission was not able to link the “areas of complaint” with specific conditions. An ailment like asthma, we were told, would have been assigned to the “thorax” area of complaint. But there is no way the Commission could determine such relationships without a massive checking of the returned questionnaires. The Commission took the view that its resources could be employed on more useful purposes.

10. It is of interest to know where the New Zealand chiropractors’ new patients came from—what previous treatment, if any, they had for their presenting complaint. Table 16.3 summarises this information.

Table 16.3

PREVIOUS TREATMENTS OF NEW CHIROPRACTIC PATIENTS IN NEW ZEALAND

Previous Treatment	Percentage of Patients
Medical only	33.5
Medical and physiotherapy	12.1
Other chiropractic only	7.7
Medical and chiropractic	4.3
Other practitioners	2.0
Physiotherapy only	2.9
Other combinations (including medical)	4.4
No previous treatment	33.1

11. More than half of the patients had first been at least to a medical practitioner and one in six had been to a physiotherapist. However, fewer than 5 percent of all these patients had actually been referred to the chiropractor by any other health practitioner.

12. Table 16.3 shows that about two-thirds of the new patients had previously sought treatment from some other health practitioner. By contrast, the chiropractors indicated that they were unlikely to refer more than 15 per cent of these same patients on to any other health professional. That means that they believed they were competent to handle the great majority of the cases without further specialised assistance.

13. One question the chiropractors were asked in their questionnaire was "How many visits are likely to be needed?" Responses to this question are summarised in table 16.4

Table 16.4
HOW MANY VISITS CONSIDERED NECESSARY

<i>Number of Visits</i>	<i>Percentages</i>
1-3	9
4-6	29
7-9	23
10-12... ..	26
13-15... ..	6
>15	7

Variations Among Chiropractors

14. While the tables we have given indicate overall trends they do conceal some important individual variations. For example one category of "area of complaint" extracted from the questionnaires was "abdomen". While this category accounts for less than 1 percent of all complaints for the chiropractors as a whole (it is included within "other" in table 16.2), 23 percent of these patients come from just 2 chiropractors of the 61. It would seem that these chiropractors may have a reputation for the treatment of Type 0 complaints. Again, while "general wellbeing" accounts for only 4 percent of all new patient treatments, for one chiropractor it accounts for 22 percent of his practice.

15. It was possible for us to identify these individual variations, and the chiropractors concerned, because each questionnaire form was coded with an identification number for the chiropractor and the Chiropractors' Association provided us with the key.

PROFILE OF CHIROPRACTOR: THE SECOND SURVEY

16. For the second survey every practising chiropractor, whether or not an association member, was issued with a questionnaire containing 51 questions. These were coded and analysed manually by members of the association. Many of these were more especially of domestic concern to the chiropractors themselves but some were of considerable interest to the Commission. There were questions covering the number of patients seen during the preceding 12 months, the duration and nature of consultations and the fees charged. Because only 57 (59 percent) of the practising chiropractors returned the questionnaires, the answers cannot be assumed to be fully representative. However, the picture of the average chiropractor which emerges is that he was trained in North America,

probably at Palmer College in the United States, he is between 25 and 50 years of age, runs his own practice, has over 30 hours per week contact with patients, and has well-equipped offices and treatment rooms and his own X-ray facilities. The "average chiropractor" sees about 150 patients per week of whom 7 are new. He spends 15-30 minutes on the initial consultation and 5-10 minutes on succeeding consultations.

17. The "average patient" will visit his chiropractor 12 times a year. The most usual fee for a treatment is \$5 and most chiropractors charge an additional \$5 or more for the initial examination. In most cases there is an additional charge for after hours or house calls and reduced charges for children and pensioners. Charges for X-rays are additional to the above and are variable. Most chiropractors charge "per examination" between \$20 and \$25 but a substantial number charge instead "per plate", the most usual plate charge being \$5.

Chapter 17. CHIROPRACTORS AND X-RAYS

X-RAY AS ADJUNCT TO CHIROPRACTIC TREATMENT

1. A chiropractor will hardly ever treat a patient until he has first taken a radiograph of the patient's spinal column. Most chiropractors have X-ray equipment in their rooms. The chiropractor can therefore make immediate physical and X-ray examinations at the one visit.

2. The chiropractor insists on an X-ray for three reasons. First, to satisfy himself that there are no contra-indications to manual therapy; secondly to help him identify the "area of involvement" if there is one; and thirdly, so that he can assess the direction and force of the adjustment that is going to be required: see also chapter 9. An X-ray can therefore be regarded as a necessary adjunct to chiropractic treatment.

3. The first reason is obviously an important one. It is essentially for the protection of the patient. It may go part of the way towards explaining why chiropractic treatment appears to be safe. It removes one element of risk.

4. The third reason is also important. Dr Scott Haldeman, a neurologist who trained as a chiropractor, told us (Transcript, p. 3357) that the clinical experience of chiropractors over the years had—

... led them to the conclusion that if they give their manipulation, their adjustment, in a direction indicated from the X-ray, that they are likely to be able to give the adjustment with less force, less dramatically, less painfully and with better effect than if they do not use the X-ray.

And Dr T. R. Yochum who is a specialist in chiropractic radiology gave evidence to the same effect (Transcript, p. 3182). We understood all the chiropractors who gave evidence and who were asked about the point to agree substantially with those views.

5. The second reason for the use of X-rays as an aid to the identification of the "area of involvement" needs further explanation. Unless the subluxation (see chapter 9) involves a degree of bone displacement it will not be detectable as such on a static X-ray. It is likely to be positively identified by motion palpation: the chiropractor's fingertips will assess the mechanical action of the vertebral segments and detect any abnormality of action and motion and any muscular involvement. The purpose of the X-ray, then, is in this respect not so much to identify the subluxation as such, but the area where it is likely to be.

6. On all the evidence we find that the X-rays taken by chiropractors serve useful diagnostic and clinical purposes. We dismiss any adverse inferences arising from the fact that expert medical radiographers do not attach the same significance as chiropractors do to what appears on the X-ray plate. It is also important to note that the chiropractor's equipment is rigged so that the patient's spine is in a normal upright position when the exposure is made. Most medical radiographs of the spine are taken with the patient in a prone position. There will therefore be differences in what the respective radiographs show.

WHAT THE PATIENT IS SHOWN AND TOLD

7. It was suggested by those opposed to chiropractic that the X-ray is used by chiropractors as a device to convince the patient that there is a

subluxation to be corrected. As counsel for the Medical Association said in his closing address (Submission 135, p. 51):

... one thing is clear: the chiropractor has successfully conveyed the notion that there is some tangible condition, some defect of the spinal column, something undetected by the medical profession, which the chiropractor with his special skills has revealed.

He then went on to say:

I remind the Commission that the vast majority of spines show some misalignments no matter how slight on X-ray film. There is almost invariably something for the chiropractor to show the patient. The conclusion is irresistible that the X-ray film is used to implant the notion of the subluxation. The patient is then ready to be convinced that it is the chiropractic subluxation which may be the cause of his symptoms because of its pervasive influence on the nervous system. The suggestion is at the same time both simple and attractive. It is the first and most important step in the operation of the chiropractic placebo, an essential element (perhaps the only element) of the efficacy of chiropractic.

8. The point made by the Medical Association may perhaps be stated in a more direct way: a subluxation which cannot be demonstrated on a static radiograph is something that exists only in the chiropractor's imagination. However, the chiropractor has to have some way of convincing his patient that he is fixing a real, not an imagined, defect. He will therefore tell the patient that a feature in the radiograph which to a medical practitioner would have no clinical significance, is really a misalignment. He will then purport to correct it, thus inducing the patient to believe he is cured. In other words the whole operation is a confidence trick.

9. It will have become obvious that we are not prepared to take that view of the matter. But at the same time the way in which chiropractors use their radiographs in the presence of patients can clearly lead to misunderstanding. Nearly every patient who gave evidence before us and who was asked about the matter deposed that when he or she reported for treatment the radiographs were on view. Many told us that the chiropractor pointed out the problem area: some told us that they could see for themselves on the radiographs that there were "bones that did not seem to line up" (Transcript, p. 797), "... neck bones, jammed down into one another" (Submission 111), and so on.

10. Now radiographs are not easy to interpret. In the course of this inquiry the commission was shown many radiographs which were said to demonstrate some abnormality. It is clear that it takes both an expert mind to know what to look for and an expert eye to detect what can truly be regarded as an abnormality. We can see how easy it would be for an uninformed patient to believe that he was looking at a point of abnormality. So it would be a simple matter for a chiropractor to capitalise on the ignorance of a lay patient.

11. We have no difficulty in accepting that it may often be desirable for the chiropractor to have the X-rays displayed in the presence of the patient as an aide-memoire and as a guide to the kind of manual therapy he will find it necessary to administer. It may well be that the chiropractor, in order to satisfy the patient's natural curiosity, will point to the area he proposes to treat and explain in simple language what he hopes to correct. There is nothing sinister in that. It may be that the X-ray is referred to as a means of reassuring the patient—using it as a talking point to put him at his ease. Every health practitioner knows the value of such an approach which is perfectly reasonable. But the evidence of many patients indicated that chiropractors sometimes go further and fall into the temptation of using the radiograph in a manner bordering on the unprofessional and even dishonest. Many patients clearly came away

from their treatment with the impression that bones which they believed the radiograph had shown to be "displaced" had been "put back into position". This we understand to be an extremely rare event.

12. We accept that chiropractors need to take X-rays and that they may frequently be of great value as an aid in diagnosis and/or mode of treatment. The possibilities for unprofessional use however are great and we think that the New Zealand Chiropractors' Association should be at pains to make their ethical stand clear on this subject and to provide for adequate disciplinary measures.

13. While the Medical Association was acting responsibly in being highly critical of chiropractors who overplay the role of the X-ray for their patient's benefit, we find their blanket criticism of the chiropractic X-rays a sweeping over-generalisation.

THE LAW

14. Chiropractors are licensed to use X-ray equipment by the Department of Health pursuant to the Radiation Protection Act 1965, sections 16-22. The department is advised by the Radiological Advisory Council, a statutory body set up under section 5 of the Act. A code of safe practice, applicable to chiropractors, and prepared by the Department's National Radiation Laboratory, was issued by the Department in February 1979. The Department has power to issue such a code: see Radiation Protection Regulations 1973 (S.R. 1973/48), Regulation 27.

AREAS OF CONCERN ABOUT CHIROPRACTORS AND X-RAYS

15. The Department of Health expressed to us two areas of concern regarding chiropractic X-rays.

16. In the first place it was said that a chiropractor cannot be regarded as having the expertise of a medical radiologist, whose field naturally includes the whole range of radiology for medical purposes. We accept that; but we accept also that chiropractors have sufficient expertise for their own limited purposes, just as dentists have sufficient expertise for theirs. No question of safety was raised.

17. Secondly, the Department of Health told us that the Maternity Services Committee had expressed concern about chiropractic X-rays of pregnant women in 1976 and again in 1978. The 1979 National Radiation Laboratory Code now lays down what must be taken to be sufficient standards of precautions in this respect, and we therefore need say nothing further about it.

18. We should add that much was made of the first point by the Medical Association in its general submission. The association pointed to what were said to be the policies of the American Chiropractic College of Roentgenology and the Radiological Consulting Committee of the American Chiropractic Association, and said (Submission 26, pp. 138-9):

The modern chiropractor is trained to practise as a community radiologist; no longer restricted to the concept of vertebral subluxation and its demonstration by the traditional '14 inches by 36 inches type of radiograph', the scope of his diagnostic training is widened to include other body systems, training which is designed to promote his image as a diagnostician and further his acceptance as a primary health-care provider.

Neither the New Zealand Medical Association nor the New Zealand Branch of the Royal Australasian College of Radiologists sees the risk of chiropractic diagnostic radiology as a technical issue: the quality of the chiropractor's equipment, the standard of his radiography—much less the size of his radiograph—count for nothing by comparison with the quality of his training. The quality of that training must be matched against its medical equivalent, the example of the medical practitioner who, in addition to his undergraduate and post-graduate medical studies, has undertaken specialised training in

diagnostic radiology; who holds a hospital appointment with the provision of continuing post-graduate education in his speciality; who has undertaken research, and contributed scientific papers to journals of international standing.

The Medical Council of New Zealand recognises certain standards of education in the case of medical practitioners who specialise in diagnostic radiology: the training of chiropractic roentgenologists fails to meet those standards. It is the chiropractor's training (or lack of it) which is the principal hazard of chiropractic Roentgenology, not gratuitous radiation.

19. We do not accept this as a realistic assessment of the position in New Zealand. The New Zealand chiropractor takes his radiograph for limited purposes: to identify contra-indications to chiropractic treatment, to identify "areas of involvement" in the spinal column, and to indicate the nature of the manual therapy required in the particular case. It is within this limited context that the chiropractor's radiographic training should be judged. Our impression is that the chiropractor is at least as well-trained in this limited area as the medical radiologist. There is no evidence that would justify us in believing it likely that New Zealand chiropractors are going to set themselves up as general specialists in diagnostic radiology or as "community radiologists", or that the powers of the Department of Health under the Radiation Protection Act 1965 are inadequate to prevent that happening.

CHIROPRACTORS AND MEDICAL X-RAYS

20. With a very few exceptions which are unimportant, medical X-ray facilities are confined to the rooms of practising specialist radiologists and to hospitals.

21. Bearing in mind that it must be accepted as desirable that a patient be exposed to as little radiation as possible, what is the position when a chiropractor accepts as a patient a man or woman who has already had medical treatment, including a medical X-ray? One would think that the first consideration would be to avoid a chiropractic X-ray if the films already taken were adequate for the chiropractor's purposes. And what is the position if a chiropractor, seeing a patient who has not previously had a medical X-ray, feels that a specialist X-ray would be warranted to assure himself that there are no contra-indications?

22. As we understand the position, medical practitioners will not release medical radiographs for inspection by chiropractors. Radiologists will not accept patients referred to them by chiropractors.

23. What are the reasons for these attitudes?

24. On the first point—the refusal to release to chiropractors existing medical radiographs—we found it difficult to secure an explanation. The nearest we came to one was in the course of our meeting in Vancouver with officers of the British Columbia Branch of the Canadian Medical Association. We were told that the reason medical radiographs are not released to chiropractors is that chiropractors might misinterpret them. We inquired how the risks to the patient of a chiropractor misinterpreting the radiographs might be balanced against the risks to the patient of further exposure to radiation because of the need for the chiropractor to have an X-ray; but all we could obtain by way of answer was that chiropractors should not take X-rays anyhow!

25. If this attitude fairly reflects the position in New Zealand, then we find it unsupportable. Chiropractors are entitled by law to take X-rays. We are satisfied they are a necessary diagnostic and clinical aid. Patients should be exposed to as little radiation as possible. If there are in existence medical X-rays which might be useful for the chiropractor's purposes,

then we consider the medical practitioner who has possession of them should in the patient's interests make them available. A refusal to do so means that the patient is exposed to more radiation than necessary. It is a problem created by the medical profession. The medical profession can and should solve it by putting the patient's interests first.

26. The attitude of radiologists who refuse to accept referrals from chiropractors is no more firmly based. A referral will be made only because the chiropractor requires a more expert diagnosis than his own. The radiologist's refusal to co-operate does not harm the chiropractor, but it could harm the patient.

27. We discuss the broader ethical issues in a later chapter.

Chapter 18. THE IMAGE OF CHIROPRACTIC

THE NEW ZEALAND CHIROPRACTOR

1. New Zealand chiropractors see themselves as established members of our health care system. The first chiropractor began practising in this country in 1911, 2 years before the death of Daniel David Palmer. New Zealand, therefore, did not have particularly primitive beginnings in this field. The professional association, the New Zealand Chiropractors' Association, was formed in 1922. Chiropractic was registered in 1960 and there are 94 chiropractors holding 1978-79 annual practising certificates. Figures 18.1 and 18.2 show their distribution throughout the country.

2. In spite of opposition, chiropractic has attracted tens of thousands of patients, many of whom consider they have benefited from its services. In 1975 there was a petition for the further recognition of it by the State, and more than 12 000 people wrote to this Commission.

3. Chiropractors accept responsibility for their patients and would like to see them receive some subsidy from Government sources. They recognise that at present, in order to avail themselves of chiropractic services, many patients must make sacrifices. Chiropractors cannot accept that their work is not worth a share of the funds allocated to health services. They are prepared to fight for this, and they support their association's efforts and those of the Patients' Association for Chiropractic Education (PACE) formed in Porirua in 1974.

4. All New Zealand chiropractors have been educated overseas, most in North America. Most were born in New Zealand, and naturally they would like to see chiropractors educated here. This is obviously impossible because of the limited numbers, so they have supported the setting up of the International College of Chiropractic in Australia. Leaders in the association, notably Dr L. C. Mudgway, have spent time and money on helping this project. We deal with this later.

5. If we look at the chiropractors as we have seen them in the course of this inquiry, they emerge as responsible members of our society. It is as difficult to type them as it would be to type general practitioners or physiotherapists. However, it is possible to say something about their motivation and the view they take of their status in the community.

6. Unless, as in some cases, they have previously followed some other career, chiropractors can, on their return to New Zealand, still be very young, perhaps 23 years old. After at least 4 years' study overseas they have knowledge, skill, and a D.C. degree (doctorate of chiropractic) to prove it. Most have been exposed to North American values and cultural patterns. They are eager to put their ideas into practice, eager to serve people but also to make good. Their parents have possibly sacrificed in order to send them overseas. Until they are 24 years old they can have provisional registration only, so they usually make arrangements to work with an established chiropractor for at least a year, often longer.

7. They learn much from observation of their older colleagues. They acquire further clinical experience and begin to see their role in health care. Their patients like their enthusiasm and up-to-date approach and are reassured by the presence and supervision of the older chiropractors. The system appears a good one.

Fig.18.1 NEW ZEALAND. NORTH ISLAND

Distribution of Chiropractors, 1979
 No. of Chiropractors with Current Practising Certificates, 76.

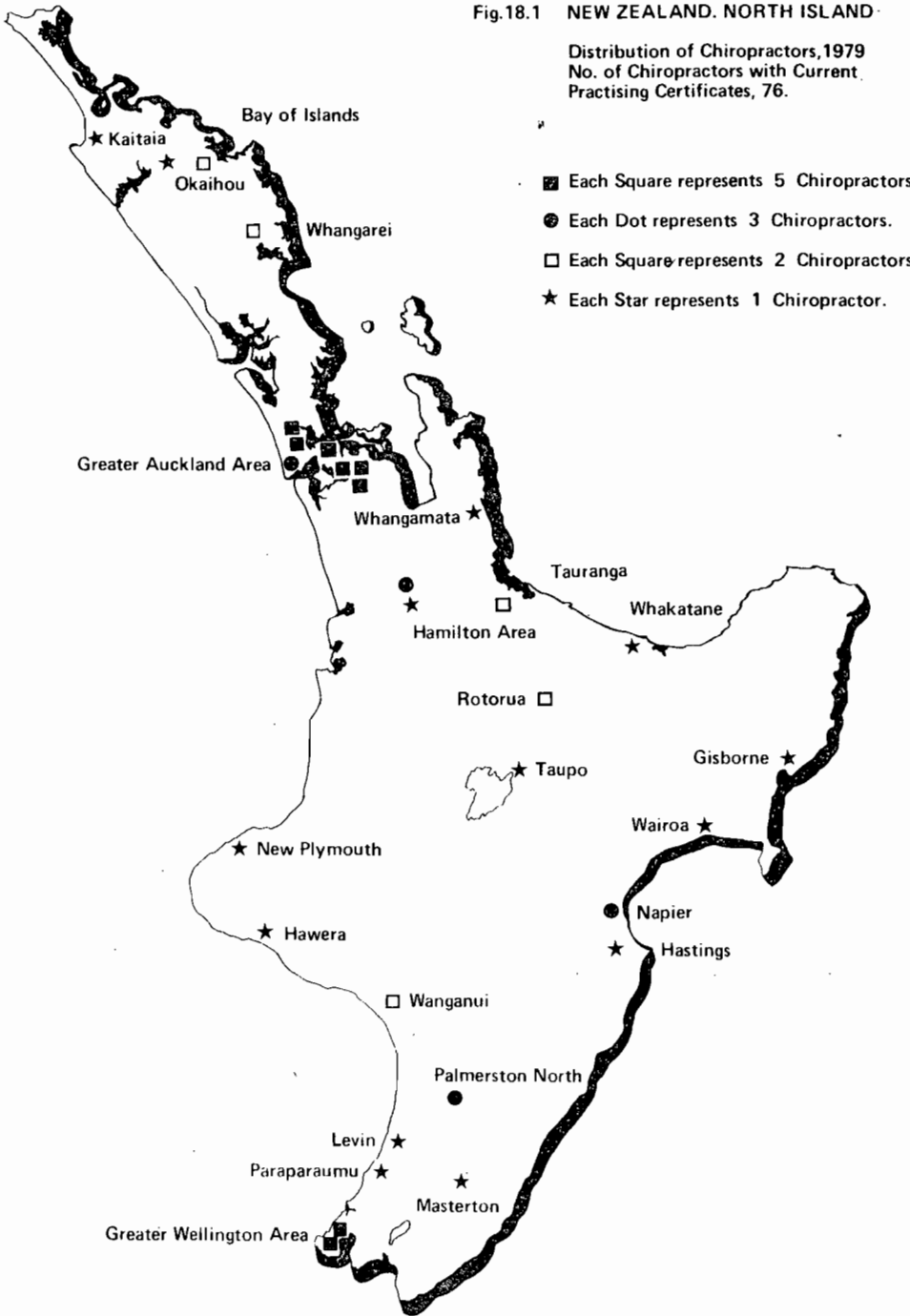
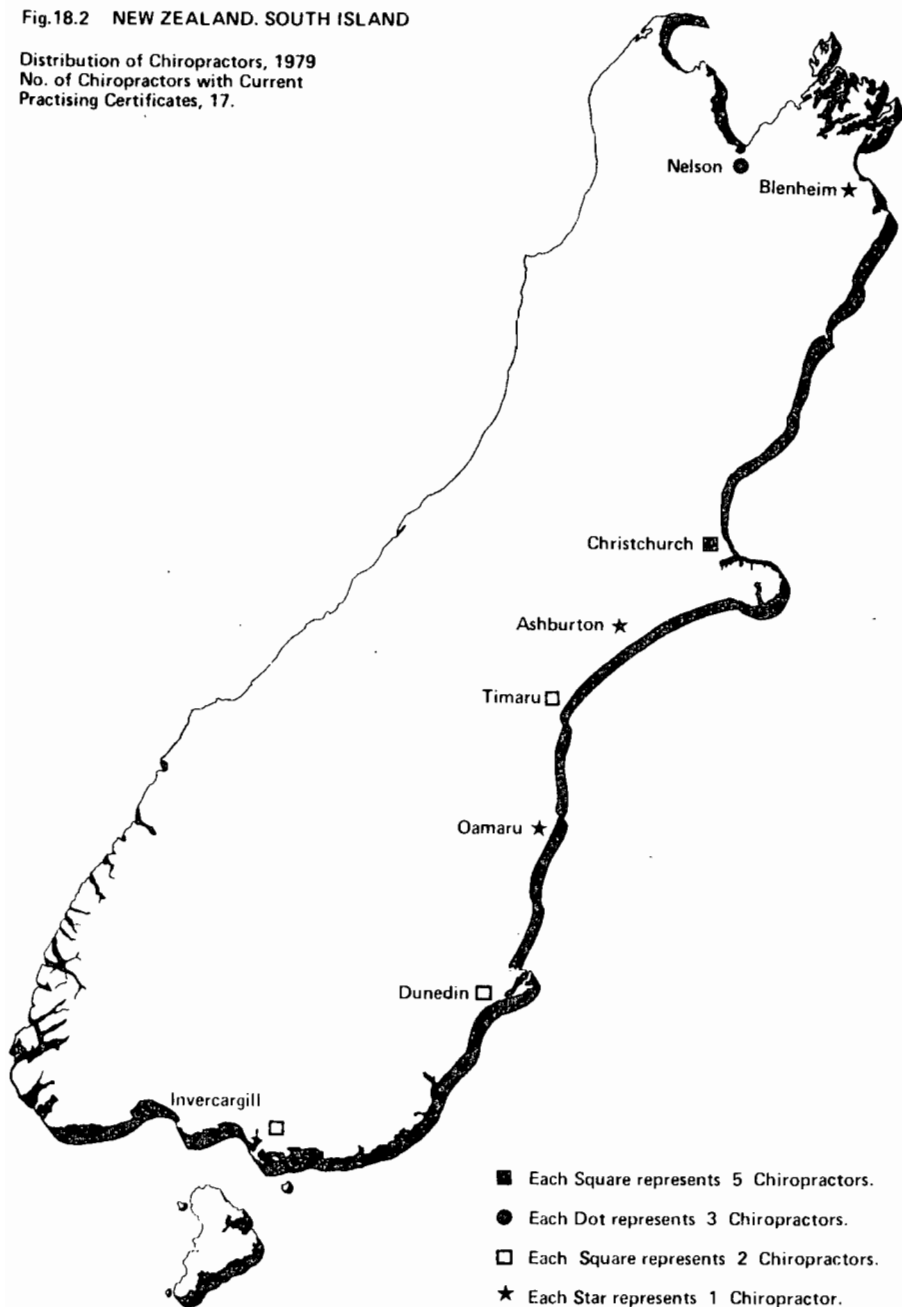


Fig.18.2 NEW ZEALAND. SOUTH ISLAND

Distribution of Chiropractors, 1979
 No. of Chiropractors with Current
 Practising Certificates, 17.



8. They are well aware that some people are not convinced of the worth of chiropractic. They often became chiropractors because they admired some particular practitioner and were prepared to discount the strength of the criticism. In the United States they have seen the powerful chiropractic lobby in action against other powerful forces and have seen the success that attended its effort. They have seen a whole range of pamphlets and advertisements designed to make the public aware of the merits of chiropractic.

9. To their dismay, young New Zealand chiropractors find that they do face opposition here. They encounter hostility in some quarters. Their colleagues shrug their shoulders and say they will get used to it. They point to their thriving practices, well-appointed rooms, their financial security. Their senior colleagues also point to the range of pamphlets displayed in reception areas, there to spread the message of chiropractic.

10. By the time the young chiropractors have their own practices, their first fine enthusiasm may have waned a little, but they believe even more in chiropractic because they have seen it work so often. They are not always sure why it works and the reasons given at college seem rather shadowy and frankly unimportant. They get on with the job.

11. They are genuine in their belief that they are trained professionals who have something unique to offer patients. They can help ease pain and discomfort. They consider they are quite capable of deciding whether to treat a patient themselves or to refer him elsewhere. They therefore regard themselves as primary health care providers.

12. They maintain that they do not want to be confused with medical practitioners. They speak of their "office" rather than their "surgery" or their "rooms". Many of their patients call them by their first name. This fits in with their idea of themselves as approachable, friendly people.

13. It is true chiropractors would like to regard themselves as having equal standing in the community with the general practitioner but in many cases they have been so firmly rebuffed that they are on the defensive. It is true that they may play golf with one or two medical men but some subjects are not mentioned. It is true that they have patients who have unofficially been told to see them by a general medical practitioner. Sometimes they even have doctors, their wives, or children as patients. Yet chiropractors still feel that they have to fight any possible attacks on chiropractic. They still feel they have to "sell" what they do.

14. They are affluent. They enjoy their work. They are respected in their community. Some are prepared to take responsibility in local body work and in sports administration. They are regarded as good neighbours, good family men. Their patients, in many cases, have become friends. Often, in cases of hardship, they waive their fees.

15. Usually they do not see themselves as cultivated, but they have been at pains to improve their powers of communication. They make a good speech in public, they can explain clearly to patients and inquirers what they are trying to do. Usually they belong to the New Zealand Chiropractors' Association although a number prefer not to be involved and feel no obligation to belong. They all know that they stand or fall as a "good" or "bad" chiropractor to an extent not known to medical practitioners. That is because they are on the fringe: they feel they have to earn their reputation as individual practitioners. This has made them consciously more concerned with their personal image than are medical practitioners. Hence the somewhat defensive attitude; the emphasis on public relations.

16. All in all, New Zealand chiropractors, as we have observed them, bear the stamp of their calling. They have a seriousness of purpose and a stability that invite comparison with the medical profession. Yet the latter officially still hang the charlatan label on them. This makes chiropractors resentful and causes them to feel threatened. At such times either they retreat somewhat from community involvement or they look to North American chiropractors and take a leaf from their book. They order some more pamphlets, even some the association has banned. These pamphlets find their way into the community and perpetuate the idea that chiropractors behave in an unethical way. We examine now some of those pamphlets.

CHIROPRACTIC PAMPHLETS

17. The pamphlets at present approved by the association are simplistic but not deliberately misleading. Some other local material and also much North American material appear objectionable in New Zealand eyes. We do not expect our professional men to advertise. They are allowed a small card. North Americans may have a different point of view, but there are different cultural patterns. We dislike seeing propaganda, subtle or unsubtle, in favour of chiropractic. We dislike the hint of blackmail, of making money out of people's fears. We forget our "good" chiropractor who has given an honest effective service for many years and see him as a dangerous quack. He is still the same sensible professional man he has always been but he has been goaded into what is stupid behaviour in the New Zealand setting. His fellow chiropractors are too uncertain themselves and do not make their disapproval felt. He needs the help of more discipline imposed from outside. We will be making recommendations about this. Left to himself he could well err again and produce advertising that may be in some people's eyes, in the words of one United States statute regulating professional advertising, "untrue, fraudulent, misleading, deceptive, flamboyant or unprofessional".

18. We have had produced to us during our inquiry pamphlets and publicity material issued relatively recently by a few New Zealand chiropractors which cause us considerable concern. We will outline some of them.

19. The first is a pamphlet entitled *What is Chiropractic?*. The copy exhibited to us bears the imprint of a Palmerston North chiropractor. It contains the following statements:

We have seen that (1) disease is primarily an abnormal function in some organ or tissue of the body, and (2) activity in organs and tissues is influenced, directly or indirectly, by the nerve system. Therefore, normal unimpeded action of the nerve system is a basic necessity for health. Interference with normal action of the nerve system constitutes a basic cause of disease.

The purpose of chiropractic care is to free the nerve system of interferences with its normal action, thus removing a basic cause of disease.

Conditions develop in the lives of most people when chiropractic care would effect a quicker and more complete restoration of health. The history of chiropractic is replete with instances when people recovered health through chiropractic after other methods had failed.

It is possible that thousands of people in every country who are seeking health, seemingly in vain, could have health through chiropractic care. They fail to seek that care because, while they know the avenue of approach of chiropractic (the spinal column), they do not have a full understanding of its purpose—to restore normal action to nerves which influence function in all organs and tissues of the body.

20. The second pamphlet is entitled *This May Answer Your Question*. The copy exhibited to us bears the imprint of an Auckland chiropractor. Parts of it read as follows:

By consulting us you have chosen a new road to health. You have made a radical change to regain your health—just as more than 30 million satisfied chiropractic patients have done.

The person who can most easily understand that a house is in danger of collapse when its frame is out of line; or that the function of an automobile will prove defective and dangerous if its supporting structures are bent and distorted, and its movable parts out of alignment, can understand as well that bent and twisted body frameworks cause ailments throughout the entire body.

The practice of chiropractic is as broad as the nervous system, which controls ALL organs, glands and tissues of the body. Therefore, modern chiropractic is applicable to a wide variety of dis-eases [sic] which affect the human body and mind.

21. Other publicity material consists of standard form letters sent out to new patients. On 14 October 1977 an Auckland chiropractor sent out such a letter to a new patient containing the following statements:

Chiropractic is an exact science based on Nature's own laws. It is founded on the proven fact that the nervous system holds the key to all health. Chiropractic, therefore, deals entirely with the nervous system, in order to correct the cause of disease.

So long as nerve impulses are flowing freely throughout the entire nervous system, the entire body must be healthy. That is Nature's recipe for health. Sickness starts when anything interferes with the flow of this vital nerve energy. Examinations made of millions of patients by Chiropractors throughout the last half century show that the most common cause of such interference is a misaligned vertebra in the spine.

Our efforts in the — Chiropractic Clinic are directed toward the location and correction, through adjustment of the vertebral displacement or displacements which are causing neurological interference and manifesting themselves in ill health.

22. Attached to the letter was what was described as a "Chart of the Nerve System (Your Health Source)". There is a diagram of the spine, with each vertebra labelled. Various disorders are identified on the chart as being related to "pressure on, or interference with" nerves associated with the labelled vertebrae. Hence the reader is able to see from the chart that attention to vertebra 8D will have some connection with his leukemia or hiccoughs, whereas attention to vertebra 3C may relate to his acne or pimples. Attention to vertebra 1L may relate to his hernia. At the foot of the chart the reader is told that:

Only the commonest conditions and diseases are listed above. It is suggested that you consult your Chiropractor in regard to anything not found on the chart.

23. We must add that according to the evidence of some chiropractors who appeared as witnesses no modern chiropractor could possibly take such a chart seriously. That does not surprise us. We doubt whether many members of the public would take it seriously, but the danger to credulous people needs no emphasis.

24. Another Auckland chiropractor sent a printed brochure to a patient on 14 March 1978. One page, headed "Help Yourself to Better Health", contains the following:

No matter what the complaint may be, always consult your Doctor of Chiropractic first. Do not hesitate to call him should your illness be of such a nature as to prevent you visiting his clinic. If yours is not a Chiropractic case, he will readily refer you to another type of therapy. If you try other therapies first and your case happens to be a Chiropractic case, you may never be referred to a Chiropractor. In order to procure his diploma, a Doctor of Chiropractic has to have knowledge of other healing sciences. Practitioners of other therapies are required to know NOTHING about Chiropractic. Therefore, regardless of their sincerity, they are not apt to refer you to a Doctor of Chiropractic.

And passages on a further page, headed "To the New Patient", read as follows:

Nerves carry the nerve impulses from the brain to every part of the body. Every cell of the body receives nerve impulses either directly or indirectly by way of the nerves passing through the spine. It is estimated that each one of the large nerve cables leaving the spine carries some 300,000 minute nerves. Pressure on these nerves caused by a misalignment of the spinal vertebrae produces an interference to their normal function and results in a decreased nerve impulse supply to the organs of the body. When the nerve impulse supply

fails to reach the organ in full strength, the organ becomes sick and begins the process of dying.

The Chiropractic adjustment of the spine is designed to correct the misalignment and remove the pressure from the nerves. Normal life then returns to the organ in exact ratio to the return of normal nerve impulses.

25. We have also had placed before us material which an Auckland chiropractor sent to one of his patients. It is a printed form headed "Confidential Report of Chiropractic Examination and Recommendations". It is dated 11 October 1978, so it was sent out while this inquiry was in progress. The form of the report bears the imprint "Form No. 145, Parker Chiropractic Research Foundation, 1975. Litho. in U.S.A.". We shall have more to say of the Parker Chiropractic Research Foundation later.

26. The form contains the following statements:

We have now completed your initial examination and find that your condition comes within the range of chiropractic care. Therefore, this report, together with our recommendations, is given to you for your consideration. But first, may we explain to you something about how your body functions and how chiropractic can not only help many conditions, but more importantly restore and maintain health . . .

Every science of healing has what is known as an 'avenue of approach'. In medicine, the physician injects drugs via a hypodermic needle through the skin; he prescribes a pill to be swallowed, which goes into the stomach. Yet there need not be anything wrong with the skin or the stomach. These are but 'avenues' through which the drugs gain access to the body.

Now, for the Doctor of Chiropractic, the 'avenue of approach' is primarily the SPINE because it houses and protects the spinal cord—the 'switchboard' of the nervous system through which nerves pass from the brain as they carry nerve supply to all parts of the body. The nerves branch off the spinal cord through openings between the movable spinal bones (or vertebrae). When these vertebrae are out of alignment there can be interference with the normal activity of the nerves. This interference can disturb normal function throughout the body and cause many diseases. Today's highly-trained Doctor of Chiropractic has spent thousands of hours—six years or more of college—earning his doctorate. He has had extensive clinical experience with the human body and how to take care of it without drugs or surgery.

Most conditions of pain or ill health are the result of some underlying cause within the body which first must be found before correction can be effected, pain relieved, and health restored and maintained. Chiropractic has developed special techniques for locating the real, fundamental, original *causes* within the body which prevent natural health, and for correcting them so that normal, *natural* body functions may be restored to all the organs, tissues, and cells of the body. . . .

27. Attached to the report are "Special Notes (For Better Understanding of Your Chiropractic Health Care)". Among the "Special Notes" are the following:

We will endeavour to clear your nerve channels with the proper spinal adjustments at the proper time. Please do not try to help things along with self-administered 'remedies' which, instead of helping may prove harmful. Please ask us first.

Bring your children in for check-ups. Don't wait until they are desperately ill before they receive their first adjustment.

Children who have already made friends with the doctor respond much more quickly. Some mothers have their babies' spines examined during the first few weeks of their lives.

No matter what your complaint may be, always consult your Doctor of Chiropractic. If yours is not a chiropractic case, he will refer you to another doctor.

Please consult with us before you seek other medical or home type care during your spinal correction. Other care or treatment may alter your progress and ultimate recovery.

28. This kind of material speaks for itself. It is, we think, totally unprofessional. It will be clear why we recommend that discipline in the chiropractic profession be radically tightened up. It is beyond us to understand how chiropractors can complain that the medical profession does not take them seriously when material of the kind mentioned can be sent out by one of their members during the course of an inquiry into chiropractic. If we had not been satisfied on the other evidence that the

majority of chiropractors do in fact act in a responsible and professional way it would have been difficult indeed for us to resist labelling all chiropractors with the folly of the few.

29. We have mentioned the Parker Research Foundation. That is a United States organisation operated by James William Parker, D.C., Ph.C. The research it has conducted appears to have been confined to public relations and office management. We have seen Parker's *Text-Book of Office Procedure and Practice Building for the Chiropractic Profession*. The Parker Research Foundation produces, on a commercial basis, various pamphlets and materials, of which the form of report mentioned above is one. The foundation has conducted seminars in practice building in many parts of the world, including New Zealand.

30. We first look at the good side of the Parker Research Foundation. There is no doubt that the Parker system, as it is called, is clearly a useful tool for a young professional man without business training. Indeed many experienced professional people could well benefit from it. We have found some of the ideas about public relations and office management refreshing and excellent.

31. We come to the bad side. There is no doubt that some New Zealand chiropractors have been influenced by some of the methods Parker advocates. A chiropractic practice tends to be regarded by Parker as an exclusively commercial undertaking. We consider that although there are some very useful features in the Parker system, great care needs to be taken to ensure that some of the totally unprofessional methods he advocates, which are offensive in a New Zealand context, are not introduced into New Zealand practices. In particular the Commission feels strongly that there is no place in New Zealand for the Parker leaflets, report forms, or other kinds of publicity material.

32. We had evidence that the Chiropractors' Association had banned the use of all leaflets and publicity material not expressly approved by the association. It is obvious that some chiropractors have either ignored or forgotten this ruling. The ruling should be policed vigorously.

"CHIROPRACTIC CLINICS"

33. We have so far said nothing about another form of chiropractic publicity: the internal and external arrangements of chiropractors' offices. In the course of our inquiry we inspected a number of these. In spite of chiropractors' assertions to us that they did not wish to be confused with medical practitioners, some nameplates and other features could cause a measure of confusion.

34. We received in evidence five photographs of chiropractic signwriting: in one the frontage of the chiropractor's premises was decorated with "DR ——— (D.C. U.S.A.)" in very large lettering. In four others the words "DOCTOR OF CHIROPRACTIC" were prominently displayed, in one instance in letters larger than the name of the chiropractor. In the yellow pages section of the 1978 Auckland Telephone Directory there is a panel giving the names of the Auckland members of the Chiropractors' Association, with the note, "Duty doctors are recorded at these numbers". In the waiting room of one chiropractor's office which we visited there was a movable sign reading "Doctor is IN/OUT". We deal with the use of the title "Doctor" at greater length elsewhere in this report.

GENERAL

35. Chiropractic treatment is of course drugless and non-surgical. Chiropractors are in the Commission's view perfectly entitled to emphasise this facet of their work. But some tend to over-emphasise the point. We think that this over-emphasis depends on how threatened they feel. They really do not want to promote an alternative system of health care which excludes allopathy or surgery. Certainly they are sincere in their conviction that they can help people whom no one else can. They have results, and not all of them can be explained away by the placebo effect. Even if there is an element of this and of self limiting factors, chiropractors have, in their view, been the means by which pain and discomfort have been eased.

36. Chiropractors do see themselves as providers of regular maintenance programmes and some extend this maintenance to the whole family. Some evidently regard themselves as family chiropractors. "Your child will enjoy his regular spinal check ups" is the theme of a leaflet put out by the Chiropractors' Association.

37. They are always ready to defend their theory and practice. However, like all busy practitioners, they tend not to keep up with their scientific reading and increasingly rely on their clinical experience.

38. Chiropractors in New Zealand do not set themselves up as healers with special powers. They do not claim to be able to cure all ills. One experienced chiropractor told us, "I offer no panacea to any patients, but I am in many cases able to relieve their pain and get them back to work (which is what most of them want) more quickly and more efficiently than medical practitioners can do." (Transcript, p. 176). They feel that their worth has by now been demonstrated. They do not underestimate their skills. They know that most patients benefit from their work and that they have the esteem of these patients.

39. They dislike the supposed distinction between Type M and Type O disorders. One of them told us that he "would object to being categorised as a Type M or O chiropractor" (Transcript, p. 2352).

40. New Zealand chiropractors do not see themselves just as "fixers of backs", but neither do they see themselves as cult figures with magic powers. They present themselves as skilled practitioners, working mainly in a well-defined area. Where they go beyond this, they follow established guide-lines and, as far as can be judged, impose sensible limitations. They would like to be recognised, in their own right, as responsible members of a health care system in which the work of every health professional fully complements that of the others. They would then cease to feel threatened and forced to assert themselves. We should then all see chiropractors as they should be seen, as partners, not outsiders.

PART III: EVIDENCE AGAINST CHIROPRACTIC

Chapter 19. INTRODUCTORY

1. The principal opposition to chiropractic came from two quarters. First there was the organised medical profession. Then there were the organised physiotherapists and a specialist group, the manipulative therapists, who aligned themselves on the whole with the medical profession.

2. Both these groups were represented during most of the Commission's public sitting days by counsel. They cross-examined very extensively. They called a number of overseas and expert witnesses in support of their position. They produced a very considerable volume of written material, all of which we have read. For the reasons they gave, and which we will explore, they were strongly opposed to any suggestion that there be health or accident compensation subsidies in respect of chiropractic treatment.

3. Other bodies took generally the same position, though not so strongly. The Consumer Council in New Zealand was one such body. The Commission invited the Consumer Council to put in a formal submission because of an investigation into chiropractic which the council had carried out as recently as 1975. The resulting published findings expressed strong reservations about chiropractic. The Consumer Council provided us with valuable information.

4. In the result we have surely read and heard all that could possibly be said against chiropractic.

5. It was a problem to know how best to deal with the mass of information supplied to us from these sources. We decided that the best course was to deal in the next two chapters with material that was most generally relied on, and then to deal specifically with witnesses called in support of organised medicine and organised physiotherapy against chiropractic.

Chapter 20. THE NEW ZEALAND CONSUMER COUNCIL

1. During 1975 Consumer Council conducted its own inquiry into chiropractic. It published its findings in the February 1976 issue of *Consumer Review*, and a review of those findings in the July 1976 issue of *Consumer*.

2. The Consumer Council was one of the first organisations we invited to make submissions. We did so because we considered that the investigations and published findings of an independent body would be of particular value to us at the outset of our inquiry.

3. We wish to acknowledge with gratitude the assistance the council gave us at that early stage. The council's director, Mr R. J. Smithies, appeared for cross-examination, and the council made the greater part of its voluminous files on the subject available to us.

4. It is quite clear that the reports published by the council relied heavily on two main sources. First, the medical and physiotherapy professions between them provided a great volume of material, information, and opinion. That is obvious from the council's files. Secondly, the general content and tone of the report resembles that of a report on chiropractic published some months earlier by the United States Consumers Union in the September and October 1975 issues of *Consumer Reports*. We have more to say about the United States report at a later stage.

5. The findings of the Consumer Council resulting from its investigation are perhaps best summarised in the council's annual report for the year ended 31 December 1976. It said:

In brief, we concluded that chiropractors help a lot of people with bad backs, and if that was all they did we would not be concerned. But since chiropractors will not state the limits of their practice, and since there is evidence that some treat medical problems which, in our opinion, they may be unqualified to diagnose let alone treat, we published our strong reservations. We share the concern expressed by medical professions in several countries plus other independent inquiries, including our sister organisation in the United States, Consumers Union. In our judgment, chiropractic treatment should not be considered for a State subsidy unless and until its boundaries are clearly defined.

6. We have said that the medical and physiotherapy professions provided much of the material on which the Consumer Council relied. No official comment or explanation about chiropractic was received by the council from the Chiropractors' Association. That was unfortunate. It made the report one-sided. It also made the chiropractors appear evasive about what they did. But we are satisfied that those responsible for publication of the report tried their best to be fair.

7. Why was there no official contribution from the chiropractic side? It was not because the Consumer Council did not ask for it. But a study of the council's files shows what happened. We will explain the situation. The chiropractors' failure to supply information was not for the reasons the Consumer Council believed.

8. It appears that no one thought of obtaining any official chiropractic comment until near the end of the investigation. By that stage a draft report had been prepared. It was sent out to the officers of the New Zealand Chiropractors' Association. That was just before Christmas 1975. Consumer Council asked for comments by early January 1976.

9. The Chiropractors' Association complained about the short notice. It wanted until February 1976 to compose a comment that would do it justice. It complained about the bias of the draft report. The Consumer Council's response (dated 23 December) was that the chiropractors could have until 13 January 1976. In response to a further complaint Consumer Council extended the time to 26 January. In a letter dated 14 January 1976 the director of Consumer Council said:

I think I should say that in the past eight years I have seen many hundreds of letters sent to firms, organisations, professions and individuals inviting comment on draft articles. Without exception, where the recipients have facts and evidence that could cause us to alter or abandon our draft findings, we receive this information within a very few days.

Let me assure you that we are most anxious to have your views. . . All comments received by due date will be fairly and carefully assessed. And I assure you that I personally will take part in the assessment.

10. The director then put a series of six questions. They were set out in full in the article in the February 1976 *Consumer Review*. They read as follows:

1. Is chiropractic confined to manipulation of the spine to relieve or correct dislocations of it?

2. If chiropractic involves more than correction or alleviation of spinal disorders, what further things does it do?

3. Is it true, as stated and implied in literature available in New Zealand, that chiropractic claims to be able to cure all or most diseases by manipulation of the spine?

4. Is it true, as implied in some literature available in New Zealand, that chiropractic claims to cure or alleviate such diseases as diabetes, leukemia and other cancers, thyroid conditions, jaundice and hay fever by manipulation of the spine alone?

5. If the basic principle of chiropractic is that derangements of the nervous system cause illness, are there any diseases that chiropractors consider are not caused by derangements of the nervous system?

6. Whether or not chiropractic claims that all diseases result from disorders of the nervous system, is the average chiropractor reasonably capable of diagnosing a wide range of medical conditions? If so, on what training?

11. To anyone not fully informed about chiropractic these questions would seem simple. The director of the Consumer Council certainly so regarded them, for he concluded his letter by saying:

I would expect that any chiropractor could answer these six questions in about 10 minutes and without reference to any other person.

That was unfortunately a mistake. As we have found to our cost these questions are not simple at all.

12. At all events, the director's letter crossed a letter dated 15 January 1976 written by the president of the Chiropractors' Association, who stressed the association's intention to comment on the draft report "so that our Profession may not be unfairly represented, and also that this publication may be as factual as possible to the readers. This will of course be prepared just as soon as we can possibly do so."

13. Because of events outside Consumer Council's control publication of the *Consumer Review* for February was delayed. The chief editor sent a telegram on 8 March advising the association of the delay and seeking the association's comments by 15 March. Again the association protested. The report was finally published.

14. We are able to look at this matter with all the advantages of hindsight. Not only that, but we have during this inquiry been able to consider very much more material than was available to the Consumer Council.

15. It is obvious what went wrong. The Consumer Council staff misjudged the situation in two ways: they relied too much on the medical advice they had received and therefore did not realise that the matter was

much more complex than it appeared to be. Secondly, they thought that the Chiropractors' Association was being evasive. That belief might have been caused partly by the rather immoderate first reaction by some of the Chiropractors' Association's officers to the draft report: clearly they believed it had been prompted by the medical profession as a means of attacking chiropractic. But in other respects the whole matter got off on the wrong foot. The original deadline for comment was in our view unrealistic. The extended deadline was not much better. The reason the pace needed to be forced in that way escapes us. There was no urgency to publish the report. It is true that in many consumer matters a quick comment on a draft report can be provided. This was not such a matter and the Consumer Council staff fell into the trap of believing that it was; they fell into the further trap of assuming that because no immediate answer was forthcoming no effective answer could be given.

16. It is easy to see the situation from the chiropractors' viewpoint. The whole draft report needed careful reworking. On any view of the matter a brief comment would not have sufficed. The chiropractors were not given sufficient time to do what was necessary.

17. We do not blame the Consumer Council staff. They thought they had made a thorough investigation. It was in fact superficial and one-sided. They were not to know that. But in the light of what has been disclosed in the course of our own inquiry it is very unfortunate that the report was published. Publication should have been delayed until the chiropractors had had a reasonable opportunity to provide a full assessment of the article. It was unsatisfactory as it stood.

18. While the six questions put by the director in his letter of 14 January 1976 were reasonable questions and while they could have been answered briefly and superficially "in about 10 minutes", such answers could not have done justice to the matters raised. There were other important unasked questions, and the director was, unknowingly, putting his foot into deep waters.

19. In the course of their investigations the Consumer Council staff had received a letter from Dr R. G. Robinson, Director of the Neurosurgical Unit of the Dunedin Hospital, and now a professor of neurosurgery. Consumer Council received that letter on 19 August 1975. It was expressed in terms which might well have put the Consumer Council on its guard.

20. The last paragraph of the letter deals in deservedly derogatory terms with a particular item of extreme chiropractic publicity material, and that has been marked for special attention by the Consumer Council staff. It was the least important part of the letter. For earlier in the letter Dr Robinson had said this:

You ask for some comments on the neurological basis of chiropractic. It is a matter of common knowledge that most tissues and organs are supplied with nerves and that the proper function of these does depend, to a varying degree, on the integrity of these. Thus, for instance, a muscle is quite useless without its nerve supply. On the other hand, the pancreas can probably get along quite well without its nerves, although of course would then be not quite fully functional. There has been a longstanding neurological theory that in some sort of way nerves give the tissues they supply some trophic function. This concept has been never very easy to conclusively prove in scientific terms. A good bit of the so called trophic changes may well be due to disuse than some mysterious trophic or vital function.

While in theory some reduction in the nerve supply to an organ might render it more liable to disease, I know of little work that has ever conclusively proven this, that is apart from those disorders where the disease process is an intrinsic disorder of the nerves itself. The usual sort of thing that happens when nerves are interfered with by pressure or misalignments are pain in the course of the nerve and if the nerve supplies some muscles

then there may be some weakness also of these muscles. It has never been very easy to take it any further than that. Thus, if the nerves going to your legs were interfered with one might have backache and sciatica, similarly in the arm one might have neckache and neuralgia.

The line of inquiry suggested by this passage was never followed up.

21. So in the end we are satisfied that the *Consumer* reports, published with the best intentions, did not tell the full story. The investigation was not complete: it did no more than skim part of the surface, and mainly from the medical viewpoint. While it provided us with a useful starting-point for our inquiry, we have travelled far beyond it.

Chapter 21. NORTH AMERICAN SOURCES

INTRODUCTORY

1. We deal in this chapter with three sources of information on chiropractic which were relied upon at various stages in our inquiry by those opposed to chiropractic. They are, first, the United States Consumers Union; secondly, the Lehigh Valley Committee against Health Fraud, Inc; and finally a book entitled *At Your Own Risk: The Case against Chiropractic*, by Ralph Lee Smith.

2. There is one general comment we need to make. It is clear that the official medical opposition to chiropractors in North America has been clamorous and unrelenting. But as far as we are able to judge it has been maintained principally by a relatively small number of people, irrepressibly vocal. Much of the North American material strongly opposed to chiropractic can be traced back to these sources. Some of it can be traced to the now defunct Department of Investigation of the American Medical Association, which seems to have had more than a little to do with the publication and distribution of the book *At Your Own Risk*.

THE UNITED STATES CONSUMERS UNION

3. The United States Consumers Union is generally regarded as a consumer organisation of high prestige. In its periodical, *Consumer Reports*, for September and October 1975, the Consumers Union published a two-part report entitled "Chiropractors, Healers or Quacks?". The report was based on a 6-month investigation by Mr Joseph R. Botta, a senior editor of *Consumer Reports* who specialised in medical and environmental reporting.

4. The report was brought to our attention at an early stage of our inquiry by the New Zealand Consumer Council. At that stage we intimated that although the Consumers Union report was plainly useful background material we doubted its probative value in relation to the chiropractic situation in New Zealand. In the first place the situations in New Zealand and in the United States were plainly different; and secondly, we had no way of knowing on what information Mr Botta had relied, and no way of testing the reliability of the report on matters of fact. On the other hand the report, dealing solely with the North American chiropractic scene, could certainly be said to have some relevance in New Zealand because the majority of chiropractors in practice here trained in the United States.

5. The report is worth reading as background material. It comes out strongly against chiropractic on a variety of grounds, which are conveniently summarised at the end under the heading "Recommendations":

Overall, CU believes that chiropractic is a significant hazard to many patients. Current licensing laws, in our opinion, lend an aura of legitimacy to unscientific practices and serve to protect the chiropractor rather than the public. In effect, those laws allow persons with limited qualifications to practice medicine under another name.

We believe the public health would be better served if state and Federal governments used their licensing powers and their power of the purse to restrict the chiropractor's scope of practice more effectively. Specifically, we think that licensing laws and Federal health-insurance programs should limit chiropractic treatment to appropriate

musculoskeletal complaints and ban *all* chiropractic use of X-rays and drugs, including nutritional supplements for the purported treatment of disease. Above all, we would urge that chiropractors be prohibited from treating children; children do not have the freedom to reject unscientific therapy that their parents may mistakenly turn to in a crisis.

If you've been considering a chiropractor for the first time, we think you'd be safer to reconsider. Even if you are dissatisfied with your physician's treatment of a back problem, you can ask for a consultation with another physician, such as an orthopedist or physiatrist (a specialist in physical medicine). Then, if manipulative treatment were indicated, it could be performed by that specialist or by a physical therapist.

6. We have decided that we cannot give the United States Consumers Union report any weight as proof that New Zealand chiropractors practise "unscientifically" or, in general, abuse their position, thus putting their patients at unnecessary risk. Whatever the situation may have been in the United States in 1975, we are concerned with the situation as it is in New Zealand in 1979. In any event it would be patently unfair to place any undue reliance on material emanating from a consumers' organisation when we had no means of testing the soundness of that material.

7. The Commission has another reason for its reservations on the weight to be placed on the Consumers Union report. That is because of evidence which was given before us by Dr Murray S. Katz, a Canadian medical practitioner who was brought to New Zealand for the purpose.

8. Dr Katz told us that he had played some part in influencing the emphasis of the report. In the course of orally presenting his submissions he volunteered this comment (Transcript, p. 2401):

The Consumers Union started off very much in favour of chiropractic. After hearing what the AMA had to say about chiropractic they were even more in favour of chiropractic, considering they had a vested interest, but it was only after Joe Botta came to Montreal and discussed this issue over many hours and many telephone calls [with me] that the Consumers Union in the United States completely reversed their stand on the chiropractic issue and went exactly the other way.

9. Under cross-examination Dr Katz enlarged on this (Transcript, p. 2426):

I can only relate secondhand that when Joseph Botta began to look into the whole issue of chiropractic he was initially favourably disposed. Stephen Barrett told Joseph Botta that he should speak to me in Canada, and Joseph Botta refused to call me up or to come to see me. As it turned out later, the reason for this was that Joe Botta—this is secondhand, it is pure hearsay, but it is what happened—felt that I was just another doctor, that I would just be saying what the American Medical Association said, and I would not be helping. However, Joe Botta did finally contact me, discuss the issue with me on the phone for 15–20 minutes, and felt impressed enough to fly down from [sic] Montreal, to spend some eight hours of discussions with me, and I think the turning point was my presenting him with the Paediatric Hospital Report, which he had not seen before, and subsequently we were in constant contact, and he has credited me with telling me so, and with other people who have spoken with him, such as Don McKenzie, with having completely reversed his position on chiropractic.

Q: To summarise, then—I don't wish to contain your answers in any way but you may feel at liberty to make them short—the position is that Dr Barrett was consulted by those who were doing the article for Consumer?

A: That is right.

Q: You were also consulted by those who were doing the article by Consumer, and you, yourself, managed to change the view of the principal author?

A: Yes. I don't know if I was the only one that did that, but I can tell you that the heart of the pages of the article by Joe Botta strongly resembled things that I have written. He is free to edit them or change them as he likes, but someone who read Consumers Reports asked me if I had written it.

We should explain that the Dr Stephen Barrett referred to by Dr Katz is, or was, the chairman of the Lehigh Valley Committee Against Health Fraud, Inc., an organisation operating out of the city of Allentown in Pennsylvania. We will speak of Dr Barrett and our assessment of the value of his contribution to the debate on chiropractic in the next section.

10. If it is true that Dr Katz was instrumental in convincing the author of the Consumers' Union report to "completely reverse his position on chiropractic", then we must record that we are provided with a further ground for placing little reliance on the report. Our reasons for taking this view of the matter will appear from our assessment of Dr Katz's submissions and evidence in a later chapter.

THE LEHIGH VALLEY COMMITTEE AGAINST HEALTH FRAUD, INC.

11. The Lehigh Valley is a district not far from Philadelphia in Pennsylvania. Allentown is a small city in that district. It is there that the Lehigh Valley Committee Against Health Fraud, Inc. has its headquarters. In 1976 the committee published a book called *The Health Robbers*. At page 312 the composition of the committee is described:

Currently, we have about 35 individual members whose interests, availability and talents are quite varied. Some are seasoned political activists, both in and out of the health field. Some are excellent writers and public speakers . . . All share a deep sense of fair play and interest in our fellow man. As time goes on, each of us carves out his or her own niche in our action network.

12. The chairman of the committee's board of directors is Dr Stephen Barrett. He is a psychiatrist and is described in *The Health Robbers* as "the nation's most vigorous opponent of health quackery". He has for some years been the moving spirit behind the committee, at least on the question of chiropractic.

13. We have considered material published over Dr Barrett's name. The chapter on chiropractic in *The Health Robbers* (entitled "The Spine Salesmen") was written by him. It is plainly propaganda. What we have seen of the rest of his writing on chiropractic has the same tone. Nothing he has written on chiropractic that we have considered can be relied on as balanced.

14. Other material which we have seen issued under the auspices of the Lehigh Valley Committee Against Health Fraud has features which in our opinion render it unreliable on matters of fact. A good example is a package of material issued by the committee concerning, among other things, experiences of the Federal Insurance Plan with chiropractic, and in particular the experience of the National Association of Letter Carriers. This package was sent by the Lehigh Valley Committee to the Senate Finance Committee under cover of a letter dated 15 February 1972. The explanatory document (to which a number of exhibits was attached) states:

The radiologist who examined 300 sets of X-rays found most of them to be of inferior quality and 'unfit for diagnostic purposes' . . . Even chiropractic officials who reviewed these X-rays could not locate the subluxations reported by the chiropractors who had submitted them.

We have italicised certain words in this passage so as to draw special attention to them.

15. According to the photocopy of the radiologist's report dated 1965, attached to the explanatory document as Exhibit E3, the radiologist examined 200, not 300, sets of X-rays. He found a "large majority" of them to be of "poor" quality and of "limited diagnostic value". According to Exhibit E4, 20 sets of X-rays (neither 300 sets nor 200 sets) were reviewed by chiropractic officials who could not identify the subluxations supposed to be portrayed in them.

16. Exhibit E2 purports to be a report by the medical consultant to the National Association of Letter Carriers on the same incident. His report

asserts that the radiologist had reviewed "over 300" sets of X-rays and had "found only one subluxation" (the radiologist's report says nothing about finding only one subluxation); and that "over fifty percent" were "totally unfit for any diagnostic purposes".

17. We do not feel it necessary to attempt to unscramble this cavalier treatment of simple straightforward facts, obvious to anyone who reads the documents. It is astonishing to find this patently unreliable data from 1965 being recited to us in an attempt to prove in 1978 that chiropractic X-rays, and their diagnoses from their X-rays, are inadequate (see Dr P. J. Modde's evidence—Submission 126, pp. 17, 19).

18. It is clear that the enthusiasm of the Lehigh Valley Committee Against Health Fraud is greater than its respect for accuracy, at least in regard to facts concerning chiropractic. We are not prepared to place any reliance on material emanating from the Lehigh Valley Committee.

"AT YOUR OWN RISK" (RALPH LEE SMITH)

19. We mention this book simply to show that we have not overlooked it. Some reliance was placed on it, and extracts from it, in the course of our inquiry. It comes down heavily against chiropractic.

20. It cannot in the Commission's opinion be regarded as a text on which any reliance can be placed. It was published in the United States and Canada in 1969. It is a piece of special pleading. There is no true attempt at objective appraisal of chiropractic. It emphasises the sensational.

21. The author does not appear to have any particular qualifications except a desire to present chiropractic in the worst possible light. The Department of Investigation of the American Medical Association seems to have had something to do with encouraging Smith's investigations; certainly the American Medical Association took a considerable hand in disseminating the book once it was published. It appears to have been published shortly before the United States Senate's Finance Committee's investigation into whether chiropractic treatment should be included in social welfare aid programmes. The Senate Finance Committee disregarded it and so do we.

Chapter 22. A NORTH AMERICAN CONSUMER SPECIALIST

1. Dr W. T. Jarvis was approached to give evidence as an expert witness by the New Zealand Society of Physiotherapists and his fares and expenses were met jointly by that society and the Medical Association. Dr Jarvis is an associate professor in the Department of Preventive and Community Dentistry at Loma Linda University, California. He gave one of his principal interests as consumer health, "food faddism, health misconceptions, medical quackery, chiropractic, etc.". He is president of the Southern California Council Against Health Fraud Inc.

2. Dr Jarvis has neither medical nor chiropractic qualifications. He holds a Ph.D. degree in health education from the University of Oregon. He has sociological training and his teaching duties include graduate courses in research methods for various programmes in dental research.

3. Dr Jarvis's main point, as we understand it, was that chiropractors had never submitted or subjected their theories to scientific scrutiny. Their general approach, he said, was unscientific. They did not, he implied, follow the scientific code of behaviour which requires that theories be advanced on the basis of merit and not persuasive rhetoric.

4. We deal with this kind of argument generally in a later chapter. Of significance for present purposes, however, are two points which Dr Jarvis enlarged upon in the course of the oral presentation of his submission and in the course of his cross-examination.

5. First, he explained that there was a difference between testing a particular form of therapy on a "scientific level" and testing it on a "consumer level". Secondly, he suggested a means of categorising complaints to which chiropractic treatment is applied. We deal with the second point first.

"TYPE M" AND "TYPE O"

6. Dr Jarvis helped clarify our thinking by dividing ailments for which chiropractic treatment is offered into two types: Type M and Type O. Type M ailments are, in his classification, concerned solely with musculo-skeletal symptoms: the sore neck or the aching back: symptoms plainly localised on the spinal column. Type O ailments, on the other hand, are organic or visceral disorders. The treatment in each case is the same, but the Type M and Type O classification tells us at what type of ailment it is directed.

7. The point that emerges is that real confusion can result when people speak of chiropractic: they may be speaking of Type O chiropractic only, but what they say may be interpreted as including Type M chiropractic. That can destroy any hope of clear thinking about chiropractic. The person who derides the chiropractor's belief that chiropractic adjustment can significantly relieve diabetes (i.e., Type O) diverts attention from the fact that the chiropractor can do wonders with an aching back (Type M). The person who has the utmost faith in the chiropractor's ability to cure his backache may not be able to appreciate that the chiropractor's wider Type O claims have to be assessed altogether separately and at a different level.

THE "CONSUMER" TEST

8. Dr Jarvis's analysis becomes of considerable importance when we return to the first point of difficulty—how to judge spinal adjustment as a form of treatment when no-one knows precisely how it works.

9. Dr Jarvis pointed out that there are two levels on which a particular form of treatment is to be judged. The first is the "consumer level". The second is the "scientific level".

10. If a particular form of treatment is known to be effective in a large proportion of cases in which it is used, and if it is safe, then, according to Dr Jarvis, it passes the "consumer" test of acceptability. If it is generally effective and safe, the question how it works is then of no more than academic interest.

11. The scientific test, on the other hand, is at a much higher level. It is a test of scientific validity, designed to establish with near certainty on biological grounds why a particular result follows from a particular treatment. This also involves identification and explanation of other factors which may intrude so as to affect the result.

12. Whether one should be satisfied with the "consumer" test alone depends on the safety of the treatment. It is a question of balancing known risks against, first, the possibility of achieving the desired result and, secondly, the desirability of the result. The smaller the risk and the more beneficial the result, the less important it is to know the exact process by which the result is achieved.

13. All this is illustrated by the following interchange between Dr Jarvis and the Commission. Dr Jarvis had introduced as an example (possibly because of the misconception shared by many Californians that New Zealand is part of Australia) the use of dingo milk as a cure for cancer. He was asked (Transcript, pp. 1461-62):

Q: Let us suppose I have developed a prosperous business of dingo milk cure, and that I have administered it only to people who have been certified by their medical advisers to have cancer. Suppose, in 90% of the cases I have treated with dingo milk, the cancer has been relieved. I have documented the results of that empirical study. Are you still going to say to me, "I do not recognise your cure until you have proved it scientifically"?

A: You already have to a great degree. You have documented the fact that the people had the disease and documented the fact that dingo milk was your primary treatment, and the fact that you have a 90% cure rate. The only thing you need from that point on is replication.

Q: You still do not know what the dingo milk did?

A: No. But in the medical world there is a saying that says technology precedes science. We use something because it works long before we understand the mechanism. Aspirin is a case in point. We know it works because we can in a double blind situation show that it works

Q: I have not used [a] double blind situation in my dingo milk production?

A: You didn't. I do not think that would necessarily have to be if you could demonstrate [a] 90% cure rate and someone else would verify it There might be other academic tests to find the active ingredient, but the clinical question has been answered.

Q: You as a scientific adversary would not at that stage expect me to prove the precise ingredient in dingo milk which acted on the cancer?

A: Absolutely not.

14. And later on Dr Jarvis was asked by counsel (Transcript, p. 1464):

. . . you have no objection either as a scientist or a consumer specialist to the use of therapy in health fields which is effective and safe but not fully understood in the sense that there is a scientific explanation?

A: Absolutely. That is scientific posture.

Q: In fact this is the manner in which health care and the medical profession have grown, by and large?

A: That is right.

15. So Dr Jarvis was able to help us by indicating a test of both Type M and Type O chiropractic, appropriate to the question of qualification for state subsidy. In approaching the vast mass of raw material produced by this inquiry we are not concerned with any preconceived notions of what results ought to emerge. What we are concerned with is whether a particular form of treatment has *in fact* achieved a particular result, and whether other factors which could have affected that result can be excluded. Propaganda on one side or the other is plainly irrelevant.

Chapter 23. A NORTH AMERICAN MEDICAL PRACTITIONER

1. Dr Murray Simon Katz was potentially a very important witness from Canada. He was called before us as an expert witness by the New Zealand Society of Physiotherapists. That society and the Medical Association jointly paid his fares and expenses. At the time he appeared before us he was chairman of the Committee of Health Affairs of the Consumers' Association of Canada.

2. Dr Katz put in a lengthy written submission. He presented it orally with the aid of projected slides. That, and his cross-examination, occupied three full sitting days. His principal thesis, as far as we were able to grasp it, was that chiropractors were like the emperor with his new clothes. In his view chiropractors had clothed themselves with a "unity" theory of disease, but when that theory was examined through impartial and unprejudiced eyes, such as those of an innocent little child, the clothing turned out merely to be a chiropractic delusion.

3. We should make it clear that Dr Katz presented himself as a most influential international figure. He is a paediatric practitioner in the city of Montreal. He set out details of his career in a notarised (i.e., sworn) preface to his written submission. As well as being a medical practitioner in active practice, Dr Katz is also an occasional journalist. He has published articles in about 11 different newspapers in North America and in Europe. His journalistic and extra-curricula activities label him, in his own words, "as a concerned advocate of consumer rights in many areas of consumer use of medical services". Using the third person to describe himself, he goes on (Submission 112, p. 3):

Through numerous radio, T.V., and news media reports, his opinions and advice have been heard, seen, and read by millions. Partly in recognition of this work, he was selected, in 1977, to be Chairman of the Committee on Health Affairs of the Consumers' Association of Canada. He continues in that capacity today.

4. It might have been thought that with that background Dr Katz would have been a witness whose submissions and evidence would be entitled to the greatest respect. Indeed, according to his statement he undertook a first hand study of chiropractic, involving interviews with over 100 different chiropractors across Canada. He attended lectures at the Canadian Memorial Chiropractic College in Toronto, and, by registering himself as a chiropractor, obtained access to information relative "to the inner workings and philosophy of chiropractic organisations in North America". In Dr Katz's own words (*ibid.*, p. 2):

The information obtained from his past and presently continuing research into the subject of chiropractic has been sought after by numerous individuals and groups. His letter correspondence on the subject is world-wide, and is in the hundreds. Over the past years he has addressed numerous meetings of lay-organisations, consumer organisations, hospital meetings, medical associations, physiotherapy associations, government commissions, and government civil servants organisations.

5. Dr Katz also asserted that his services as a consultant were in demand by Canadian Provincial Government Agencies. Again in his own words (*ibid.*, p. 2):

In 1973 Dr Katz served as a consultant to the Manitoba Health Services Commission on the subject of chiropractic. In 1973-74 he served as a consultant to the Ontario Ministry of Health. He was the principal researcher and author of the government report,

Recommendations for the Health Disciplines Act Regarding the Practice of Manipulation Therapy by Physiotherapists and Chiropractors . . . Dr Katz wishes to make it clear that the report of the Ontario Ministry of Health is not an official representation of the opinion and/or positions of the political leaders of that province. He does believe however that it does represent the basic thinking of the majority of civil servants concerned with this issue. Civil servants, however, have to adapt to political reality if they want to keep their jobs.

6. Dr Katz was insistent that the stance he adopted on chiropractic was independent. He emphasised that point again under cross-examination. In his notarised statement, from which all the above quotations are taken, he said (*ibid.*, p. 3):

In order to maintain his independence and his right to speak on behalf of consumers, Dr Katz does all his work on a volunteer basis. Beyond the cost of travel expenses he refuses to accept financial payment for his time and his expertise. He appears today before this Commission on this same basis.

That was how Dr Katz described himself in the sworn preface to his written submission. He reaffirmed it when he presented his submission orally.

7. Dr Katz might therefore be thought of as a persuasive speaker and writer and altogether an influential figure. He so regards himself, and is no doubt so regarded by some others. That makes it necessary for the Commission to take what is perhaps an unusual course. We must explain in some detail our reasons for finding, as we do, that the submissions and evidence given by Dr Katz were unreliable and entitled only to very limited weight. The Commission did not expect to have to report on the credibility of any overseas expert witness. In this case the Commission has a clear responsibility to do so.

8. As we have said, we saw and heard Dr Katz on the witness stand for 3 full sitting days. He was strongly cross-examined by counsel for the Chiropractors' Association. It was suggested during his re-examination (*Transcript*, p. 2514) that much of that cross-examination amounted to an unwarranted personal attack on him. The Commission does not agree. The cross-examination was directly relevant to credibility and bias.

9. In spite of his assertions in his evidence in chief and cross-examination that he adopted an independent stance (*Transcript*, p. 2422), we were told at a late stage of his evidence that he was in the process of suing chiropractic interests in Canada for damages for libel (*Transcript*, p. 2437). The Commission was later told at a public sitting by counsel for the New Zealand Society of Physiotherapists that the defendant was in fact the Canadian Chiropractic Association (*Transcript*, p. 3103).

10. We do not know what was the alleged libel in respect of which Dr Katz seeks damages in the Canadian courts, or how enthusiastically he is pressing his claim, but it is clear that because he is a plaintiff in litigation of this kind it is impossible for us to regard Dr Katz as an independent expert witness on the subject of chiropractic. As a plaintiff suing chiropractors for damages he has a personal and financial interest which is contrary to theirs. Plainly he could not be regarded as presenting an independent viewpoint. That must affect the weight to be given to his evidence. He said he was independent. He may well have believed he was when he gave evidence before the Commission. But in fact he was in no position to be independent.

11. Next, Dr Katz was very frank about how he came by certain material and information regarding chiropractic. It appears that he so strongly felt the need to investigate chiropractic from the inside that he adopted a series of dishonest stratagems to enable himself to do so. He gained entry to the Canadian Memorial Chiropractic College by giving

false information (Transcript, p. 2377). He induced a friend in the United States to supply him with a letter, which Dr Katz himself prepared, asserting, falsely, that Dr Katz (using another name) was a chiropractor living in the United States and wanted to move to Canada (Transcript, pp. 2377,2431). Dr Katz also had himself registered as a chiropractor: he did so by asserting that he held the degree of Doctor of Chiropractic from Palmer College (Transcript, p. 2433). He had no such degree. He had never been a student at Palmer College. His conduct was plainly fraudulent. By these means and by using various pseudonyms, he was able to gain the confidence of a number of chiropractors. He freely conceded under cross-examination—and indeed he had no alternative—that he had lied to the authorities of the Canadian Memorial Chiropractic College in Toronto, and to others, and that his assertion that he held the degree of Doctor of Chiropractic was fraudulent (Transcript, p. 2431-3).

12. At the time when he adopted this policy of lies and fraud, which was deliberate and calculated, he was a registered medical practitioner. Dr Katz told us that the medical authorities in Canada had never taken any disciplinary action against him. It is not for the Commission to say whether disciplinary action is or is not appropriate in such a case, but the Commission wishes to state that it is disappointing to find that a practising medical practitioner could think it right to indulge in a deliberate course of lies and deceit of that kind. Dr Katz told us of these matters without any appearance of shame. Bearing in mind the high standard of ethical behaviour rightly demanded of its members by the medical profession throughout the British Commonwealth, the Commission would not wish to appear to condone in any way Dr Katz's conduct in this respect.

13. Dr Katz's cover was however, blown when he gave evidence as an expert medical witness in a criminal prosecution against a chiropractor on 8 February 1974 in a Montreal court. As we understood Dr Katz's evidence, this was not a prosecution which had been initiated by the police. It was a prosecution initiated by a group of private citizens concerned with consumer affairs, of which Dr Katz was one. So much for Dr Katz's independence. After that Dr Katz found understandable difficulty in communicating with his various chiropractic contacts. It is perhaps a measure of Dr Katz's sensitivity and sense of reality that we understood him to express before us a feeling of disappointment that chiropractors would not talk freely to him or listen to speeches from him after that incident and after they knew the facts about him (Transcript, p. 2434).

14. The weight of the material and information acquired by Dr Katz, by the stratagems we have briefly outlined above is not, of course, affected by the manner in which they were obtained. We think, however, that Dr Katz's interpretation of that material and the information which he passed on to us orally must be suspect.

15. Next, as we have said, Dr Katz held himself out to us as having acted as a consultant to various Canadian Government agencies. He was cross-examined on these matters. In the course of his cross-examination official correspondence relevant to these matters was produced to us, and it was not suggested that the correspondence was anything other than genuine.

16. The first matter is Dr Katz's assertion that he served as consultant to the Manitoba Health Services Commission on the subject of chiropractic in 1973. In February 1974 the executive director of the

Manitoba Health Services Commission (Dr D. H. Crofford) wrote to the Canadian Chiropractic Association a letter which was produced to us in which it was categorically denied that Dr Katz had ever been appointed, or had ever served, as a consultant either to the Manitoba Government or to the Manitoba Health Services Commission. In fact he visited Manitoba on one occasion to talk to the commission about chiropractic.

17. On the question of Dr Katz's alleged consultancy to the Ontario Ministry of Health, on 25 February 1974 the Canadian Chiropractic Association wrote to the Minister of Health (at the time the Hon. Dr Richard Potter). A copy of the letter was produced. The relevant parts of it read:

It is with the gravest concern . . . that we received the information that the chief antagonist of regulatory legislation in the Province of Quebec has been retained as a consultant on such matters by the Government of Ontario. Dr Murray Katz of Montreal, announced in a Court of law in Montreal on February 8th that he is a consultant to the Governments of Manitoba and Ontario

We have been in touch with the Government of Manitoba and have been advised that Dr Katz is not now, and has never been, a consultant to that Government. We would like at this time to make the following inquiries of your Ministry:

1. Has Dr Murray S. Katz been appointed a consultant to the Government of Ontario or any of its ministries, branches or agencies?
2. If so, are any informational sessions planned, or have any been held between Dr Katz and officials of the Ministry

On 4 March 1974 the Minister of Health replied. The letter was produced. The relevant portions of it are as follows:

In response to your specific questions:

1. Dr Katz has not been appointed a consultant to this Ministry nor, to my knowledge, any branch of this Government
2. Ministry people have talked with Dr Katz and will no doubt have further discussions with him. . . .

So the Ontario Ministry of Health plainly took the view that Dr Katz was never its consultant.

18. Finally, there is Dr Katz's assertion that he was the principal researcher and author of the Ontario *Government* report (the italics are ours and the word "Government" is his) entitled *Recommendations for the Health Disciplines Act Regarding the Practice of Manipulation Therapy by Physiotherapists and Chiropractors*. Dr Katz represented this report as emanating from the Ontario Ministry of Health. He produced a photocopy of the original as part of his submission. Its title page bears the legend "Ontario Ministry of Health, June 1974". There can be no doubt that we were intended to believe, from the title page of the report, and from Dr Katz's evidence, that the report was in fact an official document emanating from the Ontario Ministry of Health.

19. On 14 September 1978 the Canadian Chiropractic Association wrote again to the Ontario Minister of Health. The letter, a copy of which was produced to us stated:

The Canadian Chiropractic Association has been requested to authenticate before a commission of inquiry, certain statements made by Dr Murray Katz in a submission he will present shortly to the Royal Commission of Inquiry into Chiropractic in New Zealand.

20. The Canadian Chiropractic Association then set out the passage from Dr Katz's notarised statement which we have quoted above (para. 5), attached a photocopy of the title page of the report as exhibited by Dr Katz, mentioned the letter of 4 March 1974 in which the then Minister of Health had confirmed that Dr Katz was not a consultant to the Ontario Ministry of Health, and continued:

Our Association appreciated receiving this information regarding Dr Katz. He does however continue to make these statements. As this is before a royal commission of inquiry, and as some of these statements appear to be questionable, we would be grateful if you could respond to the following

1. Has Dr Katz served as a consultant to, or been employed by the Ontario Ministry of Health subsequent to March 4th, 1974?
2. Is the referred report to an official report commissioned by the Ontario Ministry of Health?
3. If so, was Dr Katz the principal researcher and author on behalf of the Ontario Ministry of Health?
4. Were Ontario Ministry of Health officials involved in the preparation of this report?

21. The following is the Minister's reply, which was produced to us, dated 28 September 1978:

In response to your letter of September 14, 1978 regarding Dr Murray Katz, I wish to re-affirm this Ministry's response of March 4th, 1974, in which the Honourable F. S. Miller, then Minister of Health, stated: 'Dr Katz has not been appointed a consultant of this Ministry nor, to my knowledge, any branch of this government . . .' Furthermore, Dr Katz has not been appointed a consultant to this Ministry subsequent to March 4th, 1974.

I also wish to make clear that the referred to report entitled 'Recommendations for the Health Disciplines Act regarding the Practice of Manipulation Therapy by Physiotherapists and Chiropractors' was written entirely by Dr Katz and sent to this Ministry as information. This Ministry was not involved in either the researching or the authoring of this report.

22. So the report was not the ministry's report at all: Dr Katz had written the whole thing himself, no doubt hoping the ministry would adopt it.

23. Before us, Dr Katz sought to explain the patent inconsistencies between what he had sworn to in his notarised statement and his evidence in chief on the one hand, and the official responses which were produced to us, portions of which we have set out above. As we understood him, his explanation was that the official responses were dictated by political expediency. We see no reason to make any such assumption. We think the kindest thing to say is that Dr Katz has become so emotionally involved in his self-appointed role as a "concerned advocate of consumer rights" that over a period of some years he has allowed his enthusiasm to override his judgment, his sense of reality, and his sense of what is proper. In his evidence in chief he was voluble, and we are satisfied that he found it difficult to distinguish between the role of expert witness and that of an advocate. In cross-examination he tended to be evasive.

24. Having regard to the matters we have specifically mentioned, and to Dr Katz's general demeanour as a witness as we observed him during the three days of his submissions and evidence, we are abundantly satisfied that it would be quite unsafe to rely on his opinions, or on any of his evidence on matters of fact which were not completely verified from an independent and reliable source.

25. At the same time we found a limited number of the ideas which Dr Katz expressed valuable to us in throwing a new light on some aspects of our inquiry, and in suggesting some matters which we should take into account, which we might otherwise have overlooked.

26. We would add this. Dr Katz told us that he believed he had been instrumental in influencing the views of Mr Joseph R. Botta, who is the executive director of the United States Consumers Union, and that the union's report on chiropractic (see chapter 21) contained in the September and October 1975 issues of its magazine had been materially influenced by Dr Katz's views. We have already expressed some doubt whether the United States Consumers Union report is entitled to any real weight in our inquiry, since it deals with the United States situation which for a variety of reasons is different from that of New Zealand. If Dr Katz did materially influence the findings in that report, his evidence only adds to our doubts as to the weight to be attached to the report.

Chapter 24. A NORTH AMERICAN CHIROPRACTOR

1. Dr Peter J. Modde described himself as a chiropractic physician. He is in his mid thirties. He practises in Renton in the State of Washington. For the past 3 or 4 years he has aligned himself against chiropractic. He has become a chiropractic malpractice consultant. He has held himself out as being available to assist insurers in assessing claims for chiropractic treatment and to assist lawyers acting for plaintiffs in malpractice claims against chiropractors. He is a political lobbyist against chiropractic. He made it clear to us that he has rejected chiropractic, although he still practises as a "chiropractic physician". His activities have led to his expulsion from the national and state chiropractic associations to which he belonged. From that position he made submissions to us as a witness for the New Zealand Medical Association, opposing chiropractic on a variety of grounds.

2. Dr Modde has become something of an international authority on chiropractors. He tends to be relied on as an authority who is able to tell the inside story.

3. We saw and heard Dr Modde on the witness stand. It proved impossible for us to feel any confidence in Dr Modde as a reliable witness. We reject his evidence and his opinions. We must explain why.

4. What turned Dr Modde against chiropractic? He told us that some years ago he devised a plan, in association with the local university medical school, for providing a post-graduate programme in diagnosis for chiropractors. He told us that local chiropractors, after first supporting this scheme, turned it down. From that time he began to work closely with local medical practitioners, accepting referrals from them and referring patients to them. His other activities which we have mentioned began at around that time.

5. In presenting his formal submission to us, Dr Modde volunteered some further evidence as to his past history. The details we are about to mention are no secret. Dr Modde seems to have discussed them openly in an interview reported in the periodical *Medical Economics* issued on 26 June 1978.

6. After his graduation as a chiropractor he actively assisted some 200 chiropractic candidates to cheat in their State basic science examinations. These are examinations which were sat by all medical and chiropractic graduates who wished to be licensed to practise. He told us that his methods of assistance were by hand signals, or by substituting himself for a particular candidate and sitting the examination in that candidate's name. This was of course forgery as we understand the term: on any basis it was fraudulent and dishonest conduct. He accepted money from some of those he assisted. He said this was for his "expenses".

7. In explanation of this conduct he told us that cheating in examinations was widespread in chiropractic colleges. Because he did not name any we are unable to say what was the basis for this assertion. He said further that he was motivated by his belief that the State examining boards were biased against chiropractors, although in cross-examination he found it difficult to explain how the examiners could know which

candidates were chiropractors in view of the fact that the medical and chiropractic candidates were identified on the examination scripts by a number only. He was of course ultimately caught, convicted in a Federal Court, and sentenced to probation in 1968.

8. That was not the end of his troubles. In mid 1977 he was charged before the State of Washington Chiropractic Disciplinary Board with unprofessional conduct. This included overcharging, and charging the Washington State Department of Labour and Industries in compensation cases for treating patients where no treatment had in fact been given. After a defended hearing on 28 September 1977 at which Dr Modde was represented by counsel and gave evidence the board found him guilty of unprofessional conduct, including the charges mentioned above, and revoked his licence. The board, however, ordered that Dr Modde should be eligible to apply for reinstatement after 2 years, but also ordered that before applying for reinstatement he should "provide the Board with the results of a psychiatric examination performed by a Board-appointed psychiatrist".

9. Dr Modde appealed against the revocation of his licence, but in the meantime the Washington courts in other litigation ruled that the relevant statute under which the disciplinary proceedings had been taken was unconstitutional and therefore void. So that solved Dr Modde's problems in the meantime. It is clear, however, that his appeal was never heard on the merits: no court has ever ruled that the Disciplinary Board was wrong in its findings of fact.

10. Now of course we are not concerned at all with the legal position in the State of Washington in regard to the possible future of the disciplinary charges made against Dr Modde. We are, however, concerned with what weight we should place on Dr Modde's evidence before us. Dr Modde supplied us at our request with the full official transcript of the proceedings before the Disciplinary Board. He had brought the transcript with him to New Zealand. We have read it. It seems to us that the board's findings of fact are not inconsistent with the evidence as recorded, particularly in regard to the charges we have specifically mentioned. As to the board's requirement that Dr Modde undergo a psychiatric examination before applying for reinstatement, Dr Modde had two explanations: he drew an analogy with the alleged Soviet practice of treating dissidents as in need of psychiatric attention; then he told us that in any event such a requirement was laid down by statute. We have not felt any need to check to see which explanation is the more likely.

11. Now Dr Modde's general evidence in opposition to chiropractic was potentially important. He had trained at Palmer College and had practised as a chiropractor and was therefore in an excellent position to provide us with an unvarnished assessment of the quality of the training which most New Zealand chiropractors have undergone and what might be expected to happen in New Zealand if health and accident compensation benefits became payable in respect of chiropractic treatment, since the health and compensation schemes in the United States obviously provide a parallel. But having seen and heard Dr Modde on the witness stand for 2 days we cannot regard him as a reliable witness. The impression we gained of him is that he is a naive opportunist. We are left in doubt about his motives for his rejection of organised chiropractic. In any event, his setting himself up as a malpractice consultant was naive, because his past record must necessarily impose grave limits on his value as an expert witness in malpractice proceedings. That he apparently still

does not appreciate this fact throws some light on his general character.

12. Quite apart from that, we found Dr Modde's evidence to be internally unreliable, in particular his inaccurate use of source material. The following are examples. The page references are to his written submission (No. 126):

Page 7. Dr Modde cites a "recent" report of the Department of Health, Education and Welfare as concluding that chiropractic education does not prepare the chiropractor to make an adequate diagnosis and provide adequate treatment. This report was in fact not "recent", but was prepared in 1968. Its recommendations were not followed by the Senate Finance Committee after a full public hearing.

Page 7. Dr Modde relies on the decision of the Washington State Supreme Court in *State v. Wilson*, 11 Wash. App. 916, 528 P.2d 279 (1974), as presenting a "rational, objective position on laboratory testing and diagnosis by chiropractors" which was unfavourable to chiropractors.

The Court decided nothing of the sort. All it was asked to decide and all it decided was that chiropractors were prevented by a local statute from using certain techniques. The decision cannot in any way be read as containing any judicial finding on the general capability of chiropractors in the areas of laboratory testing and diagnosis.

Page 12. Dr Modde represents Firman and Goldstein, in their article, "The Future of Chiropractic", *New England J. Med* 293: 639-642, 1975, as having reached the conclusion that chiropractors have failed to produce rational scientific explanations for their theories, that their education and research was of extremely poor quality, and that they are notorious for extending their claims to competence into areas in which they have limited or no training.

That was not the authors' "conclusion" The authors were setting out what the arguments against chiropractic were as part of a general treatment of the arguments for and against chiropractic.

Pages 13-14, 15-17, 19. Dr Modde here relies on material emanating from the Lehigh Valley Committee Against Health Fraud (see chapter 21). We have sufficiently commented on the weight to be given material from that source.

Page 20. Dr Modde asserts that the NINDS (National Institute of Neurological Diseases and Stroke) Federal Conference on Chiropractic concluded that the chiropractic use of X-rays to determine spinal subluxations was unfounded and should be discontinued.

The Conference decided nothing of the kind. Dr Modde's reference is to a comment made by one radiologist in the course of the Conference: see the Conference Report, p. 266.

In all the circumstances it would clearly be wrong to give Dr Modde's submissions or his evidence any weight.

13. We should add this. In the course of explaining his own activities Dr Modde referred to the general practice of cheating in chiropractic colleges. This is the kind of explanation often given by those who are caught out themselves in cheating. It is presumably intended to suggest that it is a misfortune to be the one who is caught.

14. In the Commission's view it would be unsafe to accept as necessarily truthful Dr Modde's assertions as to any general practice of cheating in chiropractic colleges.

Chapter 25. THE GENERAL MEDICAL SUBMISSION

INTRODUCTORY

1. The medical profession in New Zealand was represented throughout our hearings and naturally took an active part. The list of medical associations so represented is impressive:

- The New Zealand Medical Association.
- The Royal Australasian College of Physicians.
- The Royal Australasian College of Surgeons.
- The Royal Australasian College of Obstetricians and Gynaecologists.
- The New Zealand College of General Practitioners.
- The Royal College of Pathologists of Australia.
- The New Zealand Branch of the Royal Australasian College of Radiologists.
- Paediatric Society of New Zealand.
- The Australian and New Zealand College of Psychiatrists.
- Medical Superintendents' Association of New Zealand.
- New Zealand Medical Women's Association.
- The Neurological Association.
- The New Zealand Branch of the New Zealand Society of Occupational Medicine.
- The New Zealand Orthopaedic Association.

The submissions made and evidence called on behalf of these bodies must be taken to represent the official view of all of them. The General Practitioner Society made its own separate submissions.

2. It is fair to say that the organisations listed above not only strongly opposed any suggestion of health and accident compensation benefits being granted in respect of chiropractic treatment, but also were deeply opposed to chiropractic itself. The only hint that they might be prepared to co-operate with chiropractors in any way was in the area of scientific investigation of chiropractic theory and practice. So the opposition of the New Zealand medical establishment to chiropractic is, for all practical purposes, intense and absolute.

3. We shall have to deal later in this report, and in considerable detail, with the precise reasons for this opposition. It is, however, helpful at this stage to offer a general summary. The position was put succinctly in the opening address of leading counsel for the New Zealand Medical Association, Mr J. T. Eichelbaum Q.C. He said (Transcript, p. 1729):

The root cause of the opposition of organised medicine is quite simply stated. It is that the basis of chiropractic is a theory of the cause of disease which is unproven and, in the minds of many thoughtful medical scientists, absurd. Not only that, but the theory is shackled to a single modality of treatment which is also unproven . . . it is the firm belief of medicine that the theory of disease on which chiropractic is founded will never be proven; that it is incapable of proof; and that in the end it will be completely discredited, if indeed that is not already the position.

This passage summarises exactly the effect of the evidence later given before the Commission by witnesses called on behalf of the medical organisations.

4. This is weighty opinion indeed and one to be treated with great

respect. For medical practitioners are essentially, by their training and expertise, the guardians of public health. In matters lying within the field of expert medical opinion it is a bold step for anyone not medically qualified to venture to disagree with what they say. But in our view there are three factors which must necessarily seriously diminish the weight to be given to medical opinion on chiropractic theory and practice.

5. In the first place no evidence was placed before us which suggested that medical science has proved current chiropractic theory to be in error, or the practice ineffective. We have no doubt at all that if such evidence had been available it would have been produced. It is all very well to assert—as some of the medical witnesses did—that some chiropractic hypotheses are absurd. But if there is no proof that chiropractic hypotheses are unsound, an assertion by a medical expert that the hypotheses are absurd can logically amount to no more than an assertion that the chiropractic hypotheses do not fit into the framework of concepts within which that medical expert is for the time being working. Hypotheses which do not fit into accepted frameworks have often in the past been derided as absurd.

6. The medical profession branded Pasteur's hypotheses absurd; the theory as to the circulation of the blood was similarly held up to ridicule by the medical profession at the time it was first propounded. The history of medicine contains many other such examples. An editorial in the *Canadian Medical Journal* (85, p. 1056, 1961) puts the position better than we could:

In medicine we have had the dubious privilege of being often wrong. Our greatest sages even, have made blunders which seem, in retrospect, astonishing. Virchow, for instance, the father of pathology, could not be persuaded that deficiency diseases might exist, and this in spite of James Lind's demonstration that scurvy is prevented and cured by lemon juice more than a century before. Claude Bernard did not grasp the immense importance of bacteriology. Lister's contemporaries, very able men, were sure that he was either a fraud or a fool, or both. Fleming was considered an amiable crank for years. So with our knowledge of previous over-certainty we can perhaps be more detached than some disciplines. We have learned to expect, even hope, that time will produce better ideas than we have now.

We therefore cannot be confident that the medical profession is always the best judge of concepts which do not for the time being relate to the pattern of established medical thinking.

7. Next, organised medicine sought to justify its position by pointing to the fact that chiropractors had never been able to provide scientific proof of their theories. The burden of proof, it was said, lay on the chiropractors. This is undoubtedly the accepted scientific stance. But is it reasonable to adopt it in the present instance? What are the facts? Chiropractic has been practised for more than 80 years. During the whole of that time it has been strongly opposed by organised medicine. During the whole of that time chiropractic, in spite of that opposition, has consistently gained in public support. During the whole of that time the research resources of established medicine have been immeasurably greater than those of the chiropractic profession. During the whole of that time the medical profession has considered chiropractic worthless. No serious research into chiropractic has been undertaken by the medical profession. There are, indeed, considerable problems in conducting controlled clinical trials: as we shall see it is a difficult research area and requires full-time trained personnel: it cannot be undertaken successfully by busy practitioners.

8. We agree that chiropractors have paid insufficient attention to recording their clinical experience. But they have been kept outside the scientific community, and their facilities have been limited.

9. The argument that the burden of proof should be placed on the chiropractors is an attractive one, but in the circumstances we find it evades the real issue. The belief central to chiropractic is that a mechanical vertebral dysfunction can, through some neurological mechanism, not only cause local pain but also influence visceral function. Current neurophysiological knowledge is simply inadequate to subject this belief to thorough scientific scrutiny, and chiropractors cannot be held responsible for these shortcomings. Certainly on present knowledge, their theory cannot be ruled out.

10. The third factor which in our view diminishes the weight of the general objections of organised medicine to chiropractic is the degree of ignorance of chiropractic which seems to us to pervade much of the medical comment on it. The principal witness for the Medical Association, himself a specialist in his field, had certainly acquainted himself thoroughly with much of the available literature, but we were unable to detect any indication that he had made a real or sustained effort to ascertain or understand the practical aspects of what a chiropractor actually sets out to do. Of course attention was rightly drawn to the least impressive aspects of chiropractic literature and some of the commercial methods adopted in the United States by some chiropractors. But these are, in the end, no more than superficialities.

11. As we have already said, a chiropractor is essentially a skilled specialist in spinal manual therapy, and we do not find it in the least surprising that the chiropractic literature should go only a small distance towards conveying the essence of chiropractic. In an art like spinal manual therapy, the means of communication most likely effectively to convey a true and faithful picture is physical demonstration and actual experience. So the medical witnesses are not altogether to blame for their ignorance. We think it clear, on all the evidence put before us in this most comprehensive inquiry, that the educational background of the present-day medical practitioner does not equip him to evaluate the refinements of a chiropractor's skill in diagnosis and treatment of spinal dysfunction of biomechanical origin. Unless chiropractic is studied on its own terms no more than an indistinct image emerges. It is like trying to get good television reception without a correctly oriented aerial.

12. For any of those reasons, then, it is impossible for us to treat the evidence called on behalf of the New Zealand Medical Association as in any way conclusive. It is certainly entitled to weight; but it is to be regarded as no more than evidence of weight among other evidence.

THE PRINCIPAL SUBMISSION

13. We should note that the case for the medical establishment as put by counsel, differed somewhat from the case as put in its principal submission (Submission 26). The chief objection of the New Zealand Medical Association to chiropractic was stated at the beginning of the submission to be simply this (Submission 26, p. 1):

That chiropractic, however it may be defined, serves in practice as a system of primary health-care: the chiropractor functions as the initial portal of entry into his own health-care system. The Medical Council of New Zealand has laid down certain standards of education for medical practitioners who provide primary health-care: the education of chiropractors fails to meet those standards. The issue does not concern the availability of manipulative services: chiropractic has its own philosophy to which treatment by manipulation is incidental.

14. In essence, as we understand the evidence, this amounted to an assertion of two separate points: first that the public should not be allowed direct access to any health practitioner who is not educated to a standard judged sufficient by the medical establishment. The second point was that chiropractors in New Zealand hold themselves out as providing a self-contained and complete health care system.

15. It is helpful to dispose of the second point first. We do not understand chiropractic in New Zealand to represent itself as a self-contained health care system, nor chiropractors in New Zealand to practise in that manner. The evidence was—and we accept it—that the great majority of chiropractors, when faced with a disorder that ought to receive orthodox medical treatment, will be aware from their training that the disorder is of that kind, and will do their best to ensure that their patient gets medical treatment. They do not believe that chiropractic can fix everything.

16. Nor are we able to accept the medical establishment's view that the public should not have direct access to a health practitioner without a qualification recognised by the medical profession. We desire at this point to say no more than that in our opinion such a view is unrealistic. We will deal later with the chiropractor's diagnostic training. Chiropractic has for some years been recognised in New Zealand by statute as an independent profession. Registered chiropractors are entitled by law to treat patients direct, without the intervention of any medical practitioner. It is simply not practicable to recommend that the position registered chiropractors and their patients have enjoyed for many years now be fundamentally altered. Nor does the evidence disclose any sufficient reason for suggesting such a change.

17. We consider the public interest would be better served if the medical establishment made some serious effort to investigate the apparent advantages of chiropractic treatment. Indeed we find it astonishing that the medical establishment has adopted a deliberate policy of ostracism on what we consider to have been illogical grounds and for inadequate reasons. We develop this point when we come to consider the medical ethic against referrals to chiropractors.

18. We now discuss the main general points of the medical opposition to chiropractic in greater detail. The Medical Association's general submission was of course prepared before the Commission's hearings began, and has been overtaken by a large volume of detailed evidence. The following are the principal general points. More specific points were made by the medical expert witnesses whose evidence we discuss in chapter 27.

The Chiropractic Lobby and the Scope of Chiropractic

19. The complaint is made that chiropractors have secured their present position not on merit but by political action. It is true that since 1966 chiropractors in this country have been active in making representations to committees of the House of Representatives and to commissions of inquiry. The point is made that the procedure of parliamentary select committees does not allow cross-examination, so that much of the chiropractic evidence presented in the past has remained untested. The general submission of the Medical Association goes on to refer to a passage of cross-examination of a chiropractor who gave evidence before the Royal Commission on Social Security in 1972. The passage was as follows:

Dr Thompson: If there was a chiropractic benefit, would chiropractors treat children with whooping cough under the scheme?

Mr Reader: I can only answer that this is a possibility.

Dr Thompson: Take a patient obviously suffering from diabetes, would you or a reputable chiropractor treat such a patient?

Mr Reader: Yes.

Dr Thompson: I understand you to say that diabetics you would treat?

Mr Reader: Yes.

Dr Thompson: By spinal manipulation?

Mr Reader: Yes.

Dr Thompson: What about high blood pressure?

Mr Reader: It depends on its origin. But perhaps your Honour, could I ask for your guidance on this particular point. We have covered several specific disorders that Dr Thompson is asking me. Are we going through from A to Z?

The Chairman: I don't know that you are, but it seems the doctor was getting into an area which was so different from the impression you gave from your description of what your activities were . . ."

This, the Medical Association goes on to say, "is a fragment of dialogue from the recent past, caught in an eternal sunbeam". The chairman's extempore comment is fastened upon as demonstrating that, whatever impression they may give to the contrary, chiropractors in fact treat a very wide range of disease.

20. We do not consider that this presents a fair or accurate picture. It is very superficial. We take from the evidence that any responsible chiropractor, faced with a patient with whooping cough, diabetes, or high blood pressure, will do his best to ensure that the patient is under medical care. But, if the patient requires it, the chiropractor will examine him. If he finds a vertebral subluxation he will correct it if he can. His clinical experience, and that of others, will lead him to hope that the correction of the subluxation may lead to an improvement in the patient's whooping cough, diabetes or blood pressure. It is quite wrong to think that a chiropractor will assume that a person with diabetes must necessarily have a vertebral subluxation which is causing the diabetes. If the patient does in fact have a vertebral subluxation, however, the chiropractor may well hypothesise that relief of the subluxation may have some bearing on the patient's condition.

21. Because the chiropractor's approach to cases of this kind is based on his own clinical experience or the accumulated clinical experience of chiropractors in general, and because we accept that chiropractors can sometimes get results in such cases, we are not prepared to write off this aspect of chiropractic practice as ludicrous or unsound. But the results are, as we find, unpredictable and some chiropractic claims have been grossly overstated. We have elsewhere fully stated our reasons for recommending that chiropractic treatment in this type of case should not attract a health subsidy unless it is given on medical referral. We have also recommended that chiropractors should not advertise that they are the practitioners to be turned to in the first instance by people with Type O complaints, and that a breach of such a prohibition should be penalised as a breach of professional ethics.

The "Chiropractic Adjustment"

22. The "chiropractic adjustment" is described in the Medical Association's general submission (Submission 26, p. 25) as:

... a specific form of spinal manipulation, not to be confused with manipulative techniques employed by physiotherapists, orthopaedic surgeons, and other members of the medical profession; it is distinguished by the suddenness or speed of the manoeuvre. Chiropractors describe the sudden manoeuvre as the "dynamic thrust" The dynamic

thrust may be performed gently or forcefully but always quickly; the procedure often produces a click-like sound in the adjusted joint. The speed of the chiropractic adjustment prevents control by the patient. By comparison, a patient can voluntarily resist—and therefore control—a manipulation which is performed slowly or rhythmically; if there is pain, for example, the patient can physically resist further movement or advise the therapist accordingly. This latter technique, which is generally called “mobilisation”, is the most common type of joint manipulation used by the medical profession.

23. On the evidence, we hold the assertion about the chiropractor’s technique to be erroneous. The Commission is satisfied that chiropractors in their “adjustments” use a wide variety of techniques of manual therapy, some of which appear to be similar to those used by physiotherapists. The real distinction lies in the greater refinement of technique and the superior skill of most chiropractors.

24. We accept that some chiropractic techniques are applied so that the patient has no means of physically resisting them. But we consider also that, if it is true that the medical profession’s techniques stop short at “mobilisation”, that is itself a limiting factor on their efficacy. In general, however, all it is necessary for us to say is that the chiropractor’s training in spinal manual therapy is more intense than anything offered in orthodox medical or physiotherapy education.

25. The Medical Association, however, went somewhat further than criticism of what is wrongly thought to be the limited nature of the chiropractor’s manual therapy. It went on to suggest (Submission 26, p. 26):

The essential difference between chiropractic adjustment and medical manipulation is “singularly chiropractic”, it is “*Why* these techniques are applied, and *why* they are applied in a certain manner” . . . W. D. Harper, President of the Texas Chiropractic College, makes exactly the same point: “It is the *reason why* that the Science of Chiropractic offers, that differentiates the *practice* of adjusting vertebrae from that of the medical profession.” In other words, it is the application of chiropractic philosophy which is the distinguishing feature of chiropractic adjustment.

26. We are therefore brought back to “chiropractic philosophy”. But what the various chiropractic writers quoted by the Medical Association are really pointing out is that a chiropractor carries out spinal manual therapy in a Type O case in the hope that particular results may be achieved. Such a prospect the medical establishment does not recognise. On the evidence before the Commission there is no doubt that the chiropractor’s therapy is immediately aimed at correcting a spinal dysfunction. In Type O cases organised medicine does not see such a dysfunction as significant; and it disagrees with chiropractors about the results which might follow. As the Commission has already said, this is not a difference of “philosophy”.

27. On this kind of question we find the medical profession curiously inconsistent. An example occurred during the evidence of Dr D. S. Cole, the Dean of the Auckland Medical School. The Commission’s question and his answer were as follows (Transcript, p. 2829):

Assume that you are a general practitioner and you have a patient with a sore back and you decide really because of your lack of knowledge of the causation of sore backs you had better refer him to Dr Mennell, who is a very prominent specialist in these areas, as we know. Dr Mennell on your referral sprays hydrocarbons on the patient’s back. This is a treatment that is not scientifically verified, it is just believed that it may be effective and no-one knows quite how but it works in a number of cases. No-one would be able to say that that treatment was scientifically based in the sense that cause and effect can be verified or that the causation can be explained. Would you have any objection to referring the patient to a medical practitioner who used that kind of treatment?

A: Sir, I believe we are all of us using treatments that are not scientifically based and spraying something on a person’s back is a good example of an impractical [*sic*] treatment. It is a little more fundamental than that, I think. I think the fundamental thing

we believe is that we should only refer patients to people with whom we are in sympathy in general terms in background training. We obviously if we get an aberrant practitioner who does strange things we retain the right to not refer our patients to him but by the same token we don't necessarily ask that he be removed from the medical register. I think we still retain the right to advise our patients and if the patients don't wish to take our advice that is obviously the patient's right in our society.

The reference was to an article by Dr J. McM. Mennell, " 'Spray and Stretch' Treatment for Myofascial Pain", *Hospital Physician*, December 1973. It is of interest to note that in the same article Dr Mennell records that his own arrhythmia was relieved by this method: "So there appears to be a body-surface trigger point for the pacemaker of the heart and a beneficial visceral effect produced by nociceptive impulses set up by the jet stream."

28. The important point, as it appears to the Commission, is that a disagreement as to the appropriate treatment of a patient between one medical practitioner and another is not classed by medical practitioners as a difference of "philosophy"; but a disagreement on the same topic between a medical practitioner and an "unqualified practitioner" is. The logical gap is obvious.

Chiropractic Vertebral Subluxations

29. The Medical Association in its general submission points out that chiropractors have, over the years, found difficulty in defining precisely what a "chiropractic vertebral subluxation" is. As far as we understood it, the implication was that there was in fact no such thing. If we are right in drawing that inference from the submission, then we reject it for reasons we have already stated in chapter 9.

The Chiropractic Consumer

30. The Medical Association's general submission places some weight on the reports on chiropractic published by the New Zealand Consumer Council and the United States Consumers Union. We have already recorded our reasons for regarding both reports as of limited impact in this inquiry: see chapters 20 and 21.

Chiropractic Education

31. A good deal of the Medical Association's general submission deals with the education of chiropractors. It appears that the purpose of that emphasis is twofold: first, to demonstrate that the chiropractor's standards in differential diagnosis cannot compare with the standards laid down in New Zealand by the Medical Council for the medical profession; and secondly to show that chiropractors are taught the management of a wide variety of disorders.

32. We have already set out our reasons for our finding that it is unnecessary for chiropractors to acquire skill in differential diagnosis to the standard required of a medical practitioner: see chapter 12. The short point is that a chiropractor's general diagnosis—as distinct from his specific spinal diagnosis—is limited to a determination of whether the patient should have medical care instead of or in addition to chiropractic treatment.

33. As to the emphasis on a wide variety of disorders in chiropractic colleges, the Commission considers that this is aimed at two points: to enable the chiropractor to identify such disorders, and then, if spinal manipulation is appropriate in a particular case, to enable the

chiropractor to know what techniques to avoid and what results may be expected. The Commission does not see chiropractic education, in the New Zealand context, as involving the chiropractor in taking over from the medical practitioner the total management of the patient. Proper discipline within the New Zealand chiropractic profession should avoid any such difficulty if it were to arise. The Commission's recommendations as to chiropractic discipline are to be found in chapter 43.

The Chiropractic Paediatrician

34. The Medical Association's general submission makes the valid point that:

The chiropractic adjustment of young children, particularly sick children, is an issue which must be of special concern to the Commission . . .

That is perfectly correct. As the Committee on Osteopathy, Chiropractic, and Naturopathy in Victoria pointed out in 1975, the chiropractic adjustment of children raises special problems. Common symptoms such as headache and abdominal pain may be simply explained by an adult who is able to provide a detailed history, but a child cannot do this.

35. Chiropractors in New Zealand do treat young children. But young children do not form a large proportion of their patients (only 5 percent under the age of 10: see chapter 16). In some cases children have been taken to a chiropractor as a last resort, and we have received anecdotal reports of some remarkable instances: see in particular chapter 32, where we set out the reported results of chiropractic treatment in some Type O cases. But in each of those cases the child had been under medical care, and they were not cases where necessary medical treatment was delayed while chiropractic treatment was undertaken.

36. There is, however, another category of case, which as far as children are concerned seems to the Commission to have elements of potential danger. That is the case of the parent who has been converted to chiropractic: converted in the sense that he or she regards the chiropractor as the first port of call when a health problem arises. We learned of a number of such cases. We have made it clear elsewhere that our view is that an ethical chiropractor should avoid encouraging any such impression. But the ailments of children are notoriously difficult to diagnose, and it seems to us that chiropractors should hesitate to accept as a patient any young child who is sick, and particularly the young child of a chiropractic "convert".

37. We hasten to say that we accept that most chiropractors in New Zealand act in a responsible way when young children are brought in to them. However, a few do not.

38. In the course of our sittings we learned of a bad case. We have mentioned this elsewhere, but it is worth repeating. It was the case of a baby with jaundice. The baby was being given hospital treatment. His condition was serious. But the parents, who were familiar with chiropractic, did not think he was responding sufficiently. So with the encouragement of their chiropractor they insisted, against medical advice, on removing the baby from the hospital. The chiropractor treated the baby who fortunately recovered.

39. The parents came before us and told us about the case. They thought it was a chiropractic triumph and that we should know about it. They showed us a letter their chiropractor had written to the doctor in charge of the case at the hospital. They could not understand why the

doctor had done all he could to persuade them not to remove the baby and place him in the chiropractor's care.

40. We do not blame the parents. They had faith in the chiropractor. But we do blame the chiropractor. He should never have allowed the parents to think that it could be right to take the baby out of hospital. That is the problem with chiropractic "converts". The chiropractor has a very grave responsibility in such a case.

41. It is of course unfair to judge all chiropractors by such a case. One very experienced chiropractor who gave evidence before us was questioned about the wisdom of treating young children, and his answer showed great sincerity and distress at the suggestion of harm to a young child: "I have never hurt a child!"

42. But in this area good intentions are less important than the risks involved. The case of the jaundiced baby makes it necessary for us to reinforce our recommendations that discipline in the chiropractic profession be greatly strengthened. It shows that in some cases young children need to be protected against uncritical enthusiasm for chiropractic treatment, not only from their parents but from the chiropractor as well.

The "Doctor of Chiropractic"

43. The Medical Association in its general submission emphasises the danger of a chiropractor being regarded as a primary health care physician. One of the points made is that it is undesirable for him to use the title "doctor".

44. The Commission accepts that a chiropractor should not be treated as a primary health care physician—that is, as one who can provide comprehensive care. The Commission agrees that the use of the title "doctor" can cause undesirable misunderstanding and we discuss the point at a later stage: see chapter 42.

The Benefits of Chiropractic

45. The Medical Association suggests that the benefits of chiropractic are largely illusory (Submission 26, p. 125):

"... there is little or no evidence to suggest that the benefit of chiropractic care is in any way due to the mechanical effects of manipulation; on the contrary, there is good evidence to suggest that the benefit stems from the transference of confidence from chiropractor to patient, the sharing in *faith* in manipulation as a form of therapy, the placebo effect of the laying-on of hands, and the fact that the minor musculo-skeletal disorders which are the backbone of chiropractic are themselves self-limiting or subject to spontaneous remission."

46. The Commission regards this as a persuasive but facile attempt to explain away the results achieved by chiropractors, some physiotherapists, and some doctors who specialise in manual therapy. The Commission accepts that in some cases some of the factors mentioned by the Medical Association may assist the practitioner in achieving the result. But on the whole of the evidence we reject the Medical Association's submission as a complete explanation of chiropractic successes.

In General

47. Looked at on its own the Medical Association's principal submission is a persuasive document. Looked at in the context of the whole of the evidence before the Commission it is a document plainly calculated to present chiropractic in the worst possible light, and to emphasise chiropractic's worst features.

48. The writer of the submission presented it orally and was cross-examined. We do not doubt his integrity. But as we watched him and listened to him it became clear that he had a degree of bias and prejudice against chiropractic so intense that it deprived him of the capacity to make any balanced or objective assessment of chiropractic. For that reason alone we could not give great weight to the Medical Association's principal submission.

49. There is another reason as well. The principal submission looks at chiropractic as if from a remote distance. Some of the chiropractic literature is examined: there has been no lack of research into the written material, although we are left wondering whether the research extended to material which tends to favour chiropractic. Be that as it may, there is no indication that the writer made any serious attempt to find out or to understand exactly what chiropractors actually do in practice in New Zealand. The submission is therefore in essence an academic exercise. Chiropractic cannot be fairly evaluated from a library desk.

50. In our evaluation of the Medical Association's principal submission we must not overlook what we see as the general medical attitude towards chiropractic. It was clearly identified for us not only by the writer of the principal submission but by other medical witnesses as well. It is an underlying bias against the health practitioner who does not have an orthodox medical qualification; an unwillingness to admit even the possibility that in the specialised art of spinal manual therapy chiropractors are better trained than any ordinary medical practitioner and more skilful in that art than most medical practitioners.

51. Now it is right that organised medicine should be sceptical of the claims of unqualified practitioners. It is in the public interest that organised medicine should have that attitude. Doctors have a professional responsibility to warn and if necessary to defend the community against any health treatment which for one reason or another could be hazardous or which is ineffective.

52. So medical scepticism has its place. And chiropractors have only themselves to blame if that scepticism is increased in their case by the more extreme chiropractic literature and the unwise activities of a few chiropractors. But, as we have said, the principal submission of the Medical Association certainly went beyond scepticism. We are satisfied that organised medicine in this country has never given chiropractic a fair trial.

Chapter 26. THE GENERAL PHYSIOTHERAPY SUBMISSION

INTRODUCTORY

1. The New Zealand Society of Physiotherapists, in association with the New Zealand Manipulative Therapists' Association and the New Zealand Private Physiotherapists' Association, was represented at almost all hearings of the Commission. The submission of the society (Submission 75), including the material supplied in connection with it, was most useful to us. The society also helped to provide experts from overseas.

2. Although the conclusions reached by the New Zealand Society of Physiotherapists and its associated groups were not in favour of chiropractic, we should like to record that the stand taken was a constructive one. The physiotherapists saw themselves as critics of chiropractic, not enemies. It did seem, too, that some day all specialists in manual therapy, whatever their background, might be able to work together in further research. However, at present, physiotherapists are aligned with the Medical Association in opposing the provision of health benefits for chiropractic patients.

3. It was noteworthy that the group of physiotherapists specialising in manual therapy were responsible for preparing the material for the submission. They also presented it and were therefore available for cross-examination. This was valuable since, apart from the chiropractors, they were better informed on the use of manual therapy than any other group who appeared. Although, in general, they echoed the medical opposition, they were more specific and were also prepared to make suggestions about integrating chiropractic into the health system. They also saw the need for research into manual therapy.

EDUCATION OF PHYSIOTHERAPISTS

4. At this point something needs to be said about the education of physiotherapists and, in particular, of manipulative therapists since they maintain that they are capable of providing all the services now mainly performed by chiropractors.

5. A 3-year full-time course is offered for the Diploma of Physiotherapy. A third of the course (1200 hours minimum) is spent in clinical practice. The rest is made up of basic sciences, physiotherapy skills, clinical science, and elective studies. Shorter than the chiropractic course, it is also much less demanding. Those who enter training in 1979 and in subsequent years will probably have a preregistration year after graduation.

6. The education of the physiotherapist at present is the education of a paramedical. He is taught the basic sciences as a general background to his role within the framework provided by the referring medical doctor. Obviously, once he is in practice, hospital or private, his skill and confidence grow. It is in rehabilitation of the patient that the work of the physiotherapist has special importance, particularly in the hospital setting. His main methods of treatment are electro-therapy, therapeutic movement (remedial exercise), traction, massage, and mobilisation procedures. Certainly physiotherapy education, with no significant

training in differential diagnosis, does not fit physiotherapists to be providers of primary health care. Moreover, we note that the staff of the physiotherapy schools are not highly qualified. Apart from part-time visiting staff, very few have qualifications beyond the physiotherapy diploma.

TRAINING IN MANIPULATIVE THERAPY

7. We come now to training in manipulative therapy, to use the term adopted by the physiotherapists. This is defined by them to be movement of joints beyond their normal passive range. The basics are taught early, but only in the last year is some limited instruction given in manipulation, including the joints of the spine. Both in New Zealand and in England the instruction appeared to be elementary, even crude. At St. Thomas' in London, even under Miss J. Hickling who has so much influenced New Zealand therapists, the training appeared unstructured.

8. In New Zealand, physiotherapists wishing to specialise in this field must undertake the post-graduate course arranged by the New Zealand Manipulative Therapists' Association. We have briefly discussed this in chapter 5. The course reaches the standards of the International Federation of Orthopaedic Manipulative Therapy and there is no doubt that some New Zealand practitioners are highly skilled.

9. However, the Commission has reservations about the way in which physiotherapists as a group acquire their manipulative training. They are taught techniques at weekend courses and at certain points are sent away to practise them, unsupervised, before they are fully trained. The Commission has a similar reservation about those medical practitioners who, with even less training, in fact considerably less, undertake spinal and other manipulation. We are satisfied that the safest source of manipulative or manual therapy in New Zealand is the chiropractor.

10. The training of physiotherapists in areas other than manipulative therapy makes them very valuable members of the health team. It would seem that they should concentrate their energies on promoting before organised medicine the benefits of physical therapy, and on improving their educational standards.

CRITICISM OF CHIROPRACTIC

11. Physiotherapists oppose chiropractic because they question the scientific training of chiropractors and the scientific basis for their theories as well as the way they shift their ground when trying to validate those theories. However, as we discuss later (chapter 38), the chiropractors' level of attainment in the basic medical sciences clearly exceeds that of the physiotherapist and approaches that of the medical graduate. We deal fully in chapter 37 with criticisms of the underlying scientific basis of chiropractic itself. As for the assertion that chiropractors "shift their ground", we have touched on the point in chapter 8, para. 17. It is an argument that leads nowhere. It can support the view that chiropractors are cultists: it can equally support the view that they have the open-minded approach of the scientist.

12. Physiotherapists criticise the single modality of the chiropractor and compare it, to the latter's disadvantage, with their own range of treatment. It is true that New Zealand chiropractors (though not necessarily North American ones) confine themselves to manual therapy whereas physiotherapists may utilise heat, light, ultra-sound, and water.

However, unless physiotherapists wish to encourage a duplication of effort, we see nothing objectionable in the chiropractor's choice of a single modality in which he specialises as long as he is fully informed of the value of physiotherapeutic methods and of the circumstances where they are indicated. An open attitude towards referral between chiropractors and physiotherapists is the best safeguard against any difficulty that might arise.

13. Manual therapy in the hands of physiotherapists, it is explained, provides treatment for the extremity joints, not just the spine. Their practitioners offer a total musculo-skeletal therapy, whereas, it is claimed, chiropractors are limited to the spine. We have already stated that current chiropractic courses provide adequate training in extremity joint procedures (see chapter 38). There is no legal impediment to chiropractors treating extremity joints, and many do.

14. Physiotherapists are convinced of the value of manipulation and argue strongly in its favour. However, they see no need for undue sophistication in this field. "It is our stance that manipulation, useful as it appears to be clinically should not be allowed to become shrouded in unnecessary sophistication which leads to overclaim inevitably and this is particularly so with regard to techniques" (Transcript, p. 1364). Clearly there are two distinct and strongly held points of view: that of the physiotherapist and that of the chiropractor.

15. The manipulative therapist learning his techniques as he does in a fragmented fashion, first very sketchily at a physiotherapy school, then in a course spread over 3 years or more in small sections, contends that while practice is essential there is little point in over-refinement of what is only a strictly limited range of techniques. The chiropractor, on the other hand, in his 4 or even 5 years at college has a much greater and more systematic exposure to techniques. He naturally believes that the expertise he achieves before he uses these techniques, unsupervised, on his patients, must with further practice give him a greater ability to help those patients. Besides, he tends to become a specialist in the one area, the spine.

16. It is claimed that chiropractors over-refine their skill. At the same time it is alleged that their technique consists mainly of the "dynamic thrust". This is claimed to be dangerous because it is a sudden high-velocity movement, the patient cannot see what is being done, cannot resist the thrust, and is therefore at the chiropractor's mercy. Until the Commission saw chiropractors at work it imagined from such descriptions that this was the only way the chiropractor operated while the physiotherapist/manipulative therapist with his gentle articulations, extensions, or mobilisations was a very different practitioner. The truth is that while the chiropractor's movements are indeed often very quick, perhaps more so than those of the manipulative therapist, they are also usually small and precise. The most forceful manipulations we saw were performed by manipulative therapists.

17. While the physiotherapists asserted that patients are often harmed by over-zealous manipulation by chiropractors, evidence in support was almost totally lacking; and we find that chiropractic treatment is safe (see chapter 15). We have no evidence which would justify us in reaching any concluded view about the safety of spinal manual therapy carried out by practitioners other than chiropractors. It is astonishing how similar some of the perfected techniques are whoever the practitioners are. It is even more astonishing how unaware they are of this similarity. However, while there are a few physiotherapists and medical practitioners who are

especially skilled manipulators, *all* chiropractors have more training and experience (they are indeed full-time manipulators) and on average can be expected to be more skilled and more effective.

PHYSIOTHERAPISTS AND MEDICAL PRACTITIONERS

18. As we have said, the general physiotherapist submission largely supports the views of the Medical Association. However, particularly from the closing address of counsel for the Society of Physiotherapists (Submission 134), it became clear that physiotherapists, especially the manipulative therapists, face certain strains in their relationship with the medical profession, some of their own making, some caused by the medical attitude to other branches of the health services. Sections of the medical profession have adapted very well to a changing role, others have still to recognise that health care services no longer consist merely of doctors and nurses. Yet as the natural leaders of the team, medical doctors must help more to define their own role and that of others. All members need to become more aware of the skills of the others. Inter-disciplinary co-operation and interchange need to be developed, especially at a formal level.

GENERAL

19. Three useful points emerged from the submission itself. First the value of manual therapy performed by a trained and experienced practitioner, secondly, the continuing need for communication and co-operation among the different practitioners, and, thirdly, the need for more clinical research in manual therapy.

20. Whether the ordinary physiotherapist or even the manipulative therapist will want to extend his role to become a primary health care provider, as appears to be the desire in the United Kingdom, Canada, and Australia, will be a matter for the profession. If this is what it wishes, the training programmes would have to be considerably extended particularly in the area of diagnosis.

21. In the main submission and especially in counsel's closing statement, a plea was made for provision within the State-supported education system of high-level training in manual medicine. Certainly, as we have said, the future of the present manipulative therapists' training programme in New Zealand seems somewhat insecure: those organising it are unable to obtain Government funding for it. In the Commission's view this denial of Government funding could be justified on the ground that the manipulative therapy programme involves a duplication of the training in manipulative therapy conducted much more effectively in the chiropractic colleges. Certainly nothing we have heard about the manipulative therapy programme convinces us that it can be compared in quality with the thorough full-time training over a period of years undergone by the chiropractor. In our opinion, if there is to be any question of Government funding for manipulative therapy education, it would be better allocated to bursary assistance to enable physiotherapists who wish to broaden their horizons to attend the Preston Institute in Melbourne. The Preston Institute, by the same token, might wish to consider whether the holder of a Diploma in Physiotherapy might receive some credits towards the chiropractic degree course.

22. In the Commission's view, the future of spinal manipulation, manual therapy, lies primarily with the chiropractic profession, but we should like to think, in close co-operation where necessary with the physiotherapists. We have more to say on this subject in chapter 45.

Chapter 27. THE NEW ZEALAND MEDICAL EXPERTS

INTRODUCTORY

1. We now deal with the submissions of four New Zealand medical specialists who gave evidence before the Commission. Sir Randal Elliott's evidence was confined largely to the reasons against any system of referral by medical practitioners to chiropractors, and we deal with it in that context (chapter 41). Dr K. E. D. Eyre is a visiting neurologist to the Auckland Hospital Board and is in private consulting neurological practice in Auckland. Dr O. R. Nicholson is an orthopaedic surgeon, Clinical Reader in Orthopaedics in the University of Auckland Medical School, Senior Visiting Orthopaedic Surgeon at Middlemore Hospital, and Surgeon in Charge of its Spinal Injuries Unit and Scoliosis Clinic. Professor J. I. Hubbard is Professor of Neurophysiology and Chairman of the Department of Physiology in the University of Otago Medical School. All were called as witnesses by the New Zealand Medical Association.

2. There is no doubt that the latter three expert witnesses are specialists in their separate fields. But as we heard them explaining and elaborating their respective points of view we became very conscious of the fact that in our examination of chiropractic we were entering a kind of no man's land into which medical and scientific knowledge had so far been unable to penetrate with any real success. It is like a French impressionist landscape; outlines are blurred and indeterminate. The objects in the landscape tend to gain a subjective identity from what each viewer expects to see. So it is with aspects of neurobiology. We can use our existing scientific knowledge to suggest what the patterns might be, but we cannot be certain. We can be hopeful that sooner or later scientists will by stages provide complete answers. But that has not happened yet.

3. The difficulty is well illustrated in a comment made by Dr R. G. Robinson, Professor of Neurosurgery at the University of Otago Medical School and Director of the Neurosurgical Unit of the Dunedin Hospital. Dr Robinson had supplied his comment to the Consumers' Institute in the course of that institute's inquiry into chiropractic in 1975. During our Dunedin sittings we took the opportunity to see Professor Robinson and to ask him if in the intervening period he had seen any reason to modify anything in what he had told the institute. His response was that he did not wish to change anything. We have already set out Professor Robinson's comment in an earlier chapter, but we repeat the relevant parts of it:

It is a matter of common knowledge that most tissues and organs are supplied with nerves and that the proper function of these does depend, to a varying degree, on the integrity of these. Thus, for instance, a muscle is quite useless without its nerve supply. On the other hand, the pancreas can probably get along quite well without its nerves, although of course would then be not quite fully functional. There has been a longstanding neurological theory that in some sort of way nerves give the tissues they supply some trophic function. This concept has been never very easy to conclusively prove in scientific terms. A good bit of the so called trophic changes may well be due to disuse than some mysterious trophic or vital function.

While in theory some reduction in the nerve supply to an organ might render it more liable to disease, I know of little work that has ever conclusively proven this, that is apart from those disorders where the disease process is an intrinsic disorder of the nerves itself.

The usual sort of thing that happens when nerves are interfered with by pressure or misalignments are pain in the course of the nerve and if the nerve supplies some muscles then there may be some weakness also of these muscles. It has never been very easy to take it any further than that.

4. Professor Hubbard, in the course of his evidence, wholly agreed with that statement.

5. Before we consider in any detail the evidence given by Dr Eyre, Professor Hubbard, and Dr Nicholson, we find it helpful to review in simple terms the possible operation of the nervous system so far as is relevant to spinal manual therapy.

THE COMPLEXITY OF HOMEOSTASIS AND THE NERVOUS SYSTEM

6. Our bodies are constructed so as automatically to cope with a hostile environment and to resist disease and disorder. It is an automatic compensatory and balancing process. It is known as homeostasis. It not only protects the whole human system from hostile influences: when hostile influences do in fact cause damage it sets to work to repair the damage. So that if we cut our finger the body's natural healing and recuperative forces are immediately marshalled to put the damage right. It sounds simple. In fact it involves processes and mechanisms complex beyond the imagination of most people. Medical science has certainly not discovered exactly how some of them work. Mechanical and electrical analogies can never provide a complete picture. The human body is much more than just a piece of complicated machinery.

7. What governs these homeostatic reactions, these processes and mechanisms which are working all the time to ensure our bodies' normal functioning and which introduce compensatory factors to correct abnormal conditions? No one really knows. What does seem clear is that the processes and mechanisms involved depend on an extremely complex series of responses and interactions in which the nervous system appears to play an important part. When we cut our finger it is probably the nervous system which takes notice of the fact and which marshals and directs the various biochemical agencies to start and carry through the healing process and to guard against infection.

8. Now as we have said, the working of the nervous system in all its details is not yet fully understood by medical science. But it does seem that science has advanced to a point where it can be said with confidence that a stimulus directed at one point in the nervous system passes through a series of stages and that the final result of the stimulus will depend not only on each of the links between the stages taken separately but also on the state of the whole chain. For this purpose it is a mistake to regard the various branches or departments of the nervous system as anything other than morphologically and functionally interconnected: their exact boundaries cannot be identified. Dr K. E. D. Eyre confirmed this when he told us, in describing its various divisions, that the nervous system had nevertheless to be regarded as "an integrated whole".

9. So if nerve stimulus arises at one point, the nervous system will respond to cope with it. It may well be that the effects of that response will be noticed at or around the site of the original stimulus, perhaps in the form of stiffness or pain.

10. But there seems to be no reason in principle why the effects of the original stimulus should not also manifest themselves elsewhere, perhaps at a point already predisposed to weakness or failure. It is like an overload

in household electrical wiring. Suppose the wiring of a kitchen power outlet is in a weakened condition. It will stand up to the power drawn by an electric kettle; but add a toaster as well and it may fail.

11. Let it be understood that a simple analogy like that cannot hope to be anything more than the crudest attempt to describe the incredible complexity of the working of the nervous system. For one thing it is plainly inappropriate to think of the nervous system in terms only of electrical impulses. But the point is this: a stimulus applied in one area may show up as a noticeable effect in another area. We do not understand that to be disputed. So if it can be postulated that a spinal dysfunction produces a stimulus in immediately adjacent nerves, that original stimulus may manifest itself in a nervous reaction in another part of the body. Of course, as Dr Eyre pointed out, the process can work the other way. But take away the original stimulus by correcting the spinal dysfunction and the nervous reaction elsewhere will—or ought to be—reduced, for its cause has gone. That is logical.

12. There is, however, one important point. It is again a logical one. Such is the complexity of the nervous system that it is only to be expected that it would be very difficult to predict what the exact result of an abnormal stimulus to one part of it might be. Because the nervous system, under the impact of an abnormal stimulus, immediately puts compensatory forces into operation to preserve its natural working balance, the effects of that abnormal stimulus may not become immediately apparent to the person concerned. If the stimulus is of relatively limited duration, or has a cause which can self-correct by other than mechanical means, one can understand—as Dr Eyre appeared to suggest—that the process of homeostasis might be expected to remedy the fault. But the stimulus may be of a kind that will continue until a mechanical correction is made. In such a case the nervous system may adjust to the continued presence of the abnormal stimulus and may settle down as, in effect, a new nervous system incorporating the stimulus. Or the result may be a gradual process of nervous excitation at another point that may go undetected for months or years before it shows up as, or translates itself into, a positive symptom of disorder. Or there may be an immediate and evident reaction. The problem is that in our present state of scientific knowledge no one can really know. A gastric ulcer, for instance, may have developed as a result of abnormal local nerve activity, and that activity may have been induced by nerve irritation at the site of a vertebral joint dysfunction. Or the abnormal activity which has given rise to the ulcer may have resulted from nervous excitation from another source altogether. Dr Eyre told us that severe burns can produce peptic ulcer. One cannot know for certain. But the chiropractor who identifies a vertebral joint dysfunction in such a case will operate on the working hypothesis that the dysfunction could be the cause of nervous irritation which in its turn could be the cause of the nervous excitation which is activating the ulcer. He adjusts the vertebrae and corrects the dysfunction. If the ulcer is relieved he may reasonably infer that his hypothesis was correct. It is, of course, and necessarily must be, a “wait and see” approach. While the chiropractor’s hypothesis enunciated above could well prove to be scientifically untenable, in the present state of knowledge about the precise working of the nervous system there is no justification for anyone to label the chiropractor’s hypothesis irrational.

13. We must enter two caveats. In the first place, in the present state of scientific knowledge we cannot assume that the nervous system is the only

part of the human mechanism that is involved. All parts of the human mechanism are inter-related in some way.

14. Secondly, there is the question of the nature and the degree of the stimulus that may be required to trigger off a reaction in some part of the body remote from the original stimulus. Dr Eyre and Dr Nicholson both addressed themselves to that question. We will look at it further as we discuss their evidence.

DR K. E. D. EYRE'S EVIDENCE

15. The essence of Dr Eyre's argument against chiropractic is seen from the summary which he supplied (Submission 114, p. i):

1. Chiropractic is one of a number of systems of medicine.
2. It is a putative alternative independent primary health care system.
3. The basis of chiropractic is the notional concept of vertebral subluxation. Disease is supposedly secondary to postulated resulting nervous system dysfunction.
4. Chiropractic attempts to prevent and cure disease by spinal adjustment which can influence only a portion of the central nervous system inflow and outflow.
5. Disease is characterised by multiplicity and complexity of cause and nature and not likely to be attributable to the simple unitary chiropractic concept or amenable to the extreme limitation of its method of treatment.
6. Chiropractic could not reasonably be considered as the basis for an independent primary health care system.

16. Three of these points may be dealt with briefly. In the first place the Commission cannot regard chiropractic as a "system of medicine". Chiropractors should not, and most in New Zealand do not, hold themselves out as providing an alternative system of comprehensive health care. In the Commission's view chiropractors are specialists who confine their diagnostic and therapeutic endeavours to biomechanical dysfunction, principally of the spinal column.

17. Secondly, in the course of his cross-examination Dr Eyre came back over and over again to the concept of chiropractic as an "independent system of disease". What Dr Eyre was referring to was the notion that diseases are caused by spinal subluxations, a notion which on its own presents a distorted view of chiropractic. But plainly Dr Eyre was on firm ground when he repeatedly told us (Transcript, pp. 3587-9) that he could not see how ". . . an independent system of disease and its treatment can be based on spinal subluxation". We entirely agree.

18. So we are able to dispose of Dr Eyre's first, second, and sixth points, and part of his third point, by partially agreeing with him but by holding, as we do, that responsible chiropractors in New Zealand do not regard themselves either as providing an alternative system of comprehensive health care or as qualified to do so. That leaves Dr Eyre's third, fourth, and fifth points.

19. Our finding is that responsible chiropractors in New Zealand recognise the "multiplicity and complexity" of the cause and nature of disease. They hold, however, that some disease may respond to correction of a spinal subluxation in some cases. Our view on the whole of the evidence is that they have reasonable grounds for so believing. That disposes of Dr Eyre's fifth point.

20. Dr Eyre's fourth point causes no great difficulty. He did not dispute that a spinal subluxation (in the medical sense) could bring about organic or visceral disorder. In answer to questions on behalf of the Chiropractors' Association he said (Transcript, pp. 3587-8):

I would readily agree that there are spinal subluxations. I see them every day and I see the effects of them. I am not denying that there is any such thing as subluxation or that spinal subluxation produces effects . . . I would agree that spinal subluxation causes disease. We would be wasting our breath to deny otherwise.

It is only fair, however, to treat Dr Eyre's reference to "subluxations" as a reference to subluxations in the medical rather than the chiropractic sense (see chapter 9). For he made it clear elsewhere in his evidence that he had difficulty in seeing how the correction of a chiropractic subluxation could bring about any alteration in organs whose nerve supply was confined to the cranial and sacral areas which, he said, were areas not susceptible to manual adjustment. He also pointed out that drastic insult to the thoraco-lumbar sympathetic outflow by, for instance, thoraco-lumbar sympathectomy (severing the sympathetic trunks) for malignant arterial hypertension did not produce visceral or organic results which might have been expected if chiropractic theory were sound.

21. As we have already seen, the chiropractic subluxation is essentially a biomechanical dysfunction. It is obvious that such a dysfunction can produce back pain. If it can do that, there seems no logical or neurobiological reason why it should not produce other disorders resulting essentially from the original stimulus. But it must necessarily be a matter of speculation: when Dr Eyre was asked, "Are the interactions between the various systems [of the nervous system] . . . yet fully understood?" his answer was a positive and immediate disclaimer (Transcript, p. 2073). At all events we take from Dr Eyre's evidence (Transcript, p. 2062) that a vertebral subluxation could cause some alteration of function in the autonomic (or visceral) nervous system and thus alteration of function in the viscera.

22. It is in the Commission's view unfortunate that Dr Eyre was invited (but certainly not by the Commission) to place the emphasis of his submissions on the demolition of chiropractic theory as an independent and total system of disease and chiropractic practice as an independent system of comprehensive health care. He was to a considerable extent flogging a dead horse. Chiropractors themselves began the demolition some years ago. The Commission's recommendations on chiropractic professional discipline (see chapter 43), if accepted, are likely to complete the job as far as the very few chiropractors are concerned who still hold themselves out as providing a total primary health care system. The Commission does not regard the remainder of Dr Eyre's evidence as negating, from a scientific standpoint, the effectiveness of chiropractic treatment in Type M and some Type O cases. The true explanation must await the results of further research.

PROFESSOR J. I. HUBBARD

23. Professor Hubbard in essence made two points. First, he emphasised the importance of obtaining the confidence of the patient: he contrasted the attention given by the medical schools to this aspect of medical care with the attitude of chiropractors, and told us that he hoped medical schools would be encouraged to underline the need for proper treatment of the patient. He went on to say (Transcript, p. 1929):

It seems to me that this is the chiropractor's strength, and that this, in itself, has great therapeutic benefit. It seems to me that with the rise of scientific medicine we may have 'thrown the baby out with the bath water'; just because we have a few specific remedies we have neglected the relationship with the patient, which in many diseases is just as efficacious as some of the remedies.

24. Professor Hubbard made this point as part of a general assertion that the placebo effect played a large part in chiropractic results. We have dealt with the placebo effect and its importance elsewhere and there is no need to repeat what we have said.

25. The second main point made by Professor Hubbard concerned the relatively recent discovery of the effect on pain of substances known as enkephalins and endorphins. Enkephalins and endorphins are pain relieving chemicals produced within the brain. He told us that people who suffer from chronic pain, including some patients with lower back pain, have lower levels of endorphins. It appears that electrical stimulation similar to acupuncture (in which Professor Hubbard is interested) raised the endorphin levels of the cerebro-spinal fluid of the patients with back pain and relieved their pain.

26. Professor Hubbard on this basis suggested that in some way the placebo effect of a chiropractor's treatment resulted in an increase in endorphin levels (Transcript, p. 1922):

... I now believe people with confidence in the chiropractor in his laying on of hands may manipulate the mood of the patient to such a degree that he would produce his own pain relieving chemicals.

The difficulty is, as Professor Hubbard acknowledged (Transcript, p. 1932), that the effect of the release of endorphins lasts only a matter of hours; then the pain reappears.

27. We must clearly add the discovery of the influence of endorphins on pain to the category of possible explanations for some of the effects of chiropractic treatment which demand further research.

DR O. R. NICHOLSON

28. Dr Nicholson gave evidence which was interesting from the orthopaedic viewpoint. He pointed out that pain in the lower back is a remarkably common disability. But he emphasised it was not a condition which had only a single cause, and because of the variety of causes not a condition for which a single method of treatment would be appropriate.

29. On the question of chiropractic treatment Dr Nicholson made the following point in his submission (Submission 72, p. 13):

The sole method of treatment available to the chiropractor is manipulation or adjustment of the vertebral column. It is apparent that in recent years many chiropractors are stating that they *may* use other methods of treatment in appropriate cases or refer cases to medical practitioners. It is also apparent that this does no more than cloud the basic and fundamental issue that chiropractic is a theory of the causation of disease which cannot be substantiated, either on the basis of clinical experience or a knowledge of the underlying pathological basis of disease.

We have already dealt with this argument and there is no need to repeat what we have said.

30. Dr Nicholson did, however, enlarge on other matters in his oral evidence. First, he verified that there can be dramatic relief from some back problems by spinal manual therapy. He pointed out that this could occur under the ministrations of "general practitioners, orthopaedic surgeons, and physiotherapists" (Transcript, p. 1995) and was not confined to the ministrations of chiropractors. He went on to say, however, that the medical explanation for what occurred in such cases was no more than conjectural, and that the opinions of manipulative authorities differed.

31. Secondly, Dr Nicholson stressed the importance of an X-ray prior to manipulation. He was asked (Transcript, p. 2011):

Q: Assume that we have a patient with low back pain and manipulation is going to be given as a treatment. Do you regard X-ray examination as essential as a general rule prior to that treatment?

A: I do not think we can say it is essential, but highly desirable, yes, as a general rule.

32. We record that at St Thomas' Hospital in London an X-ray is

regarded as an essential procedure before spinal manipulative therapy is undertaken.

33. Thirdly, Dr Nicholson made it quite clear that manipulation is the quickest treatment for back pain available for those patients for whom it works. The qualification needs explanation. As we shall see (chapter 37) Doran and Newell (*British Medical Journal*, 1975, 2, 161–164) conducted a multicentre trial in which a number of patients with low back pain were randomly allocated between manipulative therapy, definitive physiotherapy, corset, and analgesic tablets. The finding was that a few patients responded well and quickly to manipulation, but there was no way by which those controlling the trial had been able to identify such patients in advance. That was the point to which Dr Nicholson was referring. The Doran and Newell trial has not escaped criticism and we later express our reasons for not treating it as a significant factor in our general conclusions.

34. Finally, Dr Nicholson stressed the point that there is no evidence that patients with scoliosis (spinal curvature), where there is undoubted distortion of the spinal cord and spinal nerves, develop diseases or symptoms remote from the spine any more frequently than those in the general population. If it is true that a chiropractic subluxation can prompt a visceral or organic reaction and thus visceral or organic disorder, it might be expected that patients with scoliosis would commonly develop visceral or organic symptoms. That there is no evidence of this, says Dr Nicholson (Submission 72, p. 10) is:

... a most important observation and completely refutes the chiropractic concept of the production of disease.

35. We consider this an over-simplified view of the matter. In any case we do not understand chiropractors to claim that a person with scoliosis must have a subluxation. However the need for caution in considering Type O disorders in relation to chiropractors tends to be confirmed.

Chapter 28. GENERAL EVALUATION

1. The evidence against chiropractic is not as impressive as it might have seemed at first sight. At the end of the day what does it amount to?

2. The assertion is twofold, and in essence it is this: first, spinal manual therapy cannot be effective against some causes of back pain. That is because back pain is in some instances caused by certain conditions which cannot be remedied by manual adjustment of the vertebrae. Secondly, the chiropractor's principal mode of treatment which is manual therapy, is unlikely, by any presently known neurophysiological process, to be able to affect the course of visceral or organic disorders.

3. These points are supplemented by the argument that chiropractors have been unable to provide an explanation which is acceptable to medical science of how the results which are claimed to have been achieved by spinal manual therapy can be attributed to it. It is also argued that chiropractors have been unable to identify, to the satisfaction of medical science, precisely what it is they say they are treating.

4. The results which chiropractors say they achieve by means of spinal manual therapy can be explained, so it is argued, on a variety of medically known grounds involving phenomena quite independent of any direct neurophysiological consequence of the adjustment of vertebrae: the placebo effect, the release of endorphins by the psychological effect of laying on of hands, the self-limiting nature of the disorder in question, and so on.

5. Now all this is subject to two important qualifications. In the first place it is not seriously disputed that there are significant gaps in neurophysiological knowledge. Secondly, so far no definitive medical or scientific explanation of the precise mechanism of back pain has been found: we exclude, of course, certain pathological conditions known to cause back pain and which are known not to respond to spinal manual therapy.

6. Where does this leave us? The Commission is not satisfied that attempts to explain the results of spinal manual therapy by invoking phenomena independent of any direct neurophysiological consequences of such therapy are any more than attempts to explain away the undoubted successes that spinal manual therapy is known to have achieved. And we are unable to discover any evidence which would enable us to infer that the regular referral by medical practitioners of patients to physiotherapists for manipulation or mobilisation for back pain, headache, and migraine is regarded as anything other than proper and ethical medical practice.

7. However the matter is looked at, the position is that nobody is able to provide a final and definitive explanation of the exact mechanism by which the known results of spinal manual therapy appear to be achieved. In the present state of medical and scientific knowledge nobody can do any more than put up hypotheses.

8. So that leaves us, in the meantime, with what actually appears to happen. None of the evidence adduced in opposition to chiropractic satisfies us that it is unlikely that the beneficial results claimed to have followed treatment by spinal manual therapy arise other than directly from the act of adjustment regardless of whether the therapy has been delivered by a chiropractor or a physiotherapist.

9. In this general evaluation of the evidence against chiropractic we have not yet referred to the central theme running through the submissions and evidence of the Medical Association and the Society of Physiotherapists: that chiropractic could not be regarded as an independent alternative primary total health care system. As far as New Zealand is concerned we think the truth of the matter is that this horse was dead before organised medicine and physiotherapy started flogging it.

10. There is no evidence which satisfies the Commission that chiropractic is, or could be, regarded as an independent alternative primary comprehensive health care system. There is little evidence that suggests that any other than a very few New Zealand chiropractors come near to regarding it as such.

11. As far as we are able to judge, the principal evidence supporting a view of chiropractic as an independent comprehensive health care system comes from North America, where conditions are quite different. The idea has been spread by the very vocal opponents of chiropractic in North America, and we do not need to repeat our detailed assessment of the reliability and objectivity of those sources. But we ought to add that North American chiropractors have themselves created that impression by the extravagant claims in their general publicity material. So if some New Zealand chiropractors feel that the Medical Association and the Society of Physiotherapists have misrepresented the scope of their practices in their submissions in this inquiry, they should lay part of the blame at the door of their North American colleagues.

PART IV: THE EVIDENCE IN FAVOUR OF CHIROPRACTIC

Chapter 29. THE CHIROPRACTIC PATIENT: THE PATIENTS' QUESTIONNAIRE

INTRODUCTION

1. Between the time of our inaugural sitting and the date when we started hearing submissions and evidence the New Zealand Chiropractors' Association had, unknown to us, devised a questionnaire for chiropractic patients. The questionnaire was either mailed to patients or left in chiropractor's rooms for interested patients to pick up. Those who received the questionnaire were encouraged either to write a letter to the Commission or to fill in the questionnaire and send that in to the Commission. A printed envelope, addressed to the Commission, was supplied with each questionnaire form.

2. Some criticism was expressed by parties opposed to chiropractic of this means of soliciting information for the Commission, and it is therefore desirable to set out the questionnaire form and its accompanying notice. Both are stated to have been "Printed in the interests of Public Health by N.Z. Chiropractors Assn."

3. The text of the notice is as follows:

In 1975 a petition signed by over 97 000 people was presented to Parliament asking that the patients of chiropractors be entitled to the same health and accident compensation benefits as are received by patients of medical practitioners.

The Government has now set up a Commission of Inquiry to consider whether such benefits should be made available, and the Commission will commence hearings in Wellington in June 1978. The medical profession and the physiotherapists have indicated their intention to oppose very strongly the provision of any such benefits for chiropractic patients.

The Commission has given public notice inviting submissions from all interested persons by 31 May. As a patient or former patient your views could be extremely important to the Commission. The New Zealand Chiropractors Association would like you to write to the Commission. What you say and how you say it is entirely up to you. In case it may help, a list of points which are likely to interest the Commission particularly is attached. Letters should be sent to:

The Secretary,
Commission of Inquiry into Chiropractic,
P.O. Box 11343,
WELLINGTON.

It would be best if you wrote your own letter, but if you haven't time to do that would you please send the list of questions attached to the Commission with your comments on it. If you do that, please sign the form and add your address. An envelope addressed to the Commission is enclosed.

4. It is worth emphasising the care that was taken to ensure that communications from patients solicited in this way were sent to the Commission direct and that they were expressed in the patients' own words: "What you say and how you say it is entirely up to you". There was no evidence that there had been any attempt to influence patients in what they might say in their communication.

5. The text of the accompanying questionnaire was:

INFORMATION FROM PATIENTS

Information on the following points may be of assistance to the Commission of Inquiry into Chiropractic when considering the contribution of chiropractic to the health services in New Zealand.

1. Why did you first attend a chiropractor? (e.g. recommended by friend, referred by doctor or other health practitioner).
2. What ailment/s have you had treated by a chiropractor?
3. How happy were you with the treatment from the chiropractor? (e.g. very satisfied, satisfied, partly satisfied, not at all satisfied).
4. Any general comments you have on your treatment by a chiropractor or the treatment you received from other health practitioners?
5. (a) Do you think the Government should provide the same health and accident compensation benefits for chiropractic treatment as you are entitled to for treatment from a medical practitioner?
(b) My reasons are . . .

Spaces were provided for the patient's name and address.

6. The majority of the questionnaire forms were coded so that the individual chiropractors who had distributed them could be identified. The New Zealand Chiropractors' Association supplied us with the key to the coding. This was valuable because it enabled us to gain some impression of the range of disorders which in the patient's view had responded to a particular chiropractor's treatment.

THE RESPONSE TO THE QUESTIONNAIRE

7. The response was considerable. The Commission had to engage additional staff to cope with the volume of mail. Reading and analysing the responses became a major task.

8. The Commission received a total of 12 865 completed questionnaire forms, or letters which had obviously been written in response to the notice accompanying the questionnaire. To a degree the respondents were self-selected: in the main only current or satisfied patients would have had access to the questionnaire forms. In addition to that, it is reasonable to infer that the same notice prompted many of the 99 submissions put in by private individuals.

9. From the coding on the questionnaire forms we were able to see that the patients of 63 chiropractors had responded. The number of uncoded questionnaire forms was 800. The letters were of course uncoded, although in some the chiropractor was mentioned by name.

HOW WE DEALT WITH THE MATERIAL

10. In the early stages the Commission asked those who had written letters whether they wished their letters to be treated as formal submissions and, if so, whether they desired to appear before the Commission. A number responded affirmatively, and wherever possible we arranged to hear them.

11. But as soon as we became aware that most of the letters had probably resulted from the notice and questionnaire sent out by the Chiropractors' Association we altered our procedure. If the writer indicated that he or she wished to appear before the Commission, he or she was advised of the procedure to do so. In other cases letters were acknowledged and became part of the Commission's records.

12. However, in the course of reading the letters and questionnaire forms we thought it proper to pick out a limited number which either appeared representative of a great number of others, or appeared to have special features of interest. Many of these we referred to counsel appointed

to assist the Commission (Mr J. A. L. Gibson) for his opinion on whether further investigation was warranted. In the result we invited 54 individual respondents to appear before us in person. We invited them to appear in person because we felt that we could not place any real weight on assertions of fact which were not made under oath or tested by cross-examination. Eight of these 54 accepted the invitation and were available to be cross-examined by all interested parties. Another eight wished to give their evidence in private.

13. All letters and questionnaires were made available for inspection by the main organisations taking part in the inquiry and facilities were arranged for these organisations to take copies of any they required.

ANALYSIS OF THE QUESTIONNAIRES AND LETTERS

14. Unfortunately any more than a very general analysis of the responses was ruled out by the form of the questionnaire. For convenience we summarise the responses at this point.

Question 1: Why did you first attend a chiropractor? (e.g., recommended by a friend, referred by doctor or other health practitioner.)

Six hundred and fifty respondents (5 percent) reported that they had been referred by a doctor or other health practitioner.

Question 2: What ailment/s have you had treated by a chiropractor?

Nine thousand six hundred and thirty-five respondents (75 percent) reported that they had been treated for back, neck, and shoulder ailments only, and a further 566 (4 percent) for arm and leg problems. Two thousand six hundred and sixty-four respondents (21 percent) reported that they had been treated for other ailments; the number of individual cases of "other ailments" being 4193. The reason for the difference is that some respondents reported treatment for more than one ailment in this category. But many of these 2664 respondents treated for "other ailments" reported treatment for back, neck, shoulder, arm, and leg ailments as well.

Question 3: How happy were you with the treatment by the chiropractor (e.g., very satisfied, satisfied, partly satisfied, not at all satisfied).

Forty-nine respondents (0.4 percent) indicated that they were not satisfied. Eleven respondents reported that they were partly satisfied. Nine respondents reported that they were satisfied with the treatment from one chiropractor but not with the treatment from another, or satisfied with the treatment in respect of one complaint but not in respect of other complaints. We have already pointed out that the way in which the questionnaire forms were distributed could account for the nature of the response in this respect: very few dissatisfied patients would have received a questionnaire.

The responses to questions 4 and 5 were incapable of analysis, except that it was clear that the majority of respondents favoured provision of health and accident compensation benefits for chiropractic treatment.

15. It is therefore clear that the bulk of the the work of New Zealand chiropractors is treatment of back, neck, and shoulder ailments. We will adopt Dr W. T. Jarvis's classification (see chapter 22) and call these, along with arm and leg problems, Type M (musculo-skeletal) disorders.

We propose to include also in this category headache and migraine, a total of 1826 patients (14 percent), for reasons which we will explain later. With this inclusion the proportion of Type M respondents reaches 93 percent. The remaining (Type O) disorders reported by respondents as having been treated, and in most cases relieved, by chiropractors are indicated in table 29.1.

16. It is of interest to compare the analysis of the questionnaires in terms of "type of complaint" with a similar analysis of the New Patient Survey conducted by the New Zealand Chiropractors' Association and discussed in chapter 16. Clearly the two populations were selected on quite different bases but it might be expected that similar trends should appear. This is indeed so. Headache and migraine percentages are almost the same in both the questionnaire and the survey. Of the remainder, there appears to be a rather higher proportion of Type O patients in the survey but this may be for the simple reason that the rate of success for these patients would be expected to be lower and therefore a smaller proportion of Type O than Type M patients would have seen or received a questionnaire.

17. We do not consider that the various ailments listed in table 29.1 can be taken altogether literally: they are the descriptions given by the patients. In the course of our public and private sittings we invited a number of individual chiropractors to comment on some alleged Type O cases which, because of the coding, we knew related to particular chiropractors. From the largely negative responses we received we conclude that a number of these alleged cures may have been side-effects of treatment for something else, may be examples of self-remission, or that the patient had drawn the wrong conclusion from what the chiropractor had told him. But in any event in this respect we place far greater weight on the evidence we heard formally.

Table 29.1

QUESTIONNAIRE TO PATIENTS: TYPE O AILMENTS
TREATED BY CHIROPRACTORS, 7 PERCENT OF
AILMENTS REPORTED

Condition	No. of Cases
Allergy	8
Anaemia	7
Appendicitis	1
Appetite loss	2
Arthritis (all types)	249
Arterio-sclerosis	2
Asthma	188
Bedwetting	22
Bell's palsy	4
Bladder, kidney, and liver trouble	60
Bleeding nose	15
Blood clots	1
Blood poisoning	1
Blood pressure	77
Boils	1
Bowel problems (constipation, colitis, diverticulatis, etc.)	61
Brain disease (child)	1
Bronchitis	47

<i>Condition</i>	<i>No. of Cases</i>
Cerebral palsy...	1
Chest and lung complaints (coughs, colds, pains, emphysema, breathing difficulties, etc.)	112
Circulatory trouble	5
Colic	3
Concussion and blackouts	30
Croup	6
Cystitis	6
Deafness	24
Depression	37
Diabetes	5
Duodenal and gastric ulcers, etc.	22
Earache (infections, etc.)	28
Eczema	10
Epilepsy	14
Eye trouble (eyesight loss, double and blurred vision, etc.)	74
Facial pain (paralysis, numbness, neuralgia, etc.)	10
Fainting	2
Fever	2
Fits	3
Fluid retention	3
Gall-bladder trouble	11
Glandular fever	2
Glands (infected, swollen)	4
Goitre	10
Gout...	3
Gums (sore)	1
Haemorrhoids...	20
Handicapped and spastic children	3
Hallucinations	1
Hay Fever and catarrh	76
Heart trouble (palpitations, tachycardia, angina, etc.)	42
Hepatitis	3
Hernia	10
Hyperactivity (children)	6
Hypoglycemia...	3
Indigestion, heartburn, etc.	86
Insomnia	23
Loss of balance, giddiness, vertigo, etc.	91
Loss of weight	2
Mastitis cysts	1
Measles	1
Meniere's disease	6
Meningitis and after effects of meningitis	2
Menopause	6
Menstrual problems (pain, excessive bleeding, irregularity, etc.)	100
Multiple sclerosis	9
Muscular dystrophy	1
Nerves (nervous tension, breakdowns, etc.)...	135
Neuralgia	14
Neuritis	10
Osteomalacia	1
Osteomyelitis	1

<i>Condition</i>	<i>No. of Cases</i>
Paget's disease	1
Parkinson's disease	3
Perforated ear drum	1
Polio disabilities	3
Pregnancy	19
Prolapse	3
Psoriasis	2
Rheumatism	26
Rheumatic fever	2
Sarcoidosis	1
St Vitus dance... ..	3
Shingles	12
Sinusitis	247
Skin conditions	15
Sleeping sickness	1
Speech impediment	4
Speech loss	7
Stomach upsets (nerves, pains, vomiting, etc.)	115
Stroke, partial stroke, and after effects of stroke	5
Sunstroke	1
Tonsilitis, sore throats, laryngitis, etc.	49
Thrush	1
Toxaemia (child)	1
Urino-genital problems	2
Urinary infection	2
Ulcers (unspecified)	1
Varicose veins and ulcers	7
Virus infections, influenza	4
Warts	1

RELIABILITY OF THE QUESTIONNAIRES AND LETTERS

18. Obviously there are limits to the extent to which we can place weight on the questionnaire responses and letters. But a number of the respondents elected to appear, and we selected others (see above, para. 12). Nearly all the respondents we saw and heard appeared to us to be truthful people who had simply done their best to describe accurately what had happened. We consider it reasonable to take the view that at least the majority of the questionnaire responses and letters stated the facts as the respondents saw the facts. It is fair to infer that the great majority of chiropractic patients who responded believed they had been helped by chiropractic treatment. But having said that, we must obviously place much more reliance on those whom we saw and heard on the witness stand. We accept them as a representative cross section of satisfied chiropractic patients.

THE CORRESPONDENTS WHO GAVE EVIDENCE

19. The majority of the correspondents who gave evidence were impressive as witnesses. We felt that what they said could be relied on. They came from all sections of the community. They gave their evidence frankly and openly and many of them were cross-examined. All, except

the relatively few we heard in private, were available for cross-examination.

20. Many had gone to a chiropractor after unsuccessful medical and paramedical attempts to relieve their problem. Many of them went to their first chiropractic appointment with some considerable scepticism. Not many of the witnesses in this category seemed to us to be the type of person who would be fooled by glib talk or a persuasive manner: they went to the chiropractor hoping that they might get relief but not expecting to get it. The result of their experience was convincing to them.

21. That of course is not the end of the matter because it is still necessary to determine what weight is to be given to accounts of personal experiences of this kind. We deal with this aspect later.

CRITICISM OF THE QUESTIONNAIRE

22. The Chiropractors' Association was bitterly criticised by the Medical Association for having issued the questionnaire and for having elicited the responses to it. In his closing address counsel for the Medical Association made much of the matter:

In retrospect it may be seen as the single most effective, most decisive blow struck for the chiropractic cause. What other party to any inquiry or litigation has ever been sufficiently bold, daring or imaginative to flood the Tribunal with thousands of testimonials to its cause immediately before the hearing was due to commence? By a method so simple yet so subtle? So open yet so deceitful. In a way there is little point in complaining because no words will undo the effect: namely, subconsciously to implant the thought that something which has obviously done so much for so many must deserve consideration.

One may ask how any Tribunal would feel if for days and weeks prior to the opening of an important hearing they had been telephoned by individuals connected with one side of the cause which they were to hear and bombarded with laudatory messages. Yet what occurred is not different in principle. So simple a concept, yet a brilliant one, and devastating in its execution and one might add, traditionally chiropractic. The Commission, with respect, will never be able to decide objectively the extent to which it was influenced by this episode, for the reason that its influence was subconscious, subliminal, pervasive and insidious.

But there is one aspect about which the Commission may be crystal clear. This was no spontaneous outburst of letter writing by grateful patients. It was a carefully calculated exercise. The 'Notice to Patients' went out in April 1978 and stated that the Commission would commence hearings in June. Obviously it was timed so that the responses would be flowing in at or about the time that the Commission commenced its public sittings. . . .

I submit to the Commission that it should do its utmost—not to put the eleven thousand letters out of its mind, for that is impossible—but its utmost to realise and make allowance for the gigantic manipulation to which it was subjected, and to endeavour to appreciate the extent to which its thinking may have been preconditioned by this exercise. Indeed, whatever other impression one may have obtained of the skills of chiropractors during the hearings, one has to admit to a new respect for their skills in the ability to manipulate opinion as well as backs.

23. We consider these thrusts less than fair. At the outset of our Inquiry we expressly solicited submissions from the general public. We desire to say that in our view the Chiropractors' Association did not act wrongly either in arranging for our invitation to be brought to the attention of chiropractic patients or by pointing out to patients, in the questionnaire form, the points which it was believed might interest the Commission. We are quite unable to see how the encouragement of the patients to write to us about their chiropractic experiences could reasonably be regarded as an attempt to subvert the inquiry or to manipulate opinion. Indeed—bearing in mind our terms of reference and the very nature of this inquiry—we consider the Chiropractors' Association acted sensibly and properly. The result was that we were able to obtain some idea of how chiropractors appeared from their patients' viewpoint and were later able

to hear some of the patients, who had written in, giving their evidence on oath of their experiences. So we were able in this way to obtain sworn accounts, at first hand, of chiropractic treatment and its apparent results.

24. We therefore cannot regard as either reasonable or well-founded the Medical Association's criticism of the chiropractors' action in circulating the questionnaire to their patients and encouraging their patients to write to the Commission. We repeat that throughout this inquiry we were not disposed to place any real weight on assertions of fact which were not made under oath.

25. The questionnaire should of course have been better designed and less selectively distributed. The responses did not lend themselves to exact analysis, but in a matter of this kind there is room for doubt whether an exact analysis of anecdotal patient response would have served a really useful purpose. The responses on all the main points were really quite unequivocal: the view of patients as to chiropractic success in dealing with Type M problems was overwhelmingly favourable; it was also clear that a number of patients believed that they had secured through chiropractic treatment significant relief in a number of Type O disorders.

26. There is a further point we ought to mention. We do not think that the notice accompanying the questionnaire said anything that was unfair or which could have created a wrong impression. The patient was encouraged to write in, whatever his views. Nor do we think that the questionnaire was unfairly phrased so as to elicit a response only from those who favoured chiropractic treatment. The shortcoming was in the way in which the questionnaire was distributed.

"REFERRALS" BY DOCTOR

27. Of the 12 865 respondents, 551 stated in terms of question 1 of the questionnaire that they had been "referred" to a chiropractor by a doctor. We were naturally interested to know more about the circumstances in which "referrals" had been made by doctors. But by the time the questionnaires had been analysed there had already been some suggestion in evidence during our public sittings that the Medical Association had taken steps to remind medical practitioners of the ethical rule prohibiting collaboration with chiropractors. Before we made any inquiries into the "referrals" revealed by the questionnaires we therefore invited the Medical Association to say publicly whether it would refrain from taking disciplinary proceedings against any doctors whose identity might be revealed by our inquiries. We did not wish our inquiries to be frustrated by any suggestion of disciplinary proceedings.

28. The Medical Association, for technical reasons, was unable to give us an absolute assurance that no disciplinary proceedings would be taken. The Commission therefore wrote to a sample number of respondents inviting each to disclose the name of the referring doctor and to authorise the doctor to discuss the case with us. We undertook that we would treat the doctor's identity as confidential to the Commission and would hear his evidence in private unless he wished otherwise. The Commission later wrote to a number of doctors whose identity we learned in that way.

29. The result was rather as we expected. Only one doctor was prepared to tell us that he had formally referred patients to chiropractors. The other doctors who responded to the Commission's invitation all denied having "referred" patients. Indeed, many patients to whom the Commission had written replied saying that all their doctor had done was

to suggest that chiropractic treatment might be beneficial for them, leaving it to the patients to find their own chiropractor. They had answered question 1 of the questionnaire believing that the doctor's suggestion was a "referral".

30. So the reference to referral in question 1 could have been misunderstood. A formal referral by a doctor is quite different from merely suggesting to a patient that the patient might see a chiropractor: as to the formal referral process see chapter 41.

31. The one doctor who told us that he had made formal referrals to chiropractors was seen by us in private. We spent some time with him. We wish to record that we were impressed by his general attitude to the welfare of his patients. Before referring any patient to a chiropractor he had satisfied himself of the chiropractor's skill and that there were no contra-indications to chiropractic treatment. He spoke warmly of the relief his patients had obtained as a result of the referrals. It was clear that he was not prepared to let an ethical rule stand in the way of certain of his patients obtaining chiropractic treatment if that was in his opinion the best form of treatment for them.

32. We were also shown one or two letters of referral which doctors had supplied to patients for the purpose of the patients' claim to accident compensation payments for chiropractic treatment.

33. It will be seen elsewhere in this report that we consider the ethical rule in question to be wrong and no longer appropriate.

CHIROPRACTIC AS A LAST RESORT

34. It appeared from the questionnaires and letters that a very large proportion of respondents had gone to a chiropractor only after medical treatment or physiotherapy had failed them. Indeed that was a message that came to us very clearly throughout our inquiry. Those patients at least appeared to be satisfied that the chiropractor was able to put them back on their feet more quickly and more effectively than any other practitioner.

SUMMARY

35. We found the responses to the questionnaire helpful though of limited weight. We found the evidence of those respondents who appeared before us more helpful. We were able to gain a clear picture of chiropractic treatment from the patient's point of view. The great majority of patients who responded believed that they had obtained significant relief from chiropractic treatment. Most of them were treated for Type M disorders, but a proportion (7 percent) believed they had obtained at least a degree of relief in Type O ailments.

Chapter 30. THE CHIROPRACTIC PATIENTS' EVIDENCE: IN GENERAL

INTRODUCTION

1. We have already dealt with the questionnaire sent to patients by the Chiropractors' Association which elicited 12 865 responses. We now deal generally with the submissions and evidence of the chiropractic patients who appeared before us at our public sittings and those whom we heard in private at their request.

2. It must be said at once that if that testimony were taken at face value it would provide evidence of overwhelming weight of the effectiveness of chiropractic treatment, at least in the case of Type M ailments and some Type O instances.

3. But it was argued by those opposed to chiropractic that it was not permissible to take that view. Before we examine the testimony further we must therefore examine those arguments to see how far they are sound.

THE DANGER OF ACCEPTING ANECDOTAL EVIDENCE

4. A large number of chiropractic patients told us on oath of the details of their ailments and the way in which those ailments were treated. They told us their condition before they had chiropractic treatment. They told us of their condition after that treatment. Many of them spoke of the dramatic relief they experienced. It was obvious that they were speaking the truth. Why should anyone disregard evidence of that kind?

5. Yet it was strongly argued that this evidence was valueless. That was not because any witness was said to be lying. Five reasons were offered, which we summarise.

6. In the first place, it was pointed out to us that there was no way of knowing, on the evidence we had before us, what might have happened if the particular patient had been given a more orthodox means of treatment. That being so, how could we know that chiropractic treatment was any more effective than any other form of orthodox treatment? How could we know, indeed, that it was the chiropractic manipulation itself that brought about the relief, and not some other factor? There are scientifically designed tests which can eliminate extraneous factors and show positively whether it was the actual treatment itself that brought about the result. Those tests involve double blind and control procedures. No test of that kind had been carried out in New Zealand. By itself, the evidence of the patient alone does not provide a scientifically accurate criterion.

7. Secondly, and more specifically, it was said that many of these apparent cures could have been brought about by the placebo effect. That means that the patient, being convinced that something positive is being done about his ailment, convinces himself that he is cured, and his symptoms disappear. So when he says he is cured he is being perfectly truthful; but it is his state of mind, rather than the physical effect of the treatment, that has brought about the cure. That is not far-fetched. It is a recognised phenomenon.

8. Thirdly, and again specifically, it was said that because many disorders are self-limiting, the chiropractor can often mistakenly be given

the credit for a cure which has resulted, not so much from his efforts, but from the fact that the disorder has in any event run its course. So a patient, having strained his back, may be given a course of treatment by his chiropractor. When the treatment has continued for some time the stiffness and pain disappear. The argument is that this would have happened anyhow, simply because the strain fixed itself naturally. But the patient will believe, in complete honesty, that it is the chiropractor who has brought about the cure.

9. Next, there is the possibility that the medical diagnosis was wrong. A simple example will show what is involved in this point. We have already explained the phenomenon of "referred pain": see chapter 8, para. 32. Something goes wrong in the bodily system; pain is created. But the pain appears not at the site of the disorder, but at another site altogether. So the patient may have put his back out, but the pain caused by that may show up in the region of the heart and will exactly resemble the pain caused by angina. Now doctors know about referred pain and will recognise the possibility in making their differential diagnosis. Suppose the doctor who is examining our hypothetical patient mistakes the pain for anginal pain. It is easy enough to do. That means that the doctor can go on trying to manage the patient's angina with drug therapy, but the pain will remain because the doctor has mistaken its cause. Then our patient goes and sees a chiropractor. The chiropractor finds the spinal dysfunction and corrects it, and the pain goes. The patient thinks a miracle has happened: his angina has been cured. So the chiropractor gets the credit for curing a condition that had not responded to orthodox medical care. Clearly this is the sort of situation which the Commission must bear in mind. We have done so.

10. Finally, there is the argument which perhaps subsumes all the others. To accept the patient's account of his chiropractic cure is to be trapped by the logical fallacy expressed in the Latin maxim, *post hoc, ergo propter hoc*: simply because event B happens after event A, you cannot assume that event B happened *because* of event A. So simply because a patient with an aching back has chiropractic treatment and the ache disappears, it does not mean that the chiropractic treatment cured the ache.

11. Now we accept without any hesitation that the placebo effect is a medical and scientifically established reality. We accept too as a medical fact that many disorders will cure themselves in time. We have no difficulty in accepting that in the area of health care it is dangerous to jump to conclusions about cause and effect. That has been demonstrated too often to be disputed. And we acknowledge that a particular form of treatment can in principle, though not always in practice, be tested scientifically so as to determine whether it is the treatment itself and not any other factor that produces a particular result. We recognise also that a doctor can be wrong in his diagnosis, particularly in cases of referred pain which are always difficult.

12. Bearing all those matters in mind, we cannot regard as decisive the evidence of patients who told us of their belief that chiropractic treatment had materially relieved their disorders. The evidence is not decisive, but it is compelling.

13. When an isolated witness tells us that his aching back has been relieved by chiropractic treatment, the fact that the relief has come after the treatment may be pure coincidence. But when a procession of witnesses whom we accept as reliable and truthful tell us the same thing, coincidence as an explanation loses at least some force.

14. It may be that the placebo effect helps the treatment to a greater or less degree. But that does not invalidate the treatment. It may be that the treatment accelerates the self-limiting of the disorder. What we cannot accept is that in all the cases we have been told about a placebo effect was solely responsible for bringing about the cure, or that in all the cases the disorders conveniently and coincidentally self-limited themselves shortly after the treatment and independently of it.

15. We desire to add this: according to accepted medical standards of assessing the results of any form of treatment it is desirable, if possible, to eliminate all other possible causes so that it can be seen that it is the treatment itself, and not anything else, that has brought about the result. But in our opinion, in regard to the evidence we heard, the argument on behalf of those opposed to chiropractic went well beyond that position. In our view it amounted to a persistent and calculated attempt to explain away the effectiveness of chiropractic treatment by every available means. If it did not demonstrate bias and prejudice, at least it demonstrated an unfortunate reluctance to face facts.

16. So, on the evidence of the witnesses whom we have seen and heard during this inquiry, we are not satisfied that chiropractic is an ineffective form of treatment. How effective it is, and for which types of disorder, we now discuss in some detail.

Chapter 31. THE CHIROPRACTIC PATIENTS' EVIDENCE: TYPE M DISORDERS

INTRODUCTORY

1. Keeping before us all the arguments mentioned in the preceding chapter, and aware of the danger of accepting anecdotal evidence at its face value, we now examine in detail the chiropractic patients' evidence according to the category of the disorder in respect of which relief was claimed.

TYPE M DISORDERS MORE PRECISELY DEFINED

2. We now have to define our terms precisely. What does the Type M category include? Clearly enough it includes musculo-skeletal disorders of the spinal column resulting in local pain or stiffness or both in the back and neck. Conditions such as for example, some cases of sciatica must also be included.

3. The Commission considers that headache and migraine fall within the Type M category. Headaches and migraine are known to respond to cervical manual therapy (see chapter 37): indeed Mr B. R. Mulligan, a well-known physiotherapist and manipulative therapist who gave evidence before us deals with headaches and migraine by cervical manipulation as something of a specialty and on referral from doctors.

4. There is no doubt that certain symptoms which appear to be related to visceral or organic disorders but which are in reality cases of vertebrogenic referred pain should go into the Type M classification. At all events we have excluded from our discussion of Type O cases all those cases which could reasonably be thought of as examples of referred pain.

5. The Commission is not left in any doubt that chiropractors are effective in relieving Type M disorders of a kind that will respond to spinal manual therapy. We see no need to review the evidence in any detail. We do not doubt the evidence of the various chiropractic patients who came forward to speak of the relief, sometimes almost instantaneous, they experienced from painful and semi-crippling back conditions. They came from all walks of life. Quite apart from people whose daily work makes them vulnerable to back strain, we had witnesses in a wide variety of occupations and activities: accountants, businessmen, farmers, housewives, lawyers, and sportsmen.

6. A number of these people had already undergone medical or physiotherapeutic treatment before they came into the chiropractor's hands. A number of them described quite graphically the lack of success of the medical or physiotherapeutic treatment. We see no reason to disbelieve what they told us. The significance of the chiropractor's treatment for many of them was the speed of the results. We conclude that in those cases the chiropractor was able to remedy or alleviate what was wrong when the medical practitioner or physiotherapist could not. The chiropractor's diagnosis and treatment were therefore more effective than those of the doctor or the physiotherapist. The evidence supports no other conclusion.

7. We do not overlook the fact that in the main we heard of chiropractic successes. We heard very little about chiropractic failures. The mode of

distribution of the chiropractors' questionnaire was not designed to elicit reports of chiropractic failures. But as we have seen, some patients did report dissatisfaction. One such patient presented a formal submission during our hearing in Christchurch. It is worth noting that all questionnaire forms and letters of patients were made freely available to the principal parties. None of them made any apparent effort to follow up such cases. We are not naive enough to suppose that chiropractors always succeed in Type M cases. Indeed we did not understand the chiropractors to say this. But it is clear on the evidence that if a patient's ailment is of a kind that can be helped by chiropractic treatment, that treatment will usually be successful.

8. We do not overlook the argument that a chiropractor's treatment of a Type M disorder will not always produce a permanent cure. Many Type M patients told us that they had to go back periodically for further treatment. But we do not consider this as detracting from the success of the chiropractor's treatment. The point is that he keeps these patients on their feet and at work.

9. It was suggested at one stage on behalf of the Medical Association that in at least some Type M cases a period of bed rest and a course of analgesics was much more effective than any form of spinal manual therapy in providing permanent relief. That may well be so. But it is quite clear to the Commission that many people suffering from a back complaint cannot afford to be immobilised. For them a form of treatment that will put them back on their feet quickly is the best answer, even though they may have to go back from time to time for further treatment.

10. We are not surprised that people report lack of success by medical treatment in relieving their back problems. That is because medical training does not include specialised work on this kind of problem. Only very few doctors have given serious attention to it.

11. We refer again to some of the attempts to explain away chiropractic successes in Type M cases.

12. First, the placebo effect. We are prepared to accept that the placebo effect may come in as one factor in some of these cases. Any health practitioner knows the value of putting the patient in a proper frame of mind for the treatment he is receiving. But we are unable to accept that the placebo effect, if it exists in any particular case, is any more than just a factor. We accept on the evidence that successful treatment in Type M cases is due to the chiropractor's intervention.

13. Secondly, we were told that most back disorders are self-limiting. That is, they cure themselves in time. The suggestion was that if the chiropractor's treatment is carried on for long enough he will get the credit for a cure which would have occurred anyhow in the natural course of events. That may be so in some cases, but we cannot accept either that suggestion or its implications as having universal application. To suggest that the back problems of all the witnesses who came before us chose to abate themselves independently and at the time of chiropractic treatment, is to suggest a highly improbable coincidence.

14. This relationship between cause and effect is supported by two sources independent of chiropractic. First, there was the evidence of Mr R. A. McKenzie and Mr B. R. Mulligan, two physiotherapists called as witnesses by the Physiotherapists' Society. Secondly, there are the results of a trial carried out under the direction of Dr G. B. Parker in Australia: see chapter 37. This evidence confirmed exactly what the chiropractic patients said: that spinal manual therapy can relieve Type M disorders.

EXAMPLES OF TYPE M CASES

15. So that there will be a better understanding of the type of case which makes up the bulk (approximately 90 percent) of the chiropractor's workload we have selected a few of the many instances which were presented to us in evidence. We see no need to disclose the names of the patients. All but one of them gave their evidence at public sittings. None of the cases we refer to below has features which could be considered extraordinary. Each witness impressed us as reliable and accurate.

The Case of Mr S

16. Mr S had a persistent back problem. Early in 1977 his back became quite painful and he developed pain in his leg as well. His condition was diagnosed medically as rheumatism but he subsequently had X-rays taken and the resulting diagnosis was "wear and tear". He was given physiotherapy for 2 weeks without improvement and then carried on with it for another 3 or 4 weeks while he was waiting for an appointment with a specialist. The specialist recommended another 3 or 4 weeks of physiotherapy, but again there was no improvement. Mr S had reservations about going to a chiropractor but in August 1977 the pain became so bad that he pushed his scruples aside. He attended for chiropractic treatment daily for a few weeks. At once there was a marked improvement. He now goes to his chiropractor about every 6 weeks as a preventative measure. The pain has disappeared from his leg and he is now able to drive his car without any discomfort.

The Case of Mr P

17. Mr P, who is an auditor in his late fifties, suffered constant backache. He was unable to sit or stand for any length of time. He could not sleep properly. He had extensive medical treatment including X-rays, consultations with specialists, and physiotherapy. He had always regarded chiropractors as "quacks" but his wife went to one, on the advice of a friend, for severe loss of balance resulting from a fall. Her condition greatly improved and Mr P decided to visit a chiropractor too. He told us that after only one treatment the relief was so great that he felt it was like a "miracle". After the initial treatment period he now goes only on the few occasions when his back gives him minor trouble.

The Case of Mrs E

18. Mrs E, a sensible mature woman, suffered back and leg unjuries when her horse slipped and fell while she was helping to draft cattle. She spent 10 days in hospital, the principal treatment being water baths to reduce the swelling in her leg. She was discharged on crutches and then graduated to a walking-stick, and she could not sleep at night unless she elevated her leg with a pillow to get relief from pain in her lower back. All this was a problem for her, the more so because she had a family of young children. Her general practitioner put her on valium, she said to ease the pain, but it did not help. Finally she consulted a chiropractor and after a short course of treatment found that the pain suddenly disappeared and she was able to walk normally. She told us that every now and then when she was bumped by a farm animal or had some other minor accident her back played up, but she got immediate relief from chiropractic treatment. Apart from such minor and passing incidents she has had no further problems.

The Case of Mr J

19. Mr J is a solicitor. He has had experience of personal injury claims for clients with back problems and he told us that his clients had frequently been relieved from quite considerable pain even after a short course of chiropractic treatment. Mr J's main evidence was, however, in relation to his own personal experience. He was on the *Wahine* when it foundered at the entrance to Wellington Harbour. He suffered a back injury which was a matter of great concern to him during the following year. He was able to get out of bed only with great difficulty, and he was in considerable and continuous pain. He consulted medical practitioners who prescribed painkillers which were only of limited assistance to him. Finally he went to a chiropractor and as a result of the treatment he received he has had few problems with his back since.

20. Mr J initially had chiropractic treatment every second day for 6 or 8 days; then the treatments were reduced to once a week for 2 weeks; and then reduced again, until finally there was a consultation only at 6-monthly intervals. Mr J told us that he still had very minor trouble with his back, that he still visited the chiropractor every 6 months, and that chiropractic treatment seemed to assist.

The Case of Mr R

21. Mr R's experience of chiropractic took place many years ago, but his case is of interest. He is a farmer. Thirty years ago he suffered an injury to his back. Bone fusion surgery was prescribed. A few days before he was to enter hospital a friend persuaded him to try a chiropractor. After a course of treatments the effects of his injury disappeared and for 20 years he has not required further chiropractic treatment. He is now 77 and is in excellent health. He still farms. He shears sheep and takes part in axemen's events at the local sports. Photographs were shown to us of Mr R, vigorously competing as an axeman at the 1977 local sports.

The Case of Mrs D

22. Mrs D told us that she was severely injured in a car accident at the age of 7. She had had medical treatment for years. She ended up with a stabilising brace which she wore for about 10 years. Finally she saw a chiropractor. He X-rayed her and said that he would do his best to help her but because the injury to her spine was of such a long-standing nature, he could not guarantee complete success. After the first treatment she walked out of his rooms without the brace and without pain. She was able, as she told us, ". . . to enjoy [a] healthy active pain-free body".

The Case of Matron P

23. The matron of a private hospital gave evidence before the Commission. She has had extensive hospital experience. Some years ago she had a neck problem that was medically diagnosed as a disc lesion. She was given cortisone injections and a neck collar was prescribed. She also underwent physiotherapy. None of these treatments improved her condition. Ultimately, as the result of a suggestion made by a medical practitioner she knew, she consulted a chiropractor. She made it a condition of consulting him that any X-ray he took should first be examined by her medical practitioner before any chiropractic treatment was undertaken. That was done, and she underwent chiropractic treatment. Her neck condition immediately improved: she told us she had "never looked back".

24. As might be expected from her background, the witness was unemotional in speaking about her condition and its cure. She had at the start been predisposed against chiropractic by reason of her training, but her personal experience of it led her to see advantages in it, at least for her type of case. She felt that chiropractic treatment had been the answer to her problem, for which no earlier treatment had been effective. Her case is therefore a typical one. It is mentioned because her position of authority in hospital management and her training make her a particularly accurate and reliable witness.

The Case of Mr F

25. Mr F is a carrier, in business on his own account. His colleagues in the carrying trade persuaded him to try chiropractic treatment when he was suffering from a painful and nearly useless shoulder. He found the chiropractor professional, sympathetic, and realistic. X-rays were taken, carefully analysed and after five brief sessions of treatment he was back to normal.

26. More recently he suffered from sciatica. His general practitioner referred him to an experienced physiotherapist but after three sessions of ultrasonic treatment Mr F was no better and he turned to the chiropractor who had treated him previously. The chiropractor quickly relieved his sciatica, which had not returned when Mr F gave his evidence.

27. Mr F saw chiropractic as being particularly valuable to the self-employed worker who cannot afford to take a leisurely cure. The main point he wanted to make was the rapid results obtainable from chiropractic treatment as opposed to orthodox treatment.

The Case of Mr V

28. Mr V has had a bad back since 1933. He was injured in a car accident. He is a civil engineer and the work he does requires him to be able to move around freely. For the first 10 years after his accident he spent long periods in bed and was at one time partially paralysed. He was prescribed pain-relieving pills and several courses of physiotherapy but these did him little good. He eventually went to the chiropractor and benefited greatly.

29. He now goes on the average once a month. The purpose of the chiropractic treatment is mainly to keep him on his feet. It is a case where he would not need to visit the chiropractor so frequently if the work he did demanded less strain on his back, but his career requires this kind of work and he also likes to keep active around the house. So he undergoes chiropractic treatment whenever he thinks he needs it as part of the cost of staying active.

30. Mr V improved to the stage where 4 years ago he was able to build his own house. This is an example of a case where regular chiropractic treatment is able to keep an active man both in his career and doing work which he enjoys and which would otherwise be impossible.

CONCLUSION

31. The Commission is satisfied that chiropractors are successful in the diagnosis and treatment of Type M disorders. It sees no reason why medical practitioners should not refer patients with Type M disorders to chiropractors for treatment. The official medical attitude, that no such referrals can be treated as ethical, is in the Commission's judgment unjustified and not in the interests of patients.

A FURTHER CASE

32. We mention a further case which attracted some publicity when we were first told about it at a public sitting. It is of importance mainly because it provides a vivid illustration of some of the practical difficulties in concurrent medical and chiropractic treatment and the clear need for inter-professional co-operation. As with previous cases, we have disguised the name of the family concerned.

33. We heard about the case from Mrs P. A. Ferguson, who is a senior worker in a voluntary international organisation known as Janacia Child Care. Mrs Ferguson, in her submission on behalf of Janacia, told us that David K, who was 4 years old, had had some severe falls. Afterwards his parents noticed that he was holding his head in an unnatural position. They took him to the doctor, who prescribed cough mixture. It would be surprising if this prescription had been intended to relieve the position of David's neck and head; but in any event David was later taken to the Waikato Hospital where he was found to have a form of juvenile rheumatoid arthritis. He was treated there, but then the Queen Elizabeth Hospital in Rotorua started a course of treatment which was still going on at the time of our inquiry. The unit in which David was being treated is under the charge of Dr I. C. Isdale, a world authority on juvenile rheumatology.

34. When Mrs Ferguson first saw David his legs were stiff; so were his elbow joints, especially the left one. His fingers were drawing under and becoming claw-like. He cried with pain during the night. He could walk only at times, and then with great difficulty: mainly he had to be carried. That was the picture Mrs Ferguson painted of this child.

35. The Queen Elizabeth Hospital unit which was treating David shut down for the Christmas holidays. Mrs Ferguson asked David's parents if she and her fellow workers for Janacia could take charge of him over part of the holiday period. His parents agreed. During that period Mrs Ferguson took David to a chiropractor practising in Tauranga, Dr B. J. Lewis. David was given chiropractic treatment. Dr Lewis treated him without fee. Mrs Ferguson reported that David's general condition improved remarkably. He rode a tricycle, climbed, and walked quite easily.

36. On David's return home, his parents were naturally pleased at the change in him. They wanted him to continue with the chiropractic treatment. Mrs Ferguson wrote to the Queen Elizabeth Hospital in an effort to make the necessary arrangements which would naturally have to fit in with the hospital's own programme for David. She had no reply to her letter. The next development, Mrs Ferguson told us, was that Mr and Mrs K received a visit from two women hospital workers who told them that chiropractic treatment could be harmful to David: if he had further chiropractic treatment, his hospital treatment would be stopped.

37. This was Mrs Ferguson's account of the matter. She was deeply concerned about the child David, and disturbed that the hospital authorities should have threatened to discontinue his treatment if he went on with chiropractic treatment. She told us David's condition seemed to have worsened since his chiropractic treatment had been stopped. We were impressed with her sincerity and honesty.

38. Once this evidence had been given, the New Zealand Medical Association offered to have David examined by an expert in the field. We ourselves considered that the matter could obviously not be left as it was and that we must hear the other side of the case. We asked counsel

appointed to assist the Commission to make further inquiries, and through him we obtained full written reports from Dr Isdale and from Dr Lewis. We decided to hold a closed sitting in Rotorua, with counsel present, to hear further evidence about the matter. We considered that the further publicity which a public sitting would attract would not be in anyone's interests. In Rotorua we heard evidence from Dr Isdale, Dr Lewis, and Dr J. S. Boyd-Wilson whom we asked to report on the various X-ray plates covering David's condition over a lengthy period. We also saw David and his parents. We later held a further closed sitting in Wellington. These are our findings.

39. In the first place it is clear on the evidence that the changes noticed by Mrs Ferguson in David's general condition following his chiropractic treatment were not new. He had already made considerable progress at Queen Elizabeth Hospital before coming under Mrs Ferguson's care. He had already been riding a tricycle and walking quite freely but he was in a poor condition when she first saw him.

40. There could be a simple explanation for all this. It is a feature of juvenile rheumatoid arthritis that its symptoms come and go: indeed, Dr Isdale told us that David "went up and down like a yo-yo". This is a colourful way of describing the process by which sufferers from the disease enter periods of remission followed by periods of regression. When Mrs Ferguson first saw David he could have been in a period of regression. When he came under her care during the Christmas holidays he might well have entered a period of remission; if this is so he would have been greatly helped by the exceptional qualities of warmth and attention that Mrs Ferguson and her Janacia helpers were able to provide for him. This must have increased David's confidence.

41. In the second place, Dr Lewis's treatment was as follows: there was manual therapy centred on the cervical area. He also provided David with special exercises. We saw a film Dr Lewis had taken showing David's progress in movement. But Dr Lewis himself very fairly conceded that it was important for David to continue his much more general treatment at the Queen Elizabeth Hospital.

42. Thirdly, it is correct that Mr and Mrs K were approached by hospital representatives and told that if David's chiropractic treatment continued, the hospital treatment would cease. Dr Isdale explained that to us by pointing to the great difficulties there were in regulating David's hospital care if at the same time he was also receiving different treatment independently from another source. The following is a passage from his evidence:

Q: Was it your attitude . . . that the [Ks] had to make a choice either to have hospital treatment or chiropractic treatment . . . ?

A: It was going to be very difficult to organise the two together and I did not want to do it anyway. I think you are right, the choice was the [Ks].

Q: And that choice was that if they wanted to continue with the chiropractic treatment, they should realise that would be at the expense of the medical programme?

A: We would discontinue it until they wanted to come back to it.

So that confirms Mrs Ferguson's account of that aspect of the matter.

43. Fourthly, we took the opportunity while in Rotorua to see Mr and Mrs K in private. They made it clear to us that they believed David had benefited from both forms of treatment, and they told us that they wished both forms of treatment to continue. We naturally refrained from saying anything to them which could be interpreted as advice one way or the other; but we ensured that both Dr Isdale and Dr Lewis were informed of what Mr and Mrs K's attitude was.

44. Next, the closed sitting during which we heard further evidence concerning David was conducted so as to provide a full opportunity for Dr Isdale and Dr Lewis to exchange views. They had not previously met nor had they spoken together. Indeed, neither had seen the other's reports on David until after the closed sitting had begun.

45. During the closed sitting it transpired that Dr Isdale's reluctance to countenance chiropractic treatment for David stemmed from the fact that he had been given no indication of what chiropractic treatment was being applied. Plainly one of his principal concerns—apart altogether from his own views, as a medical practitioner, on the effectiveness of chiropractic—was with the possible damage that could be caused by indiscriminate manipulation on a patient suffering from juvenile rheumatoid arthritis. As time progressed, however, and as it became apparent that the refinement of Dr Lewis's treatment had been carefully judged by reference to the known medical risks, Dr Isdale's anxiety concentrated on the risks attaching to hypermobility in the cervical column, such as the likelihood of greater damage later in a whiplash injury situation.

46. We should add that David's chiropractic treatment had by then been resumed, without the hospital's knowledge. Mr and Mrs K had naturally been anxious to avoid the difficulty caused by the hospital's own attitude.

47. The Commission desires to acknowledge the obvious care and sympathetic attention given to David both by the Queen Elizabeth Hospital staff and by Dr Lewis. Dr Lewis had treated David without fee. Dr Isdale's report shows that David had improved to the point where there would be no real problem in his attending a normal school when he turned 5, although his activities would of course be restricted. So it seems that, owing to the care he received, David will be able to lead a reasonably normal life.

48. The Commission nevertheless thinks it desirable to express its opinion on some of the events which took place.

49. We consider the lack of communication between Dr Lewis and Dr Isdale up to the time of our closed sitting astonishing. There was of course opportunity for communication. It should have been taken. We find it surprising that chiropractic treatment was undertaken with the knowledge that David was under the supervision of a world expert in rheumatology and without any attempt to obtain Dr Isdale's views on the proposed treatment. Dr Lewis acted with the best intentions but his failure to communicate with Dr Isdale was in our opinion regrettable. It may be that Dr Lewis saw no point in communicating with the hospital because he believed that the hospital would decline to give him any information. We find it difficult to accept that any medical authority would take the responsibility of withholding important information from a chiropractor authorised by his patient (in this case the patient's parents) to receive it. It may be that Dr Lewis saw no purpose in communicating with the hospital in view of the fact that the hospital made no reply to Mrs Ferguson's letter seeking the hospital's co-operation for the continuation of David's chiropractic treatment. The failure to reply to that letter was an error of judgment on the hospital's part and a discourtesy. The letter opened the way for at least some discussion.

50. Next, in our opinion the hospital should never have allowed Mr and Mrs K to understand that David's hospital treatment would be discontinued if he continued to have concurrent chiropractic treatment. While the hospital's attitude is perhaps understandable, we think it

overlooks the important fact that Mr and Mrs K were perfectly entitled to secure chiropractic treatment for David if they felt it was warranted. That was their right. The hospital authorities were of course entitled to warn Mr and Mrs K, if necessary, that chiropractic treatment might not be in David's best interests; but to suggest that David's hospital treatment would be suspended could clearly be interpreted as an attempt to force the issue. Mr and Mrs K, as lay people, should never have been put under that kind of pressure. Plainly enough, no attempt whatever was made by the hospital authorities to find out what kind of chiropractic treatment was proposed. The situation was handled by the hospital with an unnecessary lack of tact and consideration.

51. We should record our findings on one further aspect of the evidence. There was a conflict of opinion over the various X-ray plates taken demonstrating David's cervical condition (at different times). Dr Lewis's view was that there had been a vertebral displacement caused by a fall. David, it will be remembered, had had no less than three falls. The medical view was that the displacement was caused by the arthritic changes. This was confirmed by Dr J. S. Boyd-Wilson, whose opinion as an expert radiographer was sought by us. Because of this difference of opinion, and because of Dr Boyd-Wilson's active involvement on behalf of the New Zealand Medical Association in this inquiry, we considered that in fairness we should obtain another expert opinion. In the result we find that while we cannot exclude the possibility that the falls contributed to David's cervical condition, this is unlikely. However, neither can we exclude the possibility that the medical practitioners and Dr Lewis were interpreting the radiographs in different ways (see chapter 9).

52. We now express our opinion on the central issue. The evidence shows that David certainly benefited from the hospital treatment. We think that he may also have benefited from Dr Lewis's treatment. But it is not possible to say to what extent.

53. We are reluctant to appear critical of Dr Lewis's part in the matter because he acted with the best intentions and at all times without fee. Nevertheless we cannot feel that he acted at all wisely. He is not long qualified as a chiropractor, and that is some excuse. But, as we have said, he made no attempt to get in touch with Dr Isdale before treating David.

54. In his evidence he displayed a reluctance to pay any real respect to the views of Dr Isdale, who is an international authority. Dr Isdale expressed his views tactfully, and accepted much of what was in Dr Lewis's report. But Dr Lewis strongly maintained his own attitude in favour of treating David in the face of Dr Isdale's view that there were contra-indications to any form of manipulative therapy on a child suffering from rheumatoid arthritis. It would not surprise us if co-operation between Dr Isdale and Dr Lewis were impossible. That is very unfortunate.

55. To Dr Lewis's credit, apart altogether from his chiropractic treatment, he seems to have given David additional confidence. No doubt David has responded to being given individual attention by Dr Lewis, instead of being only one of a number of children as he was at the hospital. An important boost to David's morale was his ability, encouraged by Dr Lewis, to climb stairs, which is something the hospital apparently did not teach him. That is surprising, because steps and stairs are a daily hazard to anyone with David's disability.

56. Mr and Mrs K are not to be blamed in any way. Like most people they had no option but to put their trust in the experts. People in that

position are vulnerable, the more so when they are deeply concerned for the health of a child. But the hospital authorities and Dr Lewis should both have been much more sensitive to that vulnerability. They should have dealt with the matter between themselves and arrived at a common viewpoint so that Mr and Mrs K need never have been drawn into the conflict.

57. What of the central figure? Having met David, we consider him a credit to himself, to his own pleasant nature, to his parents, and to all those who have worked with him, including Dr Lewis.

58. This particular matter was made unnecessarily difficult by the unfortunate course of events, for which both the hospital authorities and Dr Lewis must accept responsibility. But apart altogether from that, we are not persuaded that the chiropractic treatment offered to David was necessarily incompatible or inconsistent with the hospital treatment.

59. At the end of our closed sitting in Rotorua we intimated to Dr Lewis and Dr Isdale that although we had no power to direct them in any way, we hoped that they would co-operate in conferring over David's management, and we suggested that if in Dr Isdale's opinion any strong indications were shown at any time against chiropractic treatment, Dr Lewis might wish to reconsider his position. We record that Dr Lewis then expressed his desire to co-operate with Dr Isdale, and we suggested that there might be some reassurance in Dr Lewis providing Dr Isdale with a physical demonstration of exactly that was involved in David's chiropractic treatment. In any event we are firmly of the view in this case, as we would be in any similar case, that if concurrent chiropractic and medical treatment is to be offered, it is absolutely essential that each side knows at all stages exactly what the other is doing. That is in the patient's interests, and after all, the patient is and must be the main consideration.

Chapter 32. THE CHIROPRACTIC PATIENTS' EVIDENCE: TYPE O DISORDERS

INTRODUCTORY

1. We now deal with the far more difficult question of Type O (organic and/or visceral) disorders. Why is it a far more difficult question? The facts are not difficult: to the witnesses they were perfectly clear. The difficulty lies in drawing sound inferences from the facts.

2. The particular cases which we are about to consider are ones which seem hard to explain on any basis other than that the treatment given by the chiropractor brought about the cure. Certainly there was no convincing orthodox medical explanation. No one really knows. Perhaps it does not matter. The main point, in human terms, is that the chiropractors in some cases appeared to succeed in relieving great suffering and hardship where more orthodox methods had apparently failed.

THE NEED FOR CAUTION

3. There is a clear need for caution. Some of the cases we are about to mention may seem remarkable. They may have seemed almost miraculous to the patients themselves. But there is an obvious danger in reading too much into these cases. The most that can be said is that they are cases where a chiropractor's treatment has appeared to bring about a great improvement in the patient's condition. However, it does not follow that a person with a similar condition will also be helped by chiropractic treatment. Only too often false hopes are raised by people jumping to the conclusion that because a particular result has happened in one case the same result must happen in others.

4. Nothing has been said to us which gives us confidence in believing that chiropractic treatment is predictable in relieving Type O disorders. Some chiropractors freely admit this unpredictability. They can only wait and see what happens. As one chiropractor told us during our investigation of a Type O case given as an example in the following pages, "If someone came in to me in an identical situation . . . and asked if I could help, or could I not help, I would not know."

5. The reason for the uncertainty is that no chiropractor can really know whether a particular spinal dysfunction has or has not any influence upon a Type O condition. Until we know much more about the mechanisms involved the chiropractor's work in this area must necessarily be a matter of trial and error. If the patient's vertebrae are subluxated, then it may be supposed that he will get some advantage from having the subluxation adjusted and corrected. It is the extent of the advantage that cannot be known in advance. Some particular kinds of benefit (for instance, relief from asthma) may occur more frequently than others, and the evidence tends to support this.

6. We think it would be wrong with the present lack of knowledge in this area, either to recommend that people suffering from Type O disorders should consult a chiropractor with any expectation that they will get relief, or to recommend that chiropractic treatment in respect of this type of disorder be subsidised from public funds.

7. We make one exception. The medical practitioner of the future may discover, through experience, that some patients with Type O disorders are more likely to respond to chiropractic treatment than others. If on that basis he is prepared to refer the patient to a chiropractor we see no reason why in that situation the treatment should not be subsidised. What we see as unsatisfactory is the granting of a subsidy in a case where there can be no certainty that the treatment will work until it has been tried. To grant a subsidy in cases like that would simply be to encourage patients to continue with very lengthy treatments, with no perceptible result, in the hope that finally there might be some result.

THE CASES

8. Table 29.1 in chapter 29 shows the great variety of Type O disabilities which patients claim chiropractic treatment has relieved. The following cases are examples. One of them was heard by us in private. In all of them the witnesses were examined, and in some instances cross-examined, under oath. We see no reason to give the names of the people concerned.

The Case of Mary

9. Mary's story was told to us by her mother. Mary is now 27. When she was 11 she had an accident at school. She had cranial surgery to remove a blood clot.

10. She had always been near the top of her class, a bright and active little girl. The accident changed all that. Her memory was affected. She could not concentrate or retain any information. School became a misery for her. She was at the bottom of every class. She became difficult and frustrated at home.

11. She got a job with an understanding employer. The job involved simple repetitive work. She was able to do that, and carry out simple household tasks. But for years she remained frustrated and disturbed by her inability to concentrate and remember things. She had to leave notes for herself to remind her what to do. Even in her undemanding, repetitious job she needed notes to tell her what to do in case she lost track.

12. She could not go on a simple journey. If she did not have a note reminding her which bus or train to catch and exactly which turnings to take, she would get lost. Her dressing table was "littered with notes". The doctors did what they could, but they told the family they and Mary would have to live with this problem.

13. But Mary, for all her serious disability, was ambitious. She wanted to better herself. Her frustration drove her to consult a number of unorthodox practitioners. They were able to do nothing for her. Finally, in 1977, she telephoned a chiropractor. Her mother had suggested this after hearing of other people's experiences with chiropractors. Mary had to get complete directions from the chiropractor about exactly how to get to him and where to find him. It was not a long journey at all, simply from one suburban district to another, but Mary had to write it all down.

14. Mary found her way to the chiropractor, consulting her notes at every turn. The chiropractor examined her. He found an obvious subluxation. He adjusted her straight away.

15. Later on the same day Mary telephoned her mother. She was crying. That was because she had taken what, to her, was an immense

step forward. She had left the chiropractor and had found her own way home. She did not have to use notes.

16. She had one slight relapse. But apart from that she improved enough to go overseas by herself. Her family clubbed together so that she could go. She was able to cope with Los Angeles Airport by herself, and manage a bus trip to Utah.

17. She had not been able to read for entertainment: she kept losing her place and forgetting where she was. She had become unable to play the piano. Now she can do these things and is improving all the time. And her personality has changed. Her mother summed it up: "I think I have got the daughter back I lost . . ."

The Case of Mrs G

18. Mr G was immobilised by a back injury in 1970. His medical adviser told him that he would need to be in hospital and probably in traction for some weeks. His wife called in a chiropractor who treated him and within 2 weeks he was back to normal.

19. This was the effect of this witness's formal submission, but in the course of giving oral evidence, he told us about a completely different matter affecting his wife. He told us that he and his wife had found it impossible during some 6 years of marriage to have a child. They had undergone intensive physical and gynaecological tests and were told there was nothing wrong. They adopted two children over a period. Mrs G was sometime afterward persuaded by a friend to consult a chiropractor about her infertility. She was apprehensive. Her husband went with her for the consultation. The chiropractor examined her and found what her husband described as a misplaced vertebra. The chiropractor gave Mrs G one adjustment. Shortly after that she became pregnant.

20. This evidence was given quite spontaneously when Mr G was asked by the Commission if he felt that the fixing of back pain was the limit of what a chiropractor normally does. Mr G then told us about his wife's experience. They expected nothing but thought they would try. Mr G is a businessman with his feet firmly on the ground and we have no reason to think that he was in any way embroidering what he told us.

The Case of Mr H

21. Mr H, who was retired and in his seventies, had been seriously hurt in a motor accident. His head had been injured in some way which he was unable to specify, but the result of the injury was that he suffered extreme discomfort if he tried to lie on the side that had suffered the damage. At an earlier time of his life he had suffered from asthma which had, however, naturally remitted. But it came on again when he was in his sixties. He took prescribed medication for his asthma.

22. Mr H gave us a very refreshing, direct, and dramatic account of his consultation with the chiropractor. He told the chiropractor on no account to do anything that would affect his head. However, the chiropractor did so. Mr H protested forcibly and pungently but later found to his amazement that he had lost both the unpleasant consequences of his head injury and also his asthma. He told us this:

Anyway on the Monday he went over me and he said "Mr H, in my opinion in a few days you will be quite alright". To my astonishment I have been quite alright since.

23. Mr H told us that his asthma does still recur from time to time but when it does a chiropractic adjustment fixes it.

The Case of Mrs M

24. About 12 months ago Mrs M was in a car accident and suffered a whiplash injury which affected her neck. After hospital and physiotherapy treatment for 2 weeks she was still in severe pain and she went to her chiropractor and was treated quickly and successfully.

25. Mrs M also suffered from high blood pressure, water retention (oedema), and headaches. When she visited the chiropractor concerning her neck problem she was asked what medication she was on. She told the chiropractor about her blood pressure, a condition from which she had suffered for over 15 years, her water retention problem, and her headaches. The chiropractor told her that after a course of chiropractic treatment her blood pressure could be expected to go down so that she would not have to take medication continually, and that her water retention would also improve. Mrs M told us that although she had confidence in the chiropractor's ability to fix her neck she was very doubtful about his capacity to relieve the other conditions. She said this in her formal submission: "To my surprise, and great satisfaction, everything that he has told me has eventuated. My blood pressure is now normal, (I take no blood pressure tablets) and my water retention has improved about 75%. (I now take tablets about once weekly instead of every day) . . . I should like to mention that my headaches have almost completely disappeared."

26. Mrs M was sensible enough to have her blood pressure and water retention conditions monitored by her regular medical practitioner. In cross-examination she told us that her doctor was quite surprised that her blood pressure had reverted to normal.

27. This was one of the occasions on which the Medical Association applied for and was granted leave to obtain an expert medical opinion. Mrs M consented to her medical records being examined, and a medical expert was appointed to examine them.

28. We have received his report, which is limited to the question of blood pressure. The records of Mrs M's own doctor show that during 1970 Mrs M's blood pressure fluctuated between 170/120 and 120/90 but was on most occasions at a level indicating moderate hypertension. There is only one reading recorded in 1971 (126/104), and then there is a gap in the readings until April 1976 (150/106). The readings in May, July, and August 1976 indicate moderate to mild hypertension, and "normal" readings are recorded in November and December 1976, and January 1977. On 9 May 1977 the reading shows a mild degree of hypertension (140/100); similarly on 30 May 1977. On 15 September 1977 a normal reading is recorded, as it is on either 12 December 1977 or 12 February 1978 (the date is not clear from the report). The reading had returned to mild (135/95) on 1 June 1978 and on 13 October 1978 (140/96), the last reading we have.

29. The records show that until late 1977 Mrs M was on blood pressure lowering drugs. Declinax was stopped in either December 1977 or February 1978, and on 1 June 1978 the record reads "Tenuate Dospan prescribed, taking Lasix on and off". No prescription is recorded against the entry of 13 October 1978. (It should be noted that Mrs M's formal submission to the Commission is dated 24 May 1978, and she presented it orally on 7 August 1978.)

30. The medical expert's conclusion was that there is no justification for the claim that the chiropractic treatment returned Mrs M's blood pressure to normal. He reports that the normal readings achieved on and

after 15 September 1977 could have been due to the antihypertensive medication, other factors, or to the variable nature of the mild hypertension itself. Because no readings were taken before Mrs M was put on antihypertensive medication, it cannot be demonstrated either that Mrs M's normal readings were achieved by the antihypertensive medication.

31. The records are consistent with what Mrs M told us. She told us that she had been taking antihypertensive medication for 15 years. She said her blood pressure had always been "slightly above what was considered to be normal, but not excessively when I was taking medication" (Transcript, p. 870). She told us also that her medical advisers believed that her water retention problem was associated with the blood pressure problem: (ibid.) That explains why she was still on Lasix in 1978 "on and off" by June 1978. Mrs M told us about her being taken off Declinax (according to the medical records, in December 1977 or February 1978—the exact date is not clear): her general practitioner "was quite surprised in fact, that my blood pressure was normal when I went to him. He told me that I need no longer take the Declinax tablets I was taking, but to ensure that I went back at regular intervals to have my blood pressure checked" (Transcript, p. 871).

32. As to the water retention problem, Mrs M said "if I did not take my water retention tablets prior to my treatment with [the chiropractor], my ankles would swell up badly and it was noticeable, and my weight would increase rapidly also because of fluid, and I had to take these tablets every day in order to keep it under control. Now I find I am able to keep it under control with tablets only once or twice a week" (Transcript, p. 872).

33. It seems clear that by late 1977 or early 1978 Mrs M's doctor took the view that the ganglion-blocking agent (Declinax) as medication for hypertension was no longer required. Mrs M's intake of the rapidly acting diuretic agent (Lasix) had been reduced by June 1978, when medication specifically designed to reduce obesity by suppressing appetite was prescribed (Tenuate Dospan). That appears to be consistent with what Mrs M told us.

34. Naturally in the circumstances no firm conclusion can be drawn either on whether the prescribed medication in fact had any effect on Mrs M's hypertension, or on whether the chiropractic treatment had any effect on it. The Commission is left with facts and probabilities.

35. The facts are that before Mrs M had chiropractic treatment she was demonstrated to have mild to moderate hypertension and in the year prior to chiropractic treatment was being medicated by two drugs, one a quick-acting diuretic, and the other a hypotensive agent which acts by selectively blocking transmission in the post-ganglionic adrenergic nerves. After her chiropractic treatment her blood pressure dropped back to normal, although it later increased to a mild degree, she was taken off the ganglion-blocking agent, and her intake of the diuretic agent reduced.

36. The probabilities are that the chiropractic treatment did have the effect both of relieving her hypertension and reducing her dependency on medication, although naturally other possibilities cannot be ruled out.

The Case of Mr R's Small Boy

37. Mr R was a chiropractic patient who had suffered from a serious back problem for which he had obtained relief by chiropractic treatment.

38. One day Mr R told his chiropractor that he was concerned about the condition of his little boy, not quite 2 years old, who was an asthmatic.

The child had been taken to a specialist and was under medical care, but he seemed to be getting worse. As Mr R testified (Submission 36, p. 4):

By this time my son had developed a constant wheeze and was losing weight due to his inability to eat the right quantity of food, plus he was finding it very difficult to sleep at night due to the wheezing and shortness of breath.

And under very intensive cross-examination Mr R spoke of his son "surging, gasping for breath", and that he and his wife had to take it in turns sitting with the little boy throughout the night in case the child woke up and needed attention and comforting.

39. The chiropractor suggested that Mr R bring the child in for examination. He did not promise a cure. Mr and Mrs R took the little boy in. The chiropractor examined him, suggested the child might have had a fall at some time (which was the case) and adjusted the child's neck.

40. Immediately there was a dramatic improvement. Mr R described it, in a spontaneous answer under cross-examination, as "miraculous". "We didn't even get out of the waiting-room and his constant wheeze, which was pretty bad, had almost disappeared." Some months later, and after some further chiropractic adjustments, the little boy's asthmatic symptoms had completely gone. On the night of the first treatment the child had his first uninterrupted sleep for some considerable time.

41. As we have said, Mr R was intensively cross-examined, and we therefore had a full opportunity to assess what weight we could place on his evidence. The Commission was most impressed with him. It was clear that his son's instant response to the chiropractic treatment had left a deep impression on him. He did not expect any particular result, and that is why he spontaneously described the result as "miraculous". He was reliving the moment as he told us that.

42. It was put to Mr R in cross-examination that his son's asthmatic condition could have relieved itself naturally, and (in effect) that the chiropractic treatment had nothing to do with it. Mr R rejected that suggestion and so do we: we cannot accept that within minutes of the chiropractic treatment the little boy's asthmatic symptoms remitted themselves purely by coincidence. We are driven to find that the major relief the child experienced within that short time was a direct result of the chiropractic treatment he received.

The Case of Mrs D's Daughter

43. Mrs D told us of chiropractic relief which had been given to her young daughter.

44. Her daughter suffered from impaired hearing. Mrs D and her husband took her to an ear, nose, and throat specialist. The specialist thoroughly examined her and recommended surgery. Mrs D was reluctant to agree to this course, and thought that chiropractic should at least be tried. Mrs D had been to a chiropractor before for a back complaint. She and her husband took the child to the chiropractor who examined her and adjusted her spine in the area of the neck.

45. Much to Mr and Mrs D's surprise, the child was able to hear a whisper from across the room the following day. In Mrs D's words, recalling the child's previous condition, "that to me was miraculous".

46. They took the child back to the ear, nose, and throat specialist. The specialist tested the child. He found, to his surprise, that her hearing had improved to a level of 100/98. That was a remarkable change. Her hearing had become normal. He asked what the parents had been doing. They told him they had taken the child to the chiropractor and his response,

according to Mrs D, was "Of course if you are going to do this sort of thing you might get temporary relief but you will have her back here within 6 months".

47. Mrs D told us that that prediction had fortunately proved incorrect. Mrs D went on to say that her daughter "is now trained as a nurse and she has no problem. In fact, her hearing is a little bit too good sometimes"

48. This case provides an interesting modern parallel with the first recorded chiropractic adjustment by Daniel David Palmer which is said to have effected a cure of deafness. It is unfortunate that it was not possible to inquire into this particular case further by inviting the specialist and the chiropractor to give evidence before us. However, we have no reason to think, from seeing and hearing Mrs D on the witness stand, that she was giving us other than an accurate and unemotional report.

TWO FURTHER CASES

49. There are two further cases we wish to mention at rather greater length. They are of considerable interest.

The Case of Duncan C

50. In February 1977 Duncan C was 11 years old. He started complaining that his knees became stiff whenever he walked up or down hills. Within a week or two his knees were stiff when he got out of bed in the morning. They loosened up during the day, but started seizing up again by the evening. By late April the stiffness had spread to his hips. His parents consulted the family doctor who examined Duncan. In the doctor's words:

I could find no indication of active disease either in his joints or systemically. There was no recent history of inter current illness and, in particular, no history of sore throat or tonsillitis. The joints complained of were subjectively stiff and painful and I could find no evidence of swelling or heat. Investigations including general physical examination excluded any indication of disease especially having in mind the rheumatic diseases. I recommended that he be given Aspirin 300 mgm four times daily for symptomatic relief.

51. This medication seems to have provided temporary relief, and after about 2 months it was discontinued. But the pain returned. It not only returned but spread. Duncan now had it in his shoulders, down each arm, into his hands, and from his hips down to his toes. By November his parents had to help Duncan out of bed most mornings. He cried with the pain. Often he was unable to dress himself. The pain spread to his spine. He started tripping over his feet and his knees would flap together when he walked. He was stooped over like an elderly man.

52. The family doctor could still find no medical explanation for Duncan's condition. But he referred Duncan to the paediatric clinic at a large public hospital. The specialists carried out tests and were baffled. Duncan was admitted to hospital for further tests and what is described as a "full rheumatological investigative workup". That was in February 1978.

53. All tests proved negative. There was no sign of any organic joint disease. Both the family doctor and the specialists suggested that there could be an emotional basis for Duncan's symptoms. They apparently could not think of any other explanation. Duncan's parents were advised to make him more outgoing and to get him involved in sport. It was suggested to the parents that Duncan was far too serious, that he did not fit in at school, and that this was making him emotionally tense. But the difficulty with this view of the matter was that Duncan, according to his

teachers, had no trouble fitting in at school: they commented on how well-adjusted and secure he was; that he was easy-going and a delight to have in the classroom. He had been an active boy and enjoyed sport. That impression was amply confirmed when we saw and spoke to him ourselves.

54. By March 1978 Duncan was still going downhill. He now had to be helped to walk. His spine was very sore and he could not sit for long. He had trouble holding a pen for more than a few minutes. The family doctor, who had been fully informed of the hospital tests, reluctantly had to tell Duncan's parents that nothing more could be done.

55. Duncan's parents did not want to leave it at that. They had the constant spectacle of Duncan's pain and disability. They had done all they could for Duncan through orthodox medicine: he had had the best medical treatment. But they felt they must do something more. They were desperate. So they took Duncan to a chiropractor.

56. Although Mr and Mrs C did not know this, the chiropractor they consulted had only very recently graduated from Palmer College. He was still serving his period of provisional registration. Even if the parents had known this it probably would not have made any difference. They did not expect anything. They simply hoped that something might possibly be suggested that could help Duncan.

57. The chiropractor examined Duncan. He found three "areas of involvement" in Duncan's spine, in the cervical, thoracic, and sacro-iliac areas. It is of interest that one of the hospital reports records that "The tenderness seemed to be maximal in the vertebral column and the sacro-iliac joints".

58. Late one Friday the chiropractor made his first adjustments to Duncan's vertebral column. He told Duncan's parents that he could not predict that there would be any result; they would just have to wait and see what happened. There was no instant result, except that Duncan felt sick. His parents took him home. The chiropractor had warned them that Duncan might "feel bad" after the treatment. But three hours after the treatment Mrs C was working in the kitchen, and she heard Duncan cry out, "Come and look! I can walk without my knees flapping together!" It was true. Duncan's walking had improved out of sight. His parents were amazed.

59. By the Saturday Duncan could move his hands and fingers without pain: his hands were back to normal. He could "make a fist" without any discomfort. He had two further adjustments the following week. His general improvement was rapid. After a few more further adjustments, which we understand were essentially to consolidate the gains that had been made, he was back to normal. Duncan, who is an intelligent and articulate boy, told us that he was surprised at feeling "numb". He explained what he meant by that. He had become so accustomed to being in constant pain that he felt strange without it.

60. He has been advised by the chiropractor to avoid contact sports for a year; but he now plays tennis and table tennis regularly and without any difficulty and is looking forward to playing soccer again next season.

61. We learned about this case when Mr and Mrs C wrote to us following press publicity over another case which had come before us involving a child. We felt that we should investigate Duncan's case, but not in a public sitting. We procured a full report from the Cs' family doctor, who let us have copies of the hospital reports. We circulated these, together with the chiropractor's report and Mr and Mrs C's letter to the

Commission, to counsel for the principal parties in this inquiry, and advised them that we proposed to hold private sittings to inquire further into Duncan's case. No counsel wished to appear at those private sittings.

62. We then arranged to meet privately with Mr and Mrs C, Duncan, the family doctor, and the chiropractor, all of whom we examined under oath. All were anxious to assist us.

63. We record that we were favourably impressed with Mr and Mrs C, and Duncan. Mr and Mrs C have three children, Duncan being the eldest. They appeared to be caring parents, mature and sensible. They gave us a straightforward account of the facts. They respect their family doctor and will continue to consult him when necessary. They look on this incident as one in which their family doctor and the specialists did their best. They think it a pity that chiropractic treatment was not seen as a possibility at an earlier stage, but they appreciate the efforts made by their family doctor and the specialists in trying to help Duncan.

64. Duncan himself is a bright and intelligent boy, open and pleasant. He was able to tell us of his illness without any sign of self-pity or morbid interest in his symptoms and their relief. As was the case with his parents, he gave a straightforward account of the facts.

65. The family doctor, as we might have expected, was an experienced general practitioner, and a man of obvious integrity. He was said to be good with children, and we have no difficulty in accepting that. He could find no medical explanation for Duncan's symptoms or their relief. He told us that the result of Duncan's chiropractic treatment appeared "magical", but he was far from implying by this that he accepted it. He thought it was wrong that the chiropractor should get the credit for a result that could be explained in a different way. He felt that the simple explanation for Duncan's apparent cure was that Duncan had developed his symptoms as a response to emotional pressure, had found himself in a one-way street, and that the positive chiropractic treatment he received had finally provided him with an escape route by which he could return to normality. He did not doubt for a moment that Duncan's symptoms were genuine, and that the emotional process by which they developed and later disappeared was one of which neither Duncan nor his parents would have been consciously aware. He expressed the opinion that Duncan's parents had strong religious convictions, and that these could easily have led to emotional disturbance in Duncan's relationships with other children who did not have the same background. He told us that sometimes he used spinal manipulation himself as part of his treatment, but he did not consider it appropriate in Duncan's case.

66. The chiropractor was a young man, only very recently out of chiropractic college. We regard it as unlikely that he could have inspired the same degree of confidence as a man with the experience of the C's family doctor. But he was positive in his evidence that he had identified and corrected three areas of "spinal misalignment". He told us quite candidly that he had not been able to predict whether their correction would help Duncan. But we think it significant that he did not suggest to us in any way, either by his words or by his manner, that what he had achieved was a chiropractic triumph. The impression he conveyed was that this was the kind of result which could happen as a result of correcting "spinal misalignments". It would not necessarily be expected, but if it did happen no chiropractor would be unduly surprised. It was clear that he believed that essentially what he had done was to restore the "normal nerve supply".

67. We would add this. We asked the family doctor whether he had felt any need to discuss Duncan's case with the chiropractor. His reply was interesting. He told us that he would not wish to talk to the chiropractor about the case, since to do so would be to give the impression that he was recognising chiropractic treatment as orthodox therapy, or in a sense condoning what the chiropractor had done. Without implying any criticism of the family doctor we find this attitude curious. It is a case of an experienced medical practitioner who was faced with a patient with indisputably genuine symptoms which medical treatment had not relieved, yet who appeared to have closed his mind to the clear possibility that intervention by an unorthodox practitioner had achieved surprisingly quick relief of those symptoms. As we shall see, it cannot be said that the results of Duncan's chiropractic treatment were neurophysiologically impossible. It is in this situation odd to find no spirit of curiosity or inquiry about what the chiropractor had actually done.

68. We will examine a little further the family doctor's theory that the whole incident had an emotional basis. It is a logical explanation. Cases of this kind are well known in medical practice. But as applied to the present instance there are two weaknesses in the theory. In the first place, having seen Mr and Mrs C and Duncan, and having talked with them all at some length, we are left in considerable doubt whether the theory readily fits the facts. Secondly, it provides rather too convenient a method of explaining away what could be interpreted as a chiropractic success. We would need to be much more satisfied than we are that there was some firm basis for attributing emotional problems to Duncan before we could lend this theory our support.

69. There is a further possible explanation. It is that Duncan was in fact suffering from an arthritic condition that was in some way undiagnosed, and that at the same time as Duncan underwent treatment from the chiropractor, the arthritic condition spontaneously remitted. But Duncan's symptoms were investigated with very great care. It is possible that the specialists were wrong. It is possible that they could have overlooked something. But we do not consider it likely.

70. We took the opportunity to discuss Duncan's case with an experienced neurosurgeon. He could find no neurophysiological explanation for Duncan's cure; he pointed out that he was naturally in a difficulty because he had not been able to examine Duncan; but he also pointed out that there were still "enormous" gaps in neurophysiological knowledge, and that the effectiveness of the chiropractor's treatment, though not explicable on the basis of any neurophysiological factors known to him, could not be ruled out as impossible. That is clearly an eminently reasonable approach.

71. In the nature of things the absolute truth about Duncan's cure cannot be known. But weighing what is possible and what is likely we are inclined to think that the simple explanation is the right one: that Duncan did have something wrong with his spinal column which the chiropractor put right; that what the chiropractor put right was at least a heavily contributing factor to Duncan's symptoms, and that the chiropractor's treatment succeeded in relieving those symptoms. In other words, we think it likely that the symptoms were caused by a mechanical problem, and when that was corrected the symptoms disappeared.

72. There are three further things to be said. First, it is clear that from the outset there was, and could be, no certainty that the chiropractic treatment which Duncan received would relieve his symptoms. The

chiropractor very wisely made no promises. The most that can be said is that unless there are contra-indications to spinal manual therapy, such therapy is unlikely to do any harm and it may (as it seems to have done in Duncan's case) do good.

73. Secondly, it is clear that the chiropractor, by reason of his specialised training, was in a position to identify a spinal mechanical dysfunction which most medical practitioners would probably neither recognise nor consider significant. So if in fact, as the Commission thinks likely, the mechanical dysfunction was a material factor in Duncan's disability, it is not surprising that it was overlooked by the doctors who examined and tested Duncan. They would not have known what to look for.

74. Thirdly, whatever doubts there may be about cause and effect in Duncan's case, the clear fact remains that Duncan was in severe pain and under a severe disability, and that after he had been treated by the chiropractor the pain and disability disappeared. So whatever the chiropractor did he achieved the right result. In purely human terms the chiropractor successfully relieved human suffering when others had not. That fact should not be lost sight of in any speculation on how he brought that result about.

The Case of Mr T

75. This was a remarkable case. Mr T was one of the people who had written a formal submission. We heard him read his submission under oath and questioned him on it. His chiropractor was among those present at that public sitting. Because Mr T's case seemed of more than usual interest we called the chiropractor to give formal evidence on oath and we questioned him as well. We found the chiropractor impressive as a witness.

76. Mr T was reluctant to present his submission and give evidence in public because he felt press publicity might embarrass people whose names he had mentioned. The Commission therefore made an order suppressing publication of his submission and evidence, and on that basis the public hearing proceeded.

77. Mr T is now 31. When he was in his late teens he was involved as a passenger in a severe car accident. He was taken to the neurosurgical unit at the local hospital. He was in a bad condition. He developed paralysis from the waist down. He could not support his own body weight, even in a chair. He had no sense of balance, and could not co-ordinate his movements. He remained in hospital for 2½ years, and in that time was examined by a number of specialists who could find no cure for his condition. His calf muscles wasted away. He could encircle them quite easily with his thumb and forefinger. The doctor in charge of him suggested that he be transferred to a special unit in Auckland where he could be properly cared for. His mother would not hear of it. The doctors said there was nothing further that could be done for him. So he was discharged in a wheelchair into the care of his mother.

78. He told us something of what he experienced at that time. Conditions in his home were not geared to cope with a paraplegic. Mr T's mother did her best, but trying to cope with him, as Mr T said, nearly broke her back and her heart. The wheelchair would not go through the doorways. Whenever Mr T wanted to use the lavatory, which was outside the house, he would have to drag himself there, pulling himself along with his hands. His mother was on a widow's pension. Mr T received an

invalid's benefit. There were medical bills to pay. Their finances were very straitened. Mr T could seldom get out of the house for a break.

79. After some time Mr T was taken to a local chiropractor as a last resort, having been recommended by acquaintances. In his words, "There were people I came into contact with. I cannot remember them by name, people who said, 'Why don't you go to Mr ——?' I took the attitude that my condition seemed a bit hopeless, if the doctors cannot help me, I just supposed Mr —— could not help either, but eventually I did go. I was not a very happy man ending up in a wheelchair."

80. The chiropractor took him on and treated him. He was a very difficult case. The chiropractor had a clear recollection of the problems:

It was a difficult case because if you stood him up, he would fall over. . . . It was a battle getting him into the rooms in his wheel chair even to check him over and commence treatment. His case was one I was not sure I could help because of what he had been told, that he had permanent nerve and brain damage, and it was not really until I began to treat him that I thought I would get much response from him, and probably Mr T had more faith than I had in myself, but as I commenced treatment, I found his body began to improve and I recall him walking. . . . I continued to treat Mr T and his response continued, and we gave him not only treatment but a lot of exercises. As he indicated, he had a balance problem and he had to do a lot of rocking exercises with his knees and he gradually improved. As he improved, as he already indicated, he was able to come in without the use of a wheel chair and he was not able to balance himself at this particular time, but he would come to my rooms in a car and come across the garden on his hands and knees and come in and I can still recall the dirty marks he made in the waiting room, and he would sit down there. But gradually he improved, and as he has indicated in his submission, he was able to borrow walking aids and gradually able to give them away. The most amazing thing he told me once when he came in was that he was able to ride a horse, and I thought he was a "nut", but he could do that. When I considered he was fit, I said to him, "Go and see any doctor you like and tell him the whole story and ask for a physical examination". He did this and was given this 100 percent fitness test.

81. Mr T took his first steps about 6 months after the chiropractor's treatment had begun. He was completely back to normal after 12 months. He is in a responsible job. It requires him to work in sometimes cold and wet conditions. His average working day is 10 to 12 hours. He has not had a day's sick leave in the last 6 years. His recovery is remarkable. He told us that some time after he started work again he went to a doctor who was well acquainted with his case: after a thorough physical examination the doctor declared Mr T completely physically fit "much to his amazement".

82. While Mr T was giving his evidence, the Commission commented on his obviously fit condition:

Q: Seeing you walk up [to the witness-box] I would not have thought you had ever had the terrible condition you have told us about.

A: It is a miracle.

Q: That is how you would look at it?

A: I believe that the Lord used Mr ——'s abilities to heal me. I had no hope. I was a man without any hope at all. I was discharged [from hospital] to spend the rest of my life in a wheel-chair and I went to Mr —— and he was able to bring about my cure.

We should add that Mr T spoke of his deeply sincere religious convictions, but there was no indication that these had coloured his account of the facts.

83. What was wrong with Mr T? The hospital authorities declared him a hopeless case. The chiropractor described from memory what he had found:

As far as the lower back is concerned, my recollection is that it was mainly an involvement of the 4th and 5th lumbar. . . . involving a severe locking The condition was visible on the X-rays. . . . The method I used was basically aimed at restoring normal movement in the spine. . . . I believe there was a direct motor interference causing the problem in the lower leg. If it was not that, I don't understand why he would have responded to the treatment.

He explained that adjustments in the cervical area had remedied Mr T's difficulty in balance. So spinal manual therapy, coupled with exercises, over a period of 12 months restored Mr T from being a paraplegic to normal.

84. We visited the chiropractor's rooms later the same day and watched him treating some five or six patients. We were impressed with his professional and careful approach. We have had no difficulty in reaching the conclusion that Mr T's case is one of these apparently hopeless cases which responded to the chiropractor's special skills and technique.

85. There is a further point to be added. The chiropractor was modest about the results. He placed some weight on Mr T's determination, and Mr T's response to the confidence the chiropractor had been able to inspire in him. And the chiropractor's answer to a question from the Commission is revealing:

Q: Would it be fair to say that you would always hope that people could benefit in similar cases, but that is not always sure?

A: It is my job to accept this, I think. I can hope. It is not always clear whether we can help, but I do believe it becomes clear by the time the patient has had eight or ten visits—it becomes clear whether he can help that person, whether we have had the response which will warrant continuation or whether at that time I think they should seek other types of treatment. . . . If someone came in to me in an identical situation as Mr [T's] and asked if I could help, or could I not help, I don't know.

That response demonstrates an entirely proper and professional humility of approach, one which could in the Commission's opinion be echoed by any health professional dealing with these particularly difficult problems.

CONCLUSIONS

86. These cases are instances where chiropractors appear to have been able to help patients with Type O disorders. There are others, which appear just as impressive, which were given to us in public sittings and which we have not mentioned. Many more instances were cited to us in letters from patients and in the questionnaire responses.

87. Too much must not be read into these cases. They are not like Type M cases where there is some degree of predictability. In Type O cases the results of chiropractic treatment cannot be predicted. There is no evidence that it brings bad results; sometimes it seems to bring good results.

88. These are not cases where a health subsidy should be given except in the limited circumstances which we have outlined. However, our view is that chiropractors are not unreasonable or "unscientific" in believing that their method of treatment may sometimes have a beneficial effect on a patient's visceral and/or organic disorder. But such cases must in the mean time be regarded as frankly experimental.

89. All this should suggest to an open-minded doctor that where a patient is suffering from some organic and/or visceral disorder which does not respond significantly to orthodox treatment there might in suitable cases be no harm in a chiropractic examination and treatment. In at least two of the cases we have set out above, chiropractic treatment at an early stage might well have saved the patients a long period of distress and discomfort.

90. We say this with all the more confidence because it is clear, as we have pointed out before, that the chiropractor has a unique training and skill in identifying mechanical defects in the spinal column. The medical practitioner has no such training. It is logical to suggest that the medical practitioner, however skilled he may be in his particular field, is likely to miss what to a chiropractor would be obvious.

91. Two final comments. First, there ought to be intensified research into why spinal manual therapy in particular sometimes has the effects it appears to produce. It is no answer to accuse chiropractors of being “quacks”, to try to explain away their results, or to try to sweep their results under the carpet on the ground that they have not been verified by a scientific method. Secondly, there is the clearest possible need for a much closer degree of co-operation between doctors and chiropractors. The need for medical monitoring of a patient’s Type O condition while the patient is under chiropractic care is so obvious that it should not need to be stated. And now that it has become plain that much medical criticism of chiropractors is based on simple ignorance of what they do, cross-fertilisation becomes most desirable.

Chapter 33. THE NEW ZEALAND CHIROPRACTORS' ASSOCIATION SUBMISSION

INTRODUCTORY

1. The Chiropractors' Association put in a very full general submission. It was said to have been primarily the work of two chiropractors, Dr L. C. Blackburn, the association's president, and Dr P. D. Wells, a past president of the association, although others assisted.

2. The submission was presented orally to the Commission on 9 June 1978 and on following days by Dr L. C. Mudgway, a chiropractor who practises in Whangarei and who is a member of the Chiropractic Board and a past president of the association. He also gave evidence on his own account, and was cross-examined very extensively on behalf of the Medical Association and the Society of Physiotherapists. He was the Chiropractors' Association's principal witness.

3. Some doubt was expressed at the outset whether Dr Mudgway, who had apparently not played any major role in the preparation of the association's submission, was the best person to present it and be cross-examined on it. When he was asked by counsel for the Medical Association whether it was proposed to call Dr Blackburn or Dr Wells for cross-examination on the general submission he said he did not know. In fact Dr Blackburn and Dr Wells as the principal compilers of the submission were called only at a very late stage of the inquiry, after the Medical Association had presented its own submissions and had called its evidence, and then at the Commission's insistence. We mention this matter because it was one of the least satisfactory features of the way in which the Chiropractors' Association's case was presented to us.

4. We desire to record another unsatisfactory feature of the presentation of the Chiropractors' Association's case. The association's formal general submission contained a great many references to texts and articles in periodicals. As we did with the other interested parties, we asked that all such material be produced. We wished to read for ourselves the material in its context. We are indebted to the Medical Association and the Society of Physiotherapists for their ready co-operation—almost over-co-operation—with this request. The Chiropractors' Association was, however, slow in producing its references, and even by the end of the Commission's public sittings a number of them had still not been produced. No good explanation was offered. The Commission has therefore felt obliged to disregard those parts of the Chiropractors' Association's submissions whose authority was said to be derived from references which were not produced.

5. We now deal with parts of the association's general submission. Many of the matters raised in it were explored at great length in the course of the evidence. We have dealt with most general aspects in detail in other sections of this report. We therefore confine this present chapter to some general and some particular matters not discussed elsewhere.

THE CHIROPRACTORS' ASSOCIATION

6. The association, incorporated in 1922, represents the majority (70 percent) of chiropractors practising in New Zealand. It is the only New Zealand chiropractic professional organisation. Every applicant for registration as a chiropractor must notify the association of his or her application, and the association is entitled to object. So the association may be taken to be not only representative of New Zealand chiropractors but also the guardian of chiropractors' professional standards in this country.

THE ASSOCIATION'S ATTITUDE TO THE INQUIRY

7. The association stated its attitude to this inquiry as follows (Submission 19, pp. 2-3):

The springboard for this Inquiry was a petition presented by one R. A. Houston and 94 210 others seeking amending legislation which would provide benefits to patients in respect of chiropractic services under the Social Security Act and the Accident Compensation Act. The Medical Association of New Zealand has given clear notice that it intends to oppose any extension of benefits and to adopt a major role at the Commission's hearings in opposition to the Chiropractic profession. The New Zealand Physiotherapists Association is expected to adopt a similar attitude.

There is more than a suggestion that the medical and physiotherapy professional bodies have determined that this Inquiry should provide for them yet another opportunity for a confrontation between their professions and that of Chiropractic. The N.Z.C.A. takes the view that the occasion for such a confrontation in New Zealand is long past. It existed (and the opportunity was taken) at the time of the consideration of the Chiropractors Bill which was subsequently enacted as the Chiropractors Act 1960. The views of both sides were then aired and the issue decided firmly in favour of Chiropractic.

Since the Chiropractors Act came into force Chiropractors have had in relation to their right to practise statutory recognition similar to that which Medical Practitioners enjoy in their field. Regrettably the M.A.N.Z. seems to have made no effort to accept that situation: one could be forgiven for thinking that it seeks to place itself above the law; and officially, at any rate, it refuses to recognise what Parliament has decreed.

The N.Z.C.A. seeks no further contest with the other healing professions. Any confrontation now would simply be time-consuming, repetitive, and wasteful; and, as has happened elsewhere, would simply absorb energy and funds which could better be directed to the benefit of patients. The N.Z.C.A. takes the view that co-operation between the healing professions is in the interests of patients and is long overdue. It is being delayed largely, if not solely, by the attitude of official medicine and its ancillaries.

8. The Commission wishes to record two comments on this. In the first place, any unpleasant atmosphere of confrontation during the inquiry was avoided owing to the restraint, courtesy, and good sense which all parties demonstrated in presenting their evidence. Secondly, and in fairness to the Medical Association, it has to be repeated that the opposition of organised medicine to chiropractic has been stimulated by the extravagant claims and the attitude of a few chiropractors. If this inquiry has led to nothing else, it is to be hoped that it has made clear to New Zealand chiropractors the need to insist upon and enforce proper professional discipline. The Commission discusses this topic further and makes positive recommendations on it in chapter 43.

THE ASSOCIATION'S BASIC SUBMISSIONS

9. These are conveniently summarised in the association's own words (Submission 19, p. 5):

The N.Z.C.A. submits that this Commission should recommend to the Government that legislation should be passed—

- (a) To bring about the provision of benefits under the Social Security Act in respect of services rendered by registered Chiropractors at the same rates as are provided from time to time for general medical services.
- (b) To bring about the provision of benefits in respect of diagnostic X-ray services rendered by registered Chiropractors.

- (c) To bring about the provision of benefits in respect of diagnostic X-ray services provided by other radiological services to Chiropractors.
- (d) To provide for the payment under the Accident Compensation Act of the cost of certificates and treatment by a registered Chiropractor and the giving of certificates by registered Chiropractors for the purposes of that Act.

10. It is important to understand the implications of these submissions. Broadly, in respect of health and accident compensation payments, the chiropractor wishes to be placed in the same position as a general medical practitioner.

11. The association summarised its reasons for these submissions as follows (Submission 19, pp. 5–6):

- 1. The Chiropractic profession is recognised and accepted both in New Zealand and elsewhere as a proper source of primary health care.
- 2. Its recognition is such that it is likely to remain as a profession providing such care.
- 3. The demand for the services of registered Chiropractors is already substantial and is likely to increase.
- 4. In the context of the New Zealand approach to the provision of health care and accident benefits it is anomalous and unjust that a substantial number of persons seeking Chiropractic health care should be subject to discrimination in the provision of such benefits.
- 5. Chiropractic constitutes a healing art distinct and separate from that of other health providers and offers a form of therapy the great value of which must now be accepted.

Two of these points require special comment at this stage.

12. As to point 1, it is true that chiropractic is recognised in New Zealand as a source of primary health care. It is so recognised by the Chiropractors Act 1960. That means, as we have seen, that chiropractors are legally entitled to accept patients off the street and without prior medical consultation. It is entirely a matter for the chiropractor's sense of professional responsibility whether he treats the patient or not.

13. We interpret what the association says as meaning only that. Perhaps that is over-charitable, because there is evidence that some few chiropractors regard themselves almost as comprehensive health care practitioners. But it is desirable that we repeat that we do not regard the chiropractic profession as a "proper source of primary health care" for any and every ailment. It is an important aspect of a chiropractor's professional responsibility to prevent members of the public from believing that a chiropractor can be regarded in the same light as a general medical practitioner or a family doctor: a practitioner of first resort, who will refer the patient on for other health care if he considers the patient's health problem beyond him. We have received evidence, referred to elsewhere, that at least a few chiropractors have chosen to ignore that principle.

14. As to point 5: we do not accept that "Chiropractic constitutes a healing art distinct and separate from that of other health providers". The spinal diagnosis and manual therapy offered may be more sophisticated and skilful than that offered by other "health providers", and the expectation of results may be wider, but those factors do not mean that the chiropractors' healing art is separate and distinct. We have explored this topic in some depth in chapter 12.

PRACTICE AND THEORY

15. We have already examined this topic in chapter 8, and look at it again in chapter 39. However, it is worth restating, in the association's own words, how it sees chiropractic practice and theory. The following is from the association's submission (Submission 19, pp. 20, 26):

The practice of Chiropractic has as its central therapeutic goal the restoration of normal function to the neuro-musculoskeletal structures of the spine in order to advance

the general welfare of the patient. Its focal point of concern is the integrity of the nervous system. . . . Chiropractors do not contend that subluxation however defined, is the most significant causal factor in disease. They do claim that subluxations of different orders and types are a factor in the production of symptoms and that the adjustment of these subluxations brings about a return to more normal physiological functioning.

16. That, as we understand the evidence, is the basis on which the majority of New Zealand chiropractors would operate if they paused long enough in their busy practices to give the matter serious thought.

ALLEGED MEDICAL SUPPORT FOR CHIROPRACTIC

17. The submission suggests that there is overseas support for chiropractic among more enlightened medical specialists. We accept without any hesitation that spinal manual therapy is supported and advocated by many specialists. To the extent that chiropractors perform spinal manual therapy, it is therefore perfectly true to suggest that strong medical support can be found for that therapy. But we are unable to accept that there is much medical support for the theory of chiropractic.

18. Nevertheless one medical writer, an orthopaedic surgeon and a strong advocate of spinal manual therapy, is not prepared to dismiss chiropractic out of hand: see J. F. Bourdillon, *Spinal Manipulation*, 2nd ed., rev. (London, 1975), p. 142. Dr Bourdillon has this to say:

In discussing the origin of chiropractic, mention was made of Palmer's claim to have restored the hearing of a negro porter by manipulation of the upper thoracic spine. At first sight, this claim would appear to be completely contrary to anything known in anatomy, physiology or pathology. The claim, however, may not be quite as fantastic as it sounds, as is illustrated by one of the author's cases. The patient had no symptoms referable to the head or neck until after he had been injured when he gradually developed a Menière's syndrome consisting of unilateral deafness, tinnitus and vertigo so severe that he almost always vomited, and the only relief he obtained was by going to bed. At first he was treated by manipulation of his stiffened neck joints and although this did help, the relief was transient and very far from complete. When the thoracic spine was examined, the lesion at the T4-5 joint was found and manipulative treatment to this joint resulted in dramatic and lasting relief of all symptoms referred to, including the deafness. The sympathetic supply to the vessels of the head and neck is said to arise from the T1 and 2 segments, with an occasional supply also from T3. The dramatic improvement after treatment of the thoracic joint strongly suggests that this was the main source of the symptoms. Had the main source of the trouble been higher up, a temporary partial improvement might have occurred as the result of correction of tension at the lower level. In this patient the temporary partial improvement occurred when the higher levels were treated and the dramatic improvement only with treatment of the T4-5 joint. It may be that the anatomist's description of the sympathetic supply of the head and neck is incomplete or it may be that there are some other unknown factors.

19. Some of the association's assertions concerning medical support cannot be regarded as accurate. It is said in the association's submission that "One of the largest organisations of researchers university personnel and medical specialists concerned with chiropractic is the Co-operative Society for the Advancement of Medicine and Chiropractic" in Germany. If this were so it would be an important point. With the assistance of the Ministry of Foreign Affairs and the New Zealand Embassy in Bonn we investigated it. It is true that there used to be a West German organisation, Forschungs-und Arbeitsgemeinschaft für Chiropraktik ("FAC"), which was set up in 1953, and it is true that it was founded by a group of German physicians who had become interested in chiropractic. However, according to the secretary of its successor organisation, Deutsche Gesellschaft für Manuelle Medizin (German Society for Manual Medicine), Dr H. D. Wolff, who responded to an inquiry from the Commission on 12 October 1978, the founders of FAC not long afterwards became aware of the tensions between chiropractors and the medical

profession and put the original organisation on an indisputably medical basis. They renamed it Forschungsgemeinschaft für Arthrologie und Chirotherapie (Research Association for Arthrology and Chirotherapy) which retained the initials FAC. In 1963 the renamed FAC amalgamated with another similar organisation, the resulting consortium becoming the Deutsche Gesellschaft für Manuelle Medizin. This body has, in Dr Wolff's words "no scientific relations at all with the chiropractors".

20. It is clear that the Deutsche Gesellschaft für Manuelle Medizin is a reputable medical organisation. "Chirotherapy", which is a term used only in Germany, is manual therapy practised, developed and taught by qualified physicians with normal medical training. It is discussed in a recent article by Dr G. Gutmann ("Chirotherapie", *Med. Welt.* 29: 653-657 (1978)).

21. We have mentioned these matters in order to set the record straight and so that future confusion will be avoided. Dr Blackburn was cross-examined on the matter. It was obvious that he was completely ignorant of the developments we have mentioned. Dr Wells was not asked about them. We can only conclude that some out-of-date material was included in the association's submission from another source without any check on whether it accurately portrayed the current situation.

EDUCATION AND RESEARCH

22. The Chiropractors' Association's submission deals extensively with chiropractic education and research. We have made our own assessment of chiropractic education on the basis of the evidence of Dr A. M. Kleynhans and others and our own investigations. We deal with this matter in chapter 38.

23. Chiropractic research is a relatively new development. We agree with the association that "much more must be done in this field" (Submission 19, p. 50). Research is essential, particularly in view of the fact that some of even the more modern books on chiropractic contain some passages which are nonsense to those grounded in the basic sciences of orthodox medicine. That does not exactly encourage medical confidence. And there is a clear need for chiropractic writing to be expressed in terms which do not jar on the sensibilities of those trained in the basic medical sciences. For instance it is too easy to become distracted from much that is of interest and value in Homewood's text (A. E. Homewood, *Neurodynamics of the Vertebral Subluxation*, 3rd ed., 1977) by constantly recurring purple passages such as the following (p. 297):

The clinical proof of the truth of D. D. Palmer's principles and methods provide the necessary confidence for the doctor of chiropractic to stand tall in the company of clinicians of all schools of healing. In the broad field of prophylaxis chiropractic has no peer. It remains for the chiropractic profession to educate the general public to the availability of such a complete and encompassing mode of health care.

We deal more fully with chiropractic research in chapter 37.

PUBLIC DEMAND

24. Some emphasis is laid in the association's general submission on the public demand for chiropractic. It is said (Submission 19, pp. 76-7):

In New Zealand the established demand for Chiropractic services reflects the position overseas. The reasons for that demand include—

- (a) Dissatisfaction with the iatrogenic complications of drug therapy.
- (b) Disillusionment with the lack of personal attention given by medical practitioners.

- (c) The relative lack of success of medical procedures to assist spinal and spinally related conditions.
- (d) The undoubted improvement many patients experience under Chiropractic care.
- (e) The belief that freedom of choice should extend to health matters.
- (f) A disaffection with the 'establishment' and the superior attitude of the medical profession.
- (g) A movement—noticeable worldwide—for a return to a more natural way of doing things; in short the desire for a simpler way of life.

25. We wish to say that we do not accept public demand as necessarily a proper criterion for the evaluation of a health service. We would say this even if we had no reservations about how the public demand for chiropractic had in some instances been generated.

26. We do, however, accept that what the Chiropractors' Association has said must be regarded as a challenge to the medical profession which ought to be pursued. In particular, as Professor J. I. Hubbard pointed out to us, doctors could concentrate more on the quality of their dealings with patients on a personal level. But more important, it is clear that in the general field of spinal manual therapy the medical profession has been ostrich-like.

MATTERS WHICH CAUSE DISQUIET

27. There are some features of the Chiropractors' Association's general submission which we have found disquieting. We have mentioned one already: the association's reliance on medical interest in chiropractic in Germany some 20 years ago without any recognition of the fact that such interest was apparently short-lived.

28. We have also noticed the absence of any clear and unequivocal statement that the Chiropractors' Association recognises that in practical terms there must obviously be clear limits on the scope of a chiropractor's practice. We come back to this point several times in this report because it is of major concern to us: it is in the Commission's view quite wrong that any chiropractor should conduct himself so as to lead the public to believe that he should be considered the first port of call for all kinds of health problems. The point is important. We repeat an extract from a printed circular one New Zealand chiropractor issued to a patient in early 1978:

No matter what the complaint may be, always consult your Doctor of Chiropractic first. Do not hesitate to call him should your illness be of such a nature as to prevent you visiting his clinic. If yours is not a Chiropractic case, he will readily refer you to another type of therapy. If you try other therapies first and your case happens to be a Chiropractic case, you may never be referred to a Chiropractor. In order to procure his diploma, a Doctor of Chiropractic has to have knowledge of other healing sciences. Practitioners of other therapies are required to know NOTHING about Chiropractic. Therefore, regardless of their sincerity, they are not apt to refer you to a Doctor of Chiropractic.

29. The unpredictability of chiropractic treatment for anything other than Type M disorders calls for a far greater degree of professional restraint and caution than the general submission indicates. We find it impossible to believe that the Chiropractors' Association, having previously participated in the proceedings of two Commissions of Inquiry and at least one Parliamentary Select Committee, could have remained unaware of the feeling that any insistence on a wide scope of practice would generate. We do not in the least overlook the value of chiropractic treatment in some Type O cases. The danger lies in inflating the possibilities of chiropractic treatment: see chapter 39.

30. So in this respect the Chiropractors' Association demonstrates some insensitivity. We consider insensitivity is displayed also in the description

of a chiropractor as a “doctor of Chiropractic” (see, e.g., Submission 19, pp. 27–8):

In examination the doctor of Chiropractic uses standard methods, techniques and instruments.

Doctors of Chiropractic are knowledgeable in the standard clinical laboratory procedures and tests usual to modern diagnostic science.

And in two leaflets for the public issued by the association:

You and Chiropractic

Your Doctor of Chiropractic is concerned with more than just temporary relief and may therefore recommend continued care and supervision. . . .

Pain: Head Neck Shoulder Arm

The Doctor of Chiropractic is often called upon to treat patients having head, neck, shoulder and arm problems.

31. We are of course aware that the term “doctor of chiropractic” as distinct from the more modest term “chiropractor” has come to New Zealand from North America, where it has a cultural basis and a degree of traditional acceptance. As far as New Zealand is concerned we find the usage unnecessary and objectionable, and anyone with any sensitivity should be able to see that it must irritate the medical profession. See also chapter 42.

GENERAL

32. In general the Commission found the evidence of individual chiropractors more convincing and valuable than the association’s general submission. We now proceed to consider that evidence.

Chapter 34. THE CHIROPRACTOR WITNESSES

INTRODUCTORY

1. Fifteen practising chiropractors gave evidence in favour of chiropractic during our inquiry. Two, Dr A. M. Kleynhans (Palmer College) and Dr T. R. Yochum (National College), came from Australia, their evidence relating mainly to the educational facilities of the International College of Chiropractic at the Preston Institute in Melbourne. There were 12 New Zealand chiropractors: Dr L. C. Mudgway (Palmer College), Dr B. J. Lewis (Palmer College), Dr C. M. Ross (Los Angeles College), Dr S. J. Pallister (Canadian Memorial College), Dr R. T. Smith (Palmer College), Mr I. W. Smith (Palmer College), Mr P. V. Rose (Anglo-European College), Mr J. J. Richardson (Palmer College), Dr L. C. Blackbourn (Palmer College), Dr P. D. Wells (Palmer College), Mr D. R. Sim (Lincoln College—later merged with National College), and Dr R. J. Todd (Palmer College). A further witness who had practised as a chiropractor was Dr Scott Haldeman (Palmer College): he is medically qualified and specialises in neurology. His evidence was of great interest and importance and is dealt with in the next chapter.

2. In addition to the 12 New Zealand chiropractors who gave formal evidence, we had informal discussions with 4 other individual New Zealand chiropractors, 2 of whom demonstrated their techniques for us on patients. Three of those who gave evidence (Dr Mudgway, Dr Wells, and Mr Sim) also provided us with demonstrations.

3. We have inspected the rooms of six chiropractors, and have viewed from the outside the working premises of a number of others.

4. In having informal discussions with any chiropractor we remained aware of the need to hesitate to accept any assertions made to us which were not tested by cross-examination. All the chiropractors whose names we have mentioned were available for cross-examination with the exception of Dr R. T. Smith and Dr Todd: in Dr Todd's case we decided that because of the nature of the evidence he was likely to give about a particular patient he should be heard in private. Counsel for the principal parties were provided with a copy of his report concerning the particular patient and asked whether they wished to cross-examine Dr Todd. They declined that invitation.

5. Dr R. T. Smith came to our notice when a patient of his made confidential submissions to us. Dr Smith happened to be readily available, and we found it useful to see him privately to discuss that case further with him.

THE NEW ZEALAND CHIROPRACTORS

6. We are satisfied that we have been presented with a properly representative range of chiropractic opinion. We treat the evidence of the witnesses we have mentioned as broadly representative of chiropractic practice in New Zealand. We saw and heard nothing during our inspection of chiropractors' premises or during our informal discussions with any chiropractor which did not merely confirm what we learned from the formal evidence.

7. The chiropractors we saw and heard ranged from those with long experience to those recently qualified. Some had developed individual techniques of manual therapy. There was the expected range of apparent ability, both in intellectual breadth and in manual skills. Some had obviously kept up with their reading; others seemed simply to have concentrated on their patients, applying tried and established methods. These were the differences which one might expect to find among any group drawn at random from a professional body. All appeared to be perfectly competent in their work.

8. We draw attention to the evidence of one witness, a chiropractic patient whose work obliges him to travel continually and extensively throughout New Zealand. His particular health problems had led him to ensure that he had regular access to both chiropractic and medical treatment, and in 12 years he had been through the hands of some 20 chiropractors in various parts of the country. He told us that he had found a general uniformity in their approach and treatment that reached an impressively high professional standard.

9. This witness was articulate and well-educated. He had no difficulty in distinguishing between those of his health problems which call for medical attention and those which respond best to chiropractic treatment. We were left in some doubt whether less intelligent people would find it as easy to make the distinction, but the main point for present purposes is that this was a witness whose evidence was plainly reliable as to the general standards he had found among New Zealand chiropractors. His evidence from the consumer's point of view tends to confirm our own observations from a more detached standpoint.

10. We now propose to deal with the evidence in more detail.

Dr L. C. Mudgway

11. Dr Mudgway, an experienced chiropractor from Whangarei, had to bear the brunt of the cross-examination on behalf of the Medical Association and Society of Physiotherapists at the hands of very experienced and tenacious counsel. The cross-examination extended through 10 sitting days, although at various stages other witnesses were interpolated. We can now see at the end of the inquiry that few features of chiropractic were in fact left uncovered.

12. Dr Mudgway is a past officer of the New Zealand Chiropractors' Association and a member of the Chiropractic Board. He is also a member of the Australasian Council on Chiropractic Education and is thus concerned with the establishment of the International Chiropractic College in Melbourne as part of the Preston Institute of Technology. So Dr Mudgway was a very important witness.

13. We consider it as well to say at once that we found Dr Mudgway an impressive witness, and one on whom we could rely. For a short period at the start he tended—not unexpectedly—to be on the defensive, and his answers were inclined to be evasive. But as the cross-examination proceeded he opened out and answered the most searching and detailed questions about chiropractic with disarming frankness. In doing this Dr Mudgway won the respect of the Commission, and we believe the respect of others present at the public sittings who heard him. We must again acknowledge our debt to counsel, Mr J. T. Eichelbaum, Q.C., for the Medical Association and Mr M. J. Ruffin for the Society of Physiotherapists, who led Dr Mudgway through an extremely detailed cross-examination and thus materially helped us to get to the facts.

14. Dr Mudgway revealed himself as an honest, efficient, and hard-working practical chiropractor, dedicated to his patients' welfare, but with no pretensions to academic distinction. He plainly had strong personal convictions about the efficacy of chiropractic treatment, and it was clear that he was dedicated to the advancement of chiropractic. He was hurt—rather than resentful or aggrieved—at the attitude of the medical profession towards chiropractic. He told us how he had accepted patients referred to him by local medical practitioners for accident compensation purposes, a practice which had dried up when the local branch of the Medical Association learned of it and intervened. He was frankly but unemotionally critical of the organised medical profession's attitude in regard to this incident. He told us that he accepted there were some doctors who would never send patients to him; but he told us there were others who would do so once they realised what he could accomplish. It was easy for us to picture Dr Mudgway in a co-operative situation with sympathetic doctors.

15. The following points about chiropractic emerged from Dr Mudgway's evidence:

- Most patients come to the initial consultation for relief from a Type M problem. If any other health problem is revealed by examination, the patient will be referred for medical advice, but that will not preclude chiropractic treatment if the patient wants it (unless there are contra-indications). It would be given in the hope that the patient might be generally assisted.
- Some patients come to the initial consultation for relief from a Type O problem, having heard of previous Type O successes. As far as Dr Mudgway is concerned, he (and, he believes, most other chiropractors) would tell the patient that relief cannot be guaranteed, but he would proceed with a spinal examination and, if a dysfunction were found (which it is in the majority of cases, in Dr Mudgway's experience), adjust it.
- Dr Mudgway was cautious in defining exactly what the nature of the dysfunction (chiropractic "subluxation") might be, and in stating how it could be demonstrated. This aspect of his evidence led us to doubt whether it would be possible for anyone to establish the acceptability of a therapy which is applied to a condition the precise nature of which is not known and which is not easily demonstrable. But we had not appreciated some of the subtleties of spinal biomechanical dysfunction and its diagnosis at that stage, and as the inquiry proceeded we came to accept that there is nothing unreasonable in thinking in terms of a "subluxation" which is essentially functional and which can take a variety of forms and be dealt with in a variety of ways. We have dealt with this at length in chapter 9.
- Dr Mudgway takes a relatively broad view of the scope of chiropractic practice. The basis of his approach is that he is treating a spinal dysfunction. He is not treating a specific disorder.
- Chiropractic is seen, not as a healing art, alternative to orthodox medicine, and providing a comprehensive system of health care, but as a healing art *complementary* to orthodox medicine. Spinal dysfunction is seen, not as the cause of all disease, but as a factor which may contribute to some disorders. Dr Mudgway relies on his clinical experience as proving that to his satisfaction.

- Dr Mudgway accepted that Palmer College adopts the view that chiropractic treatment can properly be resorted to for a very wide variety of disorders, but disapproves of claims for chiropractic treatment which are on any view of the matter extravagant and which appear in publicity leaflets issued by the college. He disapproves of similar material issued by some New Zealand chiropractors (see chapter 18). In spite of the fact that the Chiropractors' Association has strongly discouraged the issuing in New Zealand of any pamphlets of the kind mentioned, the Commission had evidence to show that the association's requirements were not being adequately policed.
- On the question of referral to chiropractors by doctors, chiropractors see themselves, not as medical auxiliaries, but as spinal specialists.
- Chiropractors would like to have access to laboratories and specialist radiological services as an aid to diagnosis so that patients could, where necessary, more easily be sent to other health services.
- The idea of a "family chiropractor"—one to whom the whole family can resort for regular spinal check-ups and treatment—need not in Dr Mudgway's view be discouraged.

16. Those were the principal points which emerged from Dr Mudgway's evidence. We have dealt with them in various other parts of this report.

The Other New Zealand Witnesses

17. In labelling the 10 remaining New Zealand chiropractors as "the others", we must not be taken as suggesting that their work is less valuable or dedicated than that of Dr Mudgway. We have laid particular stress on Dr Mudgway's contribution to this inquiry because the Chiropractors' Association put him in the front line.

18. These 10 chiropractors covered a substantial range of length of experience, from the very experienced to those who had quite recently qualified or had been qualified for a few years only. Some, particularly those who had not graduated from Palmer College, tended on the whole to be more conservative: that is, to have a more realistic view of the limitations of the scope of their practice. One of the more recently qualified from Palmer College showed signs of having been infected with a "hard sell" approach to chiropractic which we cannot regard as either attractive or desirable. On the other hand two of the conservative chiropractors who gave evidence were originally brought to our attention because a patient of each had told us about remarkable recoveries at their hands from serious disorders which the medical profession had given up as incurable. We investigated both such cases and were encouraged to find that both chiropractors were very modest about these results; they did not claim to have performed a miracle cure, but treated each case as an example of what chiropractors can do if the right circumstances present themselves. In neither case had they been prepared to predict what the result of chiropractic treatment would be, but they were naturally pleased at the results.

19. That is a fairly common attitude. An example of this appears from the evidence of Dr C. M. Ross, who was being asked about the likely effect of chiropractic treatment on a variety of complaints (Transcript, pp. 2259-60):

Q: [Mr Eichelbaum] . . . For his skin rash—whatever it is, and you find a subluxation—is your position that you would proceed to endeavour to correct the subluxation and take a wait and see attitude in respect of the other conditions?

A: In a skin condition like, say, psoriasis there is no great fear in the condition advancing dangerously and if I find a subluxation of the patient's spine, yes, I would touch that.

Q: Would it be a fair conclusion from your answer that you would exercise your judgment whether there was any risk in the treatment or not?

A: Definitely.

Q: And if it was your conclusion that there was no risk then would you proceed to treat the subluxation and so far as the other condition is concerned, adopt a wait and see attitude?

A: Yes, as I said—

Q: Do you agree with that?

A: Yes. Depends on the condition of course, you know.

Q: [The Chairman] Just take the case of psoriasis. The patient presents with the back complaint and you find that the patient also has psoriasis and you decide that the risks are not sufficient to stop you treating the subluxation which you find. Would you assume as a working hypothesis that the subluxation might have something to do with the psoriasis as well as causing the symptoms of back pain—as well as the symptoms the patient has presented with?

A: Psoriasis is associated with back pain. Psoriasis is often associated with rheumatoid arthritis. I used to see a lot of that at Queen Elizabeth [Hospital] . . . I don't think anybody has a great therapy for it apart from coal tar derivatives being used. I have seen psoriasis look far the better for treatment—but I think you asked me would I therefore suspect that my adjustment had helped?

Q: What I was asking really was whether you would suspect as a working hypothesis that there might be some connection between the subluxation you found to exist and the psoriasis.

A: I think as far as the nervous system goes with all its ramifications, it could be but it needn't be.

Q: Yes, so you would basically be treating the back pain?

A: Right, and the subluxation I found on examination.

Q: Suppose the psoriasis suddenly cleared up with the back pain and the subluxation, would it be reasonable to assume that the treatment had had something to do with the psoriasis?

A: I wouldn't know. I wouldn't know if it had. I honestly wouldn't know.

Q: Is that because of the uncertainty that surrounds the precise cause of psoriasis?

A: Yes, and the ramifications of a subluxation and any nerve irritation that may come from that . . .

Q: [Mr Eichelbaum] I would like to take one of the questions a stage further, Mr Chairman. The Chairman put it to you just now—is this uncertainty because of the uncertainty as to the ramifications of psoriasis? Is that the answer or is it also uncertainty as to the ramifications of the chiropractic subluxation?

A: Well, I thought I had answered it when I said we don't know the cause of psoriasis.

Q: Is that the whole answer?

A: There can be far reaching effects from the chiropractic subluxation but I would not want to claim because of my adjustment to somebody's back that I just cured psoriasis.

20. The question of referral of patients by medical practitioners to chiropractors—assuming the present ethical ruling against it were rescinded (see chapter 41)—has some inherent problems. These are illustrated by the following passages in the cross-examination of Dr B. J. Lewis (Transcript, pp. 2237–9):

Q: [Mr Eichelbaum] We here all appreciate the present position that arises out of the Medical Association's ethical ruling but if that particular difficulty were removed could you see yourself accepting patients on referral from a medical doctor?

A: Yes, I do now.

Q: Could you see yourself doing that on a system of ethics which require that in the last resort you would have to accept the medical doctor's view of the position if there was any disagreement between you?

A: I think to a point that is possibly a fair comment. I would expect to have the opportunity to discuss it with the medical doctor as I do now. Where we are going—whether we are getting anywhere.

Q: In the discussion I think it is clear from the comments you have made that you would regard yourself as entitled to express a full opinion of your own.

A: Within the referral situation?

Q: Yes.

A: Oh, very definitely.

Q: . . . if there was the referral situation where the patient [was that] of a well recognised medical specialist, would you feel free to disagree with his views in what you thought was an appropriate case?

A: I think that is fair. Why not?

Q: Why not. For example, if treating your first case ever of juvenile rheumatoid arthritis would you feel any diffidence about differing from the view of a well recognised medical expert of long standing in that field?

A: No, I would not feel any diffidence.

Q: Would you feel any diffidence about disagreeing as to whether a particular mode of treatment was proper or appropriate or inappropriate?

A: I would disagree if I felt that way.

Q: If the medical practitioner felt that there was a significant risk of proceeding by way of chiropractic treatment in the case of a child with juvenile rheumatoid arthritis, would you feel any hesitation in disagreeing with the medical specialist?

A: No. I would still be able to disagree with it.

Q: Would it be fair to say, please say so if you disagree with me, that in that particular situation you had not a complete respect for the views of the medical specialist concerned in the case?

A: . . . I don't think respect is quite the word I would use. I would feel free to disagree with him, perhaps because of our different training. I may feel that something is better done another way but if that is his opinion he is welcome to it.

Q: Yes, but in discussion with the parents of such a child you would have no hesitation in telling them that you preferred your own view to that of the medical specialist.

A: I think we are getting into a bit of a hairy area where you are asking me—correct me if I am wrong—whether I would tell the parents he is wrong and I am right.

The Chairman: I think that is basically what he is saying.

Mr Eichelbaum: I won't flinch from that, I think that is the effect of the question I am putting to you.

A: In fact we may be both right but they may be both perfectly valid ways of treating that particular problem—we are just approaching it a little differently.

Q: Coming right down to the situation that in such a situation the medical specialist thinks there is a risk of manipulative treatment and you don't.

A: As far as relates to chiropractic, I think he would be wrong.

Q: If the area of disagreement between you is that the medical specialist thinks that there is a risk in administering chiropractic treatment in this case and you don't would you be prepared to say to the parents of the child in question that is his view but I think my view is the correct one?

A: If the parents ask me for an opinion on whether it was going to hurt the child I would have to say 'no'. That is not quite what you asked me. I don't think I would ever allow myself to be put in a position where I rubbish his opinion specifically but I would feel entitled to make my own.

21. At first sight it struck us that the attitude described by Dr Lewis (who graduated in 1974) was the kind of attitude which would make any referral system difficult. We do not now think that it need be an insurmountable obstacle. It is one example out of many we have had of a chiropractor speaking frankly and not mincing his words. Any referral system is going to require mutual respect, not chiropractic subservience. There is no point in referral unless the medical practitioner who refers understands that the chiropractor's special understanding and skill in treatment of the spine is the justification for the referral.

22. So while a chiropractor must necessarily defer to a medical opinion in an area within the special competence of a medical practitioner (and we do not consider that spinal biomechanics is necessarily such an area), the medical practitioner must also defer to the chiropractor's special expertise. That, we think, is essentially what Dr Lewis was getting at. That way of looking at the matter would appear to find general acceptance among New Zealand chiropractors. It should find acceptance among New Zealand medical practitioners.

THE AUSTRALIAN CHIROPRACTORS

23. Dr A. M. Kleynhans, the Principal of the International College of Chiropractic at Preston Institute in Melbourne, and Dr T. R. Yochum, who is the Head of the Department of Roentgenology at the same college, gave evidence before the Commission. What they said was concerned mainly with chiropractic education as it is now developing in Australia, and this important matter is dealt with in chapter 38.

24. As we might have expected, both Dr Kleynhans and Dr Yochum were intelligent and articulate people with a sound up-to-date grasp of chiropractic theory and research. As a result of their evidence we began to achieve a more adequate understanding of some matters that had previously troubled us. We summarise the evidence below.

Dr Kleynhans

25. Dr Kleynhans, one of the impressive expatriate South African chiropractors whom we met, spoke and was questioned at some length on the topic of diagnosis. His view was that the training of chiropractors should produce a competence in diagnosis equal to that of a medical practitioner but with a different emphasis; but it transpired that what he really meant was that the chiropractor should be trained to a point where he would be as competent as a medical practitioner to decide whether he should take on the patient himself or refer the patient out. That is of course quite different from training the chiropractor up to medical levels in full differential diagnosis.

26. We had up to then felt some concern at the inclusion in chiropractic courses of a wide range of medical topics which seemed to have little or nothing to do with what the chiropractor might expect to find in actual practice. The Medical Association clearly enough took the view that these subjects (obstetrics and gynaecology is an example) were being taught so as to equip the chiropractor to treat by spinal manual therapy a great range of disorders. We had ourselves wondered why such subjects were taught if not for that purpose.

27. Dr Kleynhans explained the matter in this way under cross-examination by counsel for the Medical Association (Transcript, pp. 3212-4):

A: . . . There has been consideration within the system specially at Canadian Memorial College, to get away from talking about gynaecology and instead talking about diseases of women; or obstetrics; or paediatrics and talk about diseases of children; and study as to that so as not to create confusion in terms of the health care delivery system at large that we in fact teach obstetrics to the extent that people would want to practise obstetrics or gynaecology.

That is not the intent. The intent is to provide people with sufficient bases in these diagnostic areas so that they can discriminate between cases that they should handle and should refer out, or should care for in conjunction with a member of the health care delivery team.

Q: How are we to read the word 'practice' in that subheading. To what extent does it envisage chiropractors would practise in any of these medical fields?

A: As far as practice is concerned it relates to sufficient understanding of what the other members of the health care delivery team do in various areas, so that they can intelligently refer. For example nutrition. We do not make nutritionists out of our students but do teach them how to intelligently refer to a dietitian for example. The same with clinical psychology, obstetrics and gynaecology. Unless there is some understanding of these processes I think our graduates would not fit into the health care delivery system as well as they should. That is the reason for presenting these as courses within the department of diagnosis and practice.

Q: Under two there are the headings: gastro-intestinal disorders; genito-urinary disorders; febrile disorders: Is it envisaged in the teachings of those subjects at the PIT

the teaching will be on the basis that the chiropractic subluxation may play a causative role in those various disorders?

A: I believe the main emphasis there is a differential diagnosis and the aspect of referral. It does not imply directly that chiropractors would necessarily treat a lot of these conditions, no. It does not, however, mean that it has not happened in various places where chiropractic care has been rendered that people with certain visceral conditions have in fact responded to chiropractic care, sometimes while they have been under care for a musculo-skeletal condition. That hypothesis cannot be totally eliminated although, aside from a lot of case histories from the German medical profession, there is not a whole lot of substantial research evidence for this because of the very early phase that the profession finds itself in within its development.

Q: You say that with reference to chiropractic as a whole that it is in an early stage of development?

A: As far as the research status of chiropractic as a discipline is concerned, it is in early stages of development, yes. This was borne out at the NINDS conference and was not held against the profession.

Q: Would it not be the case that, in order to teach chiropractic students the basics of gastro-intestinal disorders in the way you have just explained, and for the purpose you have just explained, is it not the case that it would be necessary to pay some regard to the causation of such disorders?

A: Indeed. The etiology of various disorders is taught in all instances.

Q: Could we go back to two or three questions ago when I asked you whether the basis or foundation of such teaching would be that the chiropractic subluxation may play a causative part in such disorders. Is that the basis?

A: The hypothesis that subluxation may play a role in the cause of visceral disorder has to be entertained and has to be retained within the area of possible research within the discipline in the future. I think that has been pretty well accepted by research symposia, etc., in the past.

Q: I would like an answer to my question which relates, not to future research, but to present teaching of your students. When you teach them the rudiments of causation of these disorders which are listed . . . does that teaching proceed on the basis, or does it not, that the chiropractic subluxation may play a part in causing those disorders?

A: The teaching does entertain the hypothesis that subluxations could play a part within a multi-factorial aspect of causology.

28. We were favourably impressed by Dr Kleynhans when he was cross-examined by the Medical Association and the Society of Physiotherapists, and questioned by the Commission. He did not avoid the issues. In particular he justified very well as a legitimate open academic approach the teaching of different chiropractic theories as unproven hypotheses.

29. On the question of training of chiropractors as general but limited diagnosticians we therefore have no hesitation in accepting Dr Kleynhans's explanation. It is really a matter of safety. If the chiropractor is to remain as a practitioner of primary contact (and we see no realistic alternative) it is clear that he must be able to identify specific symptoms and conditions, and know something about their management, so that he can adjust his own management accordingly and if necessary direct his patient to the proper area of health care. So, as Dr Kleynhans said, it is plainly necessary that chiropractors should be provided with "sufficient bases in these diagnostic areas so that they can discriminate between cases that they should handle and [those which they] should refer out . . ." (Transcript, p. 3212). That does not require a full medical training in differential diagnosis. It is necessary in order to make the chiropractor a useful member of the general health team.

Dr T. R. Yochum

30. Dr Yochum's evidence was concerned principally with chiropractic radiology (in chiropractic usage, roentgenology). He was clearly on top of his subject. He was one of the most technically impressive of the chiropractic witnesses. Counsel for the Medical Association and the

Society of Physiotherapists were present while he gave his evidence, but did not cross-examine him. His evidence was therefore unchallenged.

31. Dr Yochum gave his evidence towards the end of our public sittings. We took advantage of the opportunity to question him ourselves on the nature of the chiropractic subluxation, a central topic which up to then had proved somewhat elusive. Dr Yochum made it perfectly clear that in many cases a chiropractic subluxation would not be demonstrable on the normal static radiograph. He stated unequivocally that the principal purpose of a chiropractic radiograph was to reveal contra-indications to spinal manipulative therapy, to show postural abnormalities, and to assist the chiropractor in determining the precise mode of adjustment. We have dealt with these matters in chapter 9.

Chapter 35. A NORTH AMERICAN CHIROPRACTOR/MEDICAL SPECIALIST

INTRODUCTORY

1. The medically qualified witnesses who testified during our inquiry fell into two categories: those who were able to discuss chiropractic in terms of practical experience, and those who were not. Of the witnesses in the latter category, Dr O. R. Nicholson, the orthopaedic surgeon, had been in contact with a chiropractor in the course of his work in the Auckland Medical School and had in addition felt the need to spend a short time watching a chiropractor in action. He did this because he had learned that the Commission had seen demonstrations of chiropractic treatment and he did not wish to appear at a disadvantage in giving his evidence (Transcript, pp. 2048-9). But Dr Nicholson said nothing that persuaded us that this experience had left any more than an entirely superficial impression on him.

2. Three medically qualified witnesses were, however, able to speak of chiropractic on the basis of practical experience and knowledge. The first was a medical practitioner who saw us in private and was able to tell us of the results of his co-operation with chiropractors in the management of a variety of disorders apart from back pain (see chapter 10, para. 15). The second was Dr M. S. Katz of Montreal, who had infiltrated chiropractic for his own purposes and on whose evidence we place little weight for reasons already explained (see chapter 23).

3. The third was Dr Scott Haldeman, called as a witness by the Chiropractors' Association, who has the unique advantage of being qualified both as a chiropractor and as a medical practitioner. He has also done fundamental research in neurophysiology.

4. We will say something about Dr Haldeman's background. His father and his grandmother were chiropractors, so he was brought up in a chiropractic atmosphere. He himself turned to chiropractic as a first career. He went to Palmer College, where he graduated with distinction. Later he took a B.Sc. at the University of Pretoria in South Africa, with distinction in physiology. He went on to a master's degree, graduating with honours in neurophysiology. He then went to Canada. At the University of British Columbia he was awarded his Ph.D. in neurophysiology. At the same time he was attending the University of British Columbia Medical School, where he received his M.D. degree. The list of his university prizes, scholarships, and professional honours is impressive. Of his 39 publications in chiropractic, neurophysiological, medical, and paramedical journals, about half are research papers, and he has contributed extensively to professional symposia and review texts. He is now completing a residency in neurology at the medical school of the University of California at Irvine, and is a member of the co-ordinating committee of the Manipulation Project at that medical school. His wife is a practising physiotherapist.

5. So in Dr Haldeman we had a witness with an impeccable medical and scientific background who could also speak with authority on the current status of neurophysiological research. He had 13 years of private

practice as a chiropractor behind him. On paper, therefore, he was impressive.

6. He was equally impressive as a witness; indeed, he was one of the most impressive and valuable expert witnesses in the whole inquiry. He showed himself as independent and keen to cut through cant. The presentation of his written and oral evidence, including cross-examination by counsel and questioning by the Commission, occupied three full days. The Commission places substantial importance on his testimony.

THE EVIDENCE

7. Dr Haldeman's evidence ranged widely over chiropractic and neurophysiology. The main general points to emerge were these:

- The chiropractic "subluxation", which Dr Haldeman prefers to call a clinically significant "manipulatable lesion", is real and not imaginary. It is an omnibus term used to describe vertebral dysfunctions of various types with a neural and sometimes also a vascular component.
- Chiropractic therapy can offer significant relief in cases of back pain or referred pain that can be attributed to a manipulatable vertebral lesion.
- There is enough clinical evidence to make it difficult to discard the possibility that patients with organic and/or visceral disorders (particularly those known to have a neural content) may benefit from spinal manual therapy directed at correcting a clinically significant vertebral lesion. However: (a) such treatment should not be undertaken to the exclusion of medical management appropriate to the disorder in question; (b) such treatment should not be undertaken unless the disorder is medically monitored; and (c) in the present state of scientific knowledge, benefit from such treatment cannot be predicted with any certainty.
- In such cases, where the patient is known to have benefited from such treatment, no single theory can on our present scientific knowledge be used to explain how the benefit followed from the treatment. There may be a combination of complex processes, and various hypotheses are currently proposed.
- There are neurophysiological mechanisms which can reasonably be postulated linking vertebral dysfunction (with a neural component) to organic and/or visceral function, the cranial and sacral areas being included (see generally Transcript, pp. 3334-9).
- Chiropractic is the only profession which places its principal emphasis on spinal biomechanics and manual therapy.
- It is essential that much more research be carried out, particularly in the "grey areas" of Type O disorders.

8. We do not propose to canvass Dr Haldeman's quite extended technical reasons for reaching some of these conclusions. They may be found in Submission 131 and in the Transcript, pp. 3285-3448. He has had the unique advantages of seeing for himself the results of chiropractic treatment and being able to bring his experience in neurophysiology to bear on exploring neurophysiological explanations for those results. It is not the case of a medical specialist, with no knowledge of chiropractic, coming forward and saying that he does not believe that such results can have occurred because he can find no neurophysiological explanation for

them. It is a case of a chiropractor with medical and scientific training seeing the results which he knows have occurred, who has taken account of such factors as the placebo effect and the possibly self-limiting nature of the disorder, and who is actively searching on a constructive scientific basis for the reason those results have occurred.

9. We accept generally the propositions which can be distilled from his evidence and which we have stated above.

10. There are three further points arising out of Dr Haldeman's evidence which deserve special mention.

11. Dr Haldeman was asked by the Commission how he saw possible co-operation between chiropractors and doctors. We set out his answer in full (Transcript, pp. 3410-11):

My first point here is that of my patients as a medical trained physician a percentage will inevitably go to a chiropractor. If I have their health primarily in my mind I feel it is my responsibility, first of all, to know what is happening to them, and to ensure that the chiropractor is aware of all my opinions, so that he will not make errors through lack of knowledge. I think I have that responsibility to him as I do with anyone else who may be taking care of my patient. For this reason I feel it is almost unethical—at least against the patient's benefit—not to make information available to a chiropractor who that patient may see. There is no doubt my training as a neurologist exceeds his training in neurology and my opinions hopefully are of interest and value to him in management of his case. Therefore those opinions I assume could help protect my patient. I feel I must ethically do everything possible to protect my patient. I think the distribution of materials to him is essential—as I would with anyone else who is taking care of my patient with a potentially dangerous treatment, or who may give advice which is contrary to the advice I might give.

Q: You would expect him to accept that advice, and inform you exactly?

A: Of what he is doing.

Q: You would regard the patient as your own and would not expect him to do anything that went against your instruction?

A: Not without discussion with me. I recognise the fact we may have disagreement, as I may have with a surgeon, that I referred a case to. I expect him to take my views into account. If he proves to be wrong that is unfortunate. If I prove to be wrong that is another matter but I expect him to be aware of my views and take them into account when making his decisions, as I would with any other member of the healing arts who may be taking care of that case. At the same time I would expect to be kept informed of what he is doing and what his opinions are, because I would want to know what he did, where he did it, what his indications were, and what he expected from it. He could convey this orally or in writing, but I would expect to have that information available to me. As far as referring to a chiropractor if, in my experience and in my reading, I felt that the treatment he had offered, spinal manipulation, was likely to be of value to my patient, and there were no contra-indications, I would consider it in my patient's benefit to refer him to that type of treatment. My primary concern is the patient's benefit as a clinician.

It would be hard to put the matter more fairly than that.

12. The second matter we wish particularly to mention is this. In cross-examination on behalf of the Medical Association, Dr Haldeman was asked (Transcript, p. 3358):

Doctor, in the absence of more conclusively researched results the strongest point that can be made for chiropractic . . . seems to be on your evidence that you contend that it works.

Dr Haldeman answered that question immediately and decisively:

I think that is the strongest evidence for any form of treatment.

13. Dr Haldeman's response appears to us unanswerable. On the evidence of Dr Haldeman and other witnesses it is clear that chiropractic does work. Once it is found why it works we can expect, among other things, to have a much more reliable idea of which Type O cases are likely to respond to it, and practitioners will be able to make predictions with more confidence. Plainly, as Dr Haldeman insists, further research is necessary.

14. Finally, Dr Haldeman's evidence alone was sufficient to satisfy us that it would have been impossible to conclude that chiropractic is, or could possibly be, an alternative comprehensive health care system. Dr Haldeman made it clear, and we agree, that chiropractic must be regarded as a part of the total health care system (Transcript, p. 3358).

Chapter 36. GENERAL EVALUATION

1. On the whole of the evidence considered in part IV of this report, there can be no doubt that chiropractic treatment is effective for musculo-skeletal spinal disorders. As well as back pain, which makes up the great bulk of chiropractic practice, these must be taken to include migraine and pain radiating from the spine.

2. Nor can there be any doubt that chiropractors must by reason of their intensive and concentrated training be regarded as specialists both in the diagnosis of spinal disorders which will respond to spinal manual therapy and in that therapy itself. The Commission finds as a fact that neither general medical practitioners nor physiotherapists in this country are adequately equipped by their standard training courses to carry out spinal manual therapy although a few, by subsequent training and experience, have acquired skill in that therapy. The Commission accepts the evidence of Dr Haldeman, and holds, that in order to acquire a degree of diagnostic and manual skill sufficient to match chiropractic standards, a medical graduate would require up to 12 months' full-time training, while a physiotherapist would require longer than that (Submission 131, pp. 42-3, Transcript, pp. 3312-3, 3332).

3. On the question whether spinal manual therapy can influence organic and/or visceral disorders, the Commission is satisfied that in some cases this is at least a possibility. Moreover, there is enough anecdotal material to satisfy the Commission that in some instances chiropractors have been able to relieve patients of disorders of this nature which seem to have defeated orthodox medicine. However, the evidence does not carry us to the point of being satisfied that in such cases spinal manual therapy has necessarily been the sole operative factor. The matter must remain an open question in the meantime.

4. That leaves the question whether chiropractors should continue on primary contact to attempt to relieve Type O disorders. We can see no reason why they should not, as long as it is understood that in the present state of knowledge no chiropractor can predict whether or to what extent the patient will respond to spinal manual therapy in this class of case.

5. But in any event we are in full agreement with Dr Haldeman that if a chiropractor undertakes to treat a patient in the hope that a Type O disorder can be relieved, it is essential that he should take all reasonable steps to ensure that the patient's condition is medically monitored, and he should not undertake such treatment on the basis that it is to the exclusion of orthodox medical treatment.

6. Yet this principle obviously cannot be carried too far. If (as in two examples we have given in chapter 32) the doctors have given up the patient's condition as hopeless, if no current medical treatment is being given, and if there are no clear contra-indications against chiropractic treatment, there is plainly not much purpose in putting the patient to the trouble of seeing the doctor as well unless as an exercise in public relations so that the doctor can see and assess for himself what is happening.* We can imagine that some doctors might have a sufficient spirit of scientific curiosity to want to co-operate; others would merely be antagonistic and want to have no part in the matter. However, if the patient declines to be

medically monitored it will then be a matter for the chiropractor to decide whether he should accept the patient on those terms.

7. We did not understand any New Zealand chiropractor who gave evidence or whom we interviewed privately to maintain that chiropractic was an alternative comprehensive system of health care. It is not a separate and complete system of health care on any view of the matter. What we plainly identified was a desire on the part of chiropractors to be treated as partners in our overall system of health care.

8. On the whole of the evidence the Commission is satisfied that this should be the ultimate goal. We consider it contrary to the public interest that the undoubted skills and talents of chiropractors should be available only to people who seek chiropractors out for themselves and at their own expense. It is contrary to the public interest in three respects. First, it means that some people who might well benefit from chiropractic treatment are not getting it because they do not know of it, cannot afford it, or are actively dissuaded by their doctors from seeking it. Secondly, it means that chiropractors must, in the main, work in isolation from the medical profession. Thirdly, it leads to some chiropractors making inflated claims for chiropractic simply to attract public attention.

9. The Commission is satisfied that spinal manual therapy can be beneficial. The Commission is satisfied on the evidence that chiropractors are the practitioners best qualified to administer it. The Commission is further satisfied that treatment by a trained chiropractor carries minimal risk—less risk, perhaps, than spinal manual therapy administered by other practitioners because of the intensive training which only chiropractors undergo as a matter of course. The Commission is satisfied that although the chiropractor may not cure life-threatening diseases, he certainly improves the daily lot of many people. Without him, the quality of life of many would be less bearable. Their pain and frustration are undoubtedly relieved. There is no gainsaying that.

PART V: SCIENCE AND EDUCATION

Chapter 37. THE SCIENTIFIC BASIS FOR CHIROPRACTIC

INTRODUCTORY

1. A major objection, if not the principal objection, to chiropractic by its chief opponents in this inquiry, was that it is unscientifically based; that neither the theory on which the treatment is based nor the treatment itself has any sure foundation in science.

2. The Department of Health in its principal submission (Submission 41, p. 3) said:

... it is difficult to believe that the large majority of diseases known to man are due to a single cause and can be cured by a single technique. Nevertheless, chiropractic has such a narrow view of disease and its treatment.

In its final submission it said (Submission 133, p. 6):

In scientific terms, it is clear that the major drawback to the acceptance of chiropractic in medical and academic circles remains the absence of an adequate body of scientific research supporting chiropractic philosophy.

and further (p. 16):

... the fundamental impediment to any true dialogue or co-operation between chiropractors and practitioners of orthodox medicine is the reality that the tenets of chiropractic are set against the *science* of medicine.

3. In his opening submission, counsel for the Medical Association said (Transcript, p. 1729) that "The root cause of the opposition of organised medicine is quite simply stated. It is that the basis of chiropractic is a theory of the cause of disease which is unproven and, in the minds of many thoughtful medical scientists, absurd. Not only that, but the theory is shackled to a single modality of treatment which is also unproven." And in his final submission (Submission 135, p. 74)

It is of course the differences in philosophy, and the lack of a common scientific base, which are the root cause of the inability of the medical profession to accept cooperative treatment of patients with chiropractors.

Again for the Medical Association, Professor D. S. Cole said (Transcript, p. 2822):

... I don't believe you should spend State money on a form of alternative medicine which does not stand scientific scrutiny.

4. In its main submission, the New Zealand Society of Physiotherapists in opposing chiropractic stated that (Submission 75, p. 9):

Public protection demands that health be promoted within a scientific perspective.

and further that:

... a causative link has *not* been established between the uniquely chiropractic subluxation and disease processes resulting from defective nerve transmission.

5. So the case for State subsidies for chiropractic was attacked from all sides on the grounds that chiropractic is "unscientific" and specifically that chiropractors adopt a theory of the cause of disease which is unproven, are restricted to a method of treatment whose effectiveness is unproven, and share no common scientific base with medicine. We shall say no more here on the subject of the common scientific base with medicine—we deal with this at greater length in the following chapter—

but simply note at this point that more than half (more than 2000 hours) of the teaching which a chiropractic student receives at one of the better colleges is in topics common to a preclinical medical course and that he reaches standards in these subjects comparable with those reached by New Zealand medical students.

“UNPROVEN THEORY OF DISEASE”

6. The “unproven theory of disease” objection is understandable. Many early chiropractic writings, and some in more recent times, make outrageous claims and draw sweeping conclusions on the slenderest evidence. While those less responsible in the profession continue to make such claims, the orthodox medical attitude remains understandable but unjustifiable. It is very convenient for a medical practitioner to make the simple decision to reject chiropractic as a whole on the basis of its greatest weaknesses, while ignoring its now well-demonstrated useful contributions to health care. The fact that it remains outside orthodox medicine is probably sufficient reason for most doctors to banish it. In the words of Bourdillon, *Spinal Manipulation*, 2nd ed. London, 1975, pp. 9–10, “The medical profession claims that the healing art is its own exclusive province but unfortunately, the general public does not agree. There will always be the ‘odd man out’ who will tend to seek treatment from an unorthodox practitioner for reasons that are often quite inadequate, but the present position is that many of the public can obtain relief from unorthodox practitioners of manipulative therapy when they do not get the same relief from the orthodox profession.”

7. There are many examples in the history of medicine where progress has been delayed because new methods and new theories have been rejected because they were regarded as scientifically ridiculous. Again in the words of Bourdillon (*ibid.*, p. 6), “The attitude of the orthodox medical profession to anything strange and new has often been far from helpful and far from scientific.” As an example, attention was drawn more than once during this inquiry to the classic case of the initial rejection of the work of Louis Pasteur by the medical profession. Certainly it would not be right to use the past prejudices of medicine towards some new discoveries as justification for rejecting entirely their objections to chiropractic today: but what we do say is that chiropractic should not be rejected just because it is the current view of organised medicine that it is “unscientific”.

8. We believe the key issue today is not whether a particular theory of disease is compatible with current scientific knowledge. Rather we see the prime issue as whether a particular form of treatment (manual therapy of the spine, and particularly the form of such therapy practised by chiropractors) can be conclusively demonstrated to be effective in the treatment of specified disorders. A companion issue, but not the fundamental one, is the question of the neurobiological mechanisms by which the benefit is transmitted, i.e., a theory to explain *why* the treatment works.

9. It was Dr W. T. Jarvis, an American consumer health specialist, whose submission was solicited by the New Zealand Society of Physiotherapists, who first stated before the Commission the clear distinction between the two issues—evidence of clinical effectiveness (including safety) on the one hand and theoretical explanation on the other.

TESTS OF CLINICAL EFFECTIVENESS AND SAFETY

10. Here and later in this chapter we make use of the very good summary given by Dr Haldeman in his article "The Clinical Basis for Discussion of Mechanisms of Manipulative Therapy" from *The Neurobiologic Mechanisms in Manipulative Therapy*, the proceedings of a research workshop in the subject held at Michigan State University in 1977, edited by Irvin M. Korr.

11. It should first be noted that in the present context chiropractic treatment is one form of manipulative therapy. Dr Haldeman's first criterion on which a proposed neurobiological mechanism for manipulative therapy will be judged is the criterion of clinical effectiveness, i.e., "A specific manipulative procedure must be demonstrated to have consistent clinical results under controlled conditions in the treatment of a specific pathological process, organ dysfunction or symptom complex." (p. 53); and we should like to add, "while having no adverse effect on the patient". As Dr Haldeman points out, it is possible to find claims of successful treatment through manipulation of almost every ailment known to man. A number of these border on the absurd and have served to discredit the field as a whole. The type of condition which is most generally accepted to respond well to manipulative therapy is back and neck pain (Type M) and some chiropractors limit their practice exclusively to management of such pain. Despite this intense interest and wide usage, the documented evidence that spinal manipulation is of benefit in back and neck pain is not great. We shall summarise later some of this evidence. At this point we want to comment further on the conditions which must be met by a test (or trial) of clinical effectiveness if it is to be acceptable to the scientific community at large. These conditions are:

- Assessment of patients' condition before and after treatment must be made by objective measurements. This may require any or all of the therapists, the patient and the assessor or observer (who should not be the same as the therapist) being blinded, i.e., not to know who they are treating or how they are being treated and by whom.
- One or more control treatments to be used on other identical groups of patients. One such control should be essentially "no treatment" (although the patients will not know this) in order to eliminate a possible placebo effect or, over the course of time, natural remission.
- Sufficient numbers of patients in each group so that differences which may be regarded as clinically significant will be statistically significant.
- The trial must be designed *before* treatment is undertaken and the objectives clearly stated. In other words it should be prospective. A retrospective trial based on examination of clinical records could only in very special circumstances be scientifically acceptable.

12. What we have stated in brief outline only are the components that go to make up a piece of scientific clinical research. It should be clear that the difficulties in the case of manual therapy are quite formidable. For a start, one measure of effectiveness of treatment must be reduction of pain but measurements of pain are notoriously difficult and a completely objective measure of pain intensity has yet to be devised.

13. It is claimed (e.g., by Glover, *et al.*, Brit. J. Ind. Med. 31: 59, 1974) that "It is impossible to carry out a double-blind clinical trial comparing

manipulation with any of the other orthodox or unorthodox treatments of back pain, for both the doctor and the patient will know which of the treatments . . . have been allocated. The best that can be done in the way of a randomized trial is to have an observer, who does not know which treatment has been given, assessing the results independently of the therapist."

14. Then again, human beings are involved. It is impossible to have identical groups. You can compare patients. You can compare treatments. But when it comes to interpreting responses, the problem is that no two patients can ever be the same. It is clear then, that a scientific clinical trial is a major undertaking and certainly beyond the powers of a clinician in the course of his daily practice. We know of no completed clinical trial of chiropractic treatment which satisfies all the conditions we have stated, although one approaches this. In the absence of such evidence the New Zealand Medical Association, the New Zealand Society of Physiotherapists, and the Department of Health would have us reject chiropractic treatment as being unworthy of government subsidy. Their argument seems convincing. In order to assess it we first need to consider what evidence exists for the effectiveness of chiropractic treatment and compare this with the evidence of effectiveness of the treatment which does attract Government support, that of the medical and physiotherapy professions. The anecdotal testimonies of satisfied patients of New Zealand chiropractors are dealt with elsewhere. While we do not discount these testimonies, they alone would be an inadequate basis for any State subsidy. There is more evidence available, however, in the form of a number of uncontrolled trials and a few controlled trials conducted here and elsewhere. We consider now a representative selection of these trials.

UNCONTROLLED TRIALS

Dr J. W. Fisk

15. In 1971 Dr J. W. Fisk published a review of 369 episodes of backache in 327 New Zealand patients, all of whom were treated by spinal manual therapy ("manipulation") (Fisk, "Manipulation in General Practice", *N.Z.M.J.* 74: 172-5, 1971). Of the 378 "spinal lesions" treated, Dr Fisk reported that 339 (90 percent) of the treatments were considered a complete success, 20 (5 percent) were considered "worth while", and 19 (5 percent) were failures.

16. This is of course no more than a report of clinical findings. Dr Fisk refers to the fact that "The difficulties of conducting and assessing a clinical trial to evaluate the results of manipulation are almost insurmountable", and, with refreshing candour, remarks that "the most that one can claim about the effects of any form of treatment is that the patient recovered while being treated" (*ibid.*, p. 173). The Commission regards this review with particular interest, coming as it does from a registered medical practitioner in New Zealand. Towards the end of our inquiry we took the opportunity to visit Dr Fisk and we learned more about his work.

17. Dr Fisk specialises in back pain and manipulation. He is the only doctor practising specifically in this area who is on the New Zealand specialist register. He has written extensively on the subject: see "The Straight Leg Raising Test: Its Relevance to Possible Disc Pathology", *N.Z.M.J.* 81: 557-60, 1975; "An Evaluation of Manipulation in the Treatment of the Acute Low Back Pain Syndrome in General Practice", in *Approaches to the Validation of Manipulation Therapy*, ed. Buerger and

Tobis (Springfield: Thomas, 1977), 236–70; *A Practical Guide to the Management of the Painful Neck and Back* (Springfield: Thomas, 1977); and “The Significance of Disordered Muscle Activity in the Perpetuation and Treatment of Low Back Pain, with particular Reference to the Effect of Manipulation” (unpublished M.D. Thesis, University of Edinburgh, 1978).

18. The Commission went to some pains to secure a copy of the last work and is indebted to the University of Edinburgh for providing us with a photocopy. It is clear that it is a most valuable contribution to the literature in this field and ought to be generally available.

19. Dr Fisk has devised an objective method of assessing the improvement in patients who have undergone manipulation therapy for low back pain problems. It involves the measurement of the available stretch in the hamstring muscles. Dr Fisk has produced statistically sound evidence that these tension measurements may be different on the two sides of a patient suffering from one-sided low back discomfort, and that in specific cases this difference can be modified by a particular manipulative procedure which Dr Fisk describes and which seems little different from standard chiropractic manoeuvres (although our impression is that the latter are likely to be more specific, refined, and precise). The alteration in the tension measurements reflects improvement in the patient’s symptoms.

20. It is of course of major interest that a promising objective measure of the effects of spinal manipulation has been found for one range of conditions. We have felt some misgivings about the procedure adopted in other trials, which have relied ultimately on the patient’s subjective response, and which have encountered difficulty in establishing satisfactory controls to eliminate the influence of any placebo effect.

21. A further point of major significance is that one of the findings on which Dr Fisk reports in his thesis is that manipulative therapy is a major contributing factor in the relief of back pain over and above any placebo effect or self-remission.

22. This is a case of a prophet receiving little honour in his own country. The Medical Association, which must have known about Dr Fisk’s work, neither called him as a witness nor made any attempt to produce his published work. It was a chiropractic witness who referred to the importance of Dr Fisk’s work and drew it to our attention towards the end of our public sittings.

Doran and Newell

23. The next trial we discuss is that of Doctors Doran and Newell (“Manipulation in Treatment of Low Back Pain”, *Brit. Med. J.* 2: 161–4, 1975). It was a multicentre trial in which “manipulation” by physiotherapists was compared with definitive physiotherapy, corsets and analgesia. The techniques of manipulation, which were widely different, were left to the therapists involved, and there is no indication of what were the relative skills of those who administered them. The results were lumped together. The finding was that a slightly higher number of patients improved after three weeks under manipulation, but the difference was not statistically significant and disappeared after 3 weeks.

24. This trial was used by the Medical Association in their submissions (initially Transcript, pp. 1777–8) as evidence that manipulative treatment is no more effective than other conservative treatments. The trial did not include chiropractors. Criticisms of various aspects of this trial have been

made by different writers. These are summarised in the closing submission of the Chiropractors' Association (Submission 136, pp. 63-7). We agree that the trial was of little value in assessing the clinical effectiveness of manual therapy as delivered by chiropractors.

Dr G. E. Potter

25. Dr Potter is a Canadian. He is consultant to the Department of Orthopaedic Surgery at the University Hospital, Saskatoon, Saskatchewan. He has medical and chiropractic qualifications.

26. His review ("A Study of 744 Cases of Neck and Back Pain Treated with Spinal Manipulation", *Journal of the Canadian Chiropractic Association*, December 1977, pp. 154-6) is of some interest. In what appears to have been a combined orthopaedic and chiropractic venture, a large number of patients received chiropractic "manipulation". Five categories were used to assess the results: recovered (free of symptoms and unrestricted as to work and activity; some recurring episodes which respond completely); much improved (not 100 percent free of symptoms, but functioning normally at work or other activity); slightly improved (not a satisfactory response); no change; and worse.

27. In the review, patients with the following conditions presented themselves: acute low back pain, no involvement of legs; acute low back pain, leg pain but no neurological signs; acute low back pain with neurological signs; chronic low back pain, no leg involvement; chronic low back pain—at least one previous back operation; chronic low back pain, leg pain but no neurological signs; chronic low back pain, leg pain but no neurological signs—at least one previous back operation; chronic low back pain, leg involvement with neurological signs; chronic low back pain, leg involvement with neurological signs—at least one previous back operation.

28. The review presents detailed figures for the results of the treatment against each category of patient. The overall result is as follows:

					Percent
Recovered	...	...	...	268	(36.0)
Much improved	...	...	...	257	(34.5)
Slightly improved	...	...	...	54	(7.3)
No change	...	...	...	161	(21.6)
Worse	...	...	...	4	(0.6)

29. It is interesting to note that following the conclusion of this survey at the end of 1975 the co-operative health care net at the Saskatoon University Hospital became more widely spread so that the patient, as well as receiving chiropractic treatment, is assisted also by physiotherapy. Various analgesics, muscle relaxants, trigger point injections, and intrathecal steroids are medically prescribed as required.

Dr J. S. Wight

30. Dr Wight is a Scottish chiropractor. A group of 87 patients with either common or classical migraine was treated by chiropractic "adjustment" and the results analysed 2 years after the final treatment by means of a "headache questionnaire" (Wight, "Migraine: A Statistical Analysis of Chiropractic Treatment", *A.C.A. Journal of Chiropractic*, 15, September 1978).

31. Of the patients with common migraine 85 percent of females and 50 percent of males were either much improved or their headaches ceased

altogether. Patients with classical migraine had an improvement rate of 78 percent for females and 75 percent for males. Comparisons between the improvement rates for male and female patients and between the improvement rates for common and classical migraine were not found to be statistically significant.

32. It is interesting to compare the results of Wight's uncontrolled clinical trial with those of the Parker trial (see below). Although the Parker trial was inconclusive in its comparison between the manual therapy of chiropractors and that of other practitioners, it established statistically that spinal manual therapy of some kind is an effective treatment for migraine.

CONTROLLED TRIALS

Glover, et al.

33. In 1974 Glover, Morris, and Khosla ("Back Pain: A Randomized Clinical Trial of Rotational Manipulation of the Trunk", *Brit. J. Ind. Med.* 31: 59-64) conducted a single blind controlled study on 84 patients (the observer only was "blind"), comparing the results of a single rotatory spinal "manipulation" with detuned ultrasound which was intended to act as a placebo.

34. Manipulation was significantly more effective in pain relief only for those patients who were being treated within 7 days of their first attack and even this significant advantage disappeared within 3 days. Over a period of 7 days there was a considerable overall improvement in all patients whether treated or not, i.e., their condition was self-limiting.

35. The authors conclude that the care and attention which patients received may have been just as important as their treatment in the long term. However, there were clear indications of the value of manipulation in the immediate relief of acute pain and these suggested some follow-up studies. No chiropractors were involved and the type of rotational manipulation carried out (the same for all patients) would not necessarily have been considered by a chiropractor to be appropriate.

Bergquist-Ullman and Larsson

36. These investigators reported ("Acute Low Back Pain in Industry", *Act. Orthopaed. Scan. Suppl.* 170, 1977) the results of a controlled trial as demonstrating that patients whose low back pain had been treated by physiotherapy (including spinal "manipulation") recovered in half the time it took those "treated" with a placebo to recover. Again this indicates that while much low back pain is self-limiting, techniques which include spinal manual therapy, are likely to provide much quicker relief.

Evans, et al.

37. A controlled cross-over trial of rotational spinal "manipulation" in 32 patients with low back pain was conducted by Evans, Burke, Lloyd, Roberts, and Roberts ("Lumbar Spinal Manipulation on Trial", *Rheum. and Rehab.* 17 (1): 46-53, 1978). Again the single clear result is that pain relief was obtained more quickly with manipulation than without it.

Buerger and Tobis

38. This trial, the first in which an attempt is being made to blind both patient and observer, is in the process of being carried out at the University of California at Irvine. Preliminary results only are available,

but at the time of writing this report had not been published. We were told about the trial by Dr Haldeman (Submission 131, pp. 19–20), who is involved in the trial. The protocol is designed to distinguish clearly between spinal manual therapy itself and placebo effects, such as patient-doctor interaction, or the “laying on of hands”. The therapists are osteopathically trained spinal manipulators.

39. The preliminary results show:

- (a) Unsophisticated patients cannot distinguish between manipulation of the lumbar spine and soft-tissue massage in the area, i.e., sham manipulation. It appears therefore that the investigators may have been successful in “blinding” the patients.
- (b) The patients undergoing manipulation show significantly greater improvement in such parameters as straight leg raising, ability to reach, bend, etc., when compared with the sham manipulation group.

THE PARKER TRIAL

40. Before it finished its sittings the Webb Committee in Australia (Australian Government Committee of Inquiry into Chiropractic, Osteopathy, Homoeopathy, and Naturopathy) commissioned a trial to evaluate chiropractic treatment for migraine. We heard that the committee had already had the views of two world medical experts on migraine, one of whom had claimed that he could not understand how spinal manipulation could affect migraine; the other, more graphically, maintained that a treatment for migraine, equally as effective as spinal manipulation, would be pulling on the patient’s leg (see Transcript, pp. 2715–6). So the committee commissioned a trial to test the question.

41. The principal responsibility for organising it was placed in the hands of Dr G. B. Parker, Senior Lecturer in Psychiatry, University of New South Wales, who was brought from Australia by the New Zealand Medical Association to tell us about it.

42. It was the first time such a trial had been planned in advance to involve chiropractors and to be evaluated statistically. It was therefore a very important trial. It is unfortunate that before the trial came to an end the Webb Committee reported and disbanded. So the Webb Committee was unable to provide an evaluation in its report of the trial it had commissioned. For these reasons we deal with the trial and its results in some detail.

Nature of the Trial

43. The trial took place over a period of 6 months. Prospective participants, migraine sufferers, were advertised for. Dr D. S. Pryor, a neurologist, diagnosed the condition of those sufferers who had passed through an initial screening process. Miss H. Tupling, a research assistant experienced in statistical analysis, noted their expectations of the trial and their experience of other therapies for migraine. She made sure that they knew how to fill in forms recording the severity and duration of their migraine attacks. All patients had a cervical spinal X-ray and the films were distributed to the therapists.

44. Three forms of treatment were provided, the patients being assigned at random among them. For the first form of treatment four chiropractors took part, and were required to “manipulate” the cervical spine, that is, to move the cervical joints beyond their normal limitations. They were also free to manipulate other parts of the spine.

45. The second form of treatment was provided by two medical practitioners and four physiotherapists. They were required to perform cervical manipulation on the patients, but were also free to perform other manipulatory techniques as well.

46. The third form of treatment was intended as the "control". One medical practitioner and six physiotherapists were required to perform "cervical mobilisation"—small oscillatory movements to the joints within their normal range—and were also free to "mobilise" other parts of the spine.

47. "Mobilisation" was chosen as the control technique for two reasons. First, Dr Parker and his team were unaware of any claims that mobilisation had been advocated by anyone as a treatment for migraine. Secondly, the purpose of the trial was to test "manipulation" as the principal therapeutic component under study.

48. The choice of "mobilisation" as the control was probably a mistake. For, as this Commission has learned in the course of this inquiry, mobilisation in the sense prescribed for the trial is only one method of manual therapy. It is different from "manipulation" in degree rather than nature. The aim of both mobilisation and manipulation is, at the least, to improve the function of the vertebral joints. A more genuine control could have been achieved by selecting as a form of treatment a "mock" mobilisation or manipulation: that is to say, the patients in the control group would not in fact have had their cervical spines either mobilised or manipulated, but would have had some completely neutral form of manual therapy, e.g., as provided for in the study of Buerger and Tobis (see above).

49. So what the Parker trial was in fact assessing was the efficacy of one kind of manual therapy against another. On the view this Commission takes of chiropractic treatment, the Parker trial was also comparing the expertise and skill of one group of manual therapists with another. The last point is of importance because the practitioners in the first two groups were asked to do the same thing. The only difference between their treatments would be their respective knowledge of spinal mechanics and their respective skills in "manipulation".

The Trial in Progress

50. The trial had three phases. The first was a 2-month pretreatment phase. During that phase patients were excluded who did not report four or more migraine attacks in that period.

51. The second phase was a 2-month treatment phase. Those patients then accepted into the trial were allocated at random to one of the three treatment groups. Therapists did not treat more often than twice a week. After the first consultation every therapist completed a form giving details of their physical examination and prognosis. The patients' evaluation of the therapy and the therapist was obtained by Miss Tupling at that time. At the end of that 2-month phase every therapist documented the duration, site, type, and number of the treatment.

52. The third phase was a 2-month post-treatment phase. During that phase, as in the second phase, patients reported on their migraine attacks.

53. Ninety-nine patients were provisionally accepted into the trial. Following the pretreatment phase, 14 were excluded for various reasons. During the trial three more patients disqualified themselves.

The Results

54. For the purposes of the trial the pretreatment scores were compared with the post-treatment scores. The following hypotheses were postulated by the researchers (Submission 106, pp. 6, 9):

(A) Post-treatment scores for the whole sample would be less than pre-treatment scores. [A high score means high disability.]

(B) Cervical manipulation (whether performed by chiropractor, medical practitioner or physiotherapist) would be more effective than the control treatment (cervical mobilization).

(C) Chiropractic treatment would be more effective than the other two treatments considered together.

(D) . . . a post-hoc hypothesis that chiropractic treatment would be more effective than the control treatment alone . . .

The results are summarised in table 37.1.

55. In addition to the figures recorded in this table, Dr Parker gave us in the course of his oral evidence, the figures for what were taken to be complete cures. Eleven patients had no attack at all in the post-treatment phase. Seven of them had been treated by chiropractors and four by mobilisation (7 out of 30 and 4 out of 28 respectively).

56. So, looking at the figures, it was natural for the New Zealand Chiropractors' Association to suggest to Dr Parker in cross-examination that the chiropractors had performed substantially better than those applying "mobilisation" (the "control" group), and that both of them together had performed substantially better than those non-chiropractors who had applied "manipulation". These suggestions were, however, based only on a superficial qualitative interpretation of the data which did not take into account statistical principles. Dr Parker, aided by counsel for the Medical Association, in re-examination explained this very clearly (Transcript, p. 2770):

Q: Say there was a study to find out whether a majority of the world's population had grey eyes and you took a group of 100 persons and analysed the colour of their eyes and found that 55 had grey eyes and 45 had not—now Mr Craddock would put to you, that clearly shows that the majority of persons have grey eyes. What is the way in which one reaches that arithmetical result to a statistically significant finding?

A. . . . you would be looking at the number of grey eyes, the number that were not and you would be trying to decide whether that could have come about by chance or because there was some factor or fact operating and the level of significance is in a sense trying to give an estimate of how likely the event occurred by chance or whether it exceeded some estimate of chance.

57. So the purpose of a proper statistical analysis is, as far as possible, to eliminate the element of chance in a particular result, or in a comparison between two or more particular results.

58. To do this the statistician selects, among other statistical tools, what is known as the "level of significance". In doing so he has in mind the need to guard against what are known as "Type I" and "Type II" errors. A Type I error occurs when a result is wrongly interpreted as indicating a real effect because the level of significance has been set too low. The Chiropractors' Association's qualitative interpretation just referred to is an example: that took no account of any level of significance. A Type II error occurs when a result is wrongly interpreted as indicating no real effect because the level of significance has been set too high or the experiment, through lacking statistical "power", produces a non-significant result.

59. In the present instance, so Dr Parker told us, those who were advising his team considered that a level of significance of 0.01 was the most appropriate. This means that for a result to be regarded as real the probability that it would have occurred by chance is required to be less

Table 37.1
MEAN VARIATE SCORES DURING THE THREE PHASES OF THE TRIAL AND EFFECTS OF TREATMENT
 (Source: Submission 106)

<i>Variate</i>	<i>Mean Group Scores for Trial Phase*</i>									<i>F Ratio†</i>			
	<i>Chiropractic Manipulation</i>			<i>Manipulation</i>			<i>Control</i>			<i>Hypotheses</i>			
	<i>I</i>	<i>II</i>	<i>III</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Mean frequency of attacks	8.5	7.3	5.1	11.4	11.1	9.9	8.7	7.3	5.7	27.14	0.23	1.24	0.13
Mean duration in hours/attack	30.5	21.1	19.4	12.2	10.8	11.2	14.9	13.5	11.9	4.31	0.34	3.14	1.05
Mean disability	2.8	2.3	1.8	2.7	2.5	2.6	2.8	2.2	2.2	12.74	0.01	4.32	1.55
Mean intensity of pain	4.9	4.3	2.8	5.0	4.6	4.4	5.3	4.4	4.5	19.12	1.14	7.13	4.70

*I=pretreatment; II=during treatment; III=post-treatment phase.

† $F_{0.01}(1,83)=6.95$.

than 1 in 100. Thus, in order to determine whether any of the hypotheses selected for the trial were valid, a number, called an F ratio, is calculated by a formula which takes into account the significance level (0.01) and the number of observations (patients in the trial). The appropriate F ratio is 6.95. That figure was matched against the figures shown for the four hypotheses. Any figure relating to any hypothesis *exceeding* 6.95 is statistically significant (that is, the probability is less than 1 in 100 of it resulting from chance). Any such figure *below* 6.95 is not statistically significant on that test.

60. It is convenient to repeat from table 37.1 the figures relating to the effects of the treatments and referable to each hypothesis. These are shown in table 37.2.

Table 37.2
EFFECTS OF TREATMENTS
(Source: Drawn from table 37.1)

<i>Variate</i>	<i>Hypotheses—F Ratio*</i>			
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Mean frequency of attacks	27.14	0.23	1.24	0.13
Mean duration in hours/attack	4.31	0.34	3.14	1.05
Mean disability	12.74	0.01	4.32	1.55
Mean intensity of pain	19.12	1.14	7.13	4.70

* $F_{0.01}(1,83)=6.95$.

61. Now it is immediately seen that hypothesis A (that post-treatment scores would be less than pretreatment scores) is supported on all variates except mean duration of attacks. Hypothesis B (that cervical manipulation would be more effective than mobilisation) is not supported. Hypothesis C (that chiropractic treatment would be more effective than the other two considered together) is supported only on the mean intensity of pain variate. Hypothesis D (that chiropractic treatment would be more effective than mobilisation alone) is not supported.

62. Those results are summarised by Dr Parker in the following way (Submission 106, Foreword):

The efficacy of cervical manipulation for migraine was evaluated. In a six-month trial, 85 volunteers suffering from migraine were randomly allocated to three treatment groups. One group received cervical manipulation performed by a medical practitioner or by a physiotherapist, another received cervical manipulation performed by a chiropractor, while the control group received mobilization performed by a medical practitioner or by a physiotherapist. For the whole sample, migraine symptoms were significantly reduced. No difference in outcome was found between those who received cervical manipulation, performed by chiropractor or orthodox therapist, and those who received the control treatment. Chiropractic treatment was no more effective than the other two treatments in reducing frequency, duration or induced disability of migraine attacks, but chiropractic patients did report a greater reduction in pain associated with their attacks.

Further Statistical Analysis of the Parker Trial Data

63. As we listened to Dr Parker explain the trial and the methods by which it had been conducted and analysed, it occurred to us that the data his team had used could be valuable in our inquiry if further analysed in the light of some of the questions about chiropractic treatment that were then beginning to suggest themselves to us.

64. Dr Parker kindly agreed to let us have copies of the coding sheets used in the trial, and we secured the assistance of Dr H. R. Thompson,

Director of the Applied Mathematics Division of the Department of Scientific and Industrial Research, to carry out a further analysis of the data.

65. Three matters emerged from that analysis. We discuss them below.

(a) *Common and Classical Migraine*

66. In regard to treatment by the doctors and physiotherapists either by manipulation or by mobilisation, the patients with classical migraine did not score as well on the pretreatment/post-treatment analysis as those with common migraine: migraine without cortical involvement.

67. In regard to treatment by the chiropractors, there was no difference between patients with common and those with classical migraine in the scores on the pretreatment/post-treatment analysis.

68. Chiropractors performed better in treating classical migraine than the other practitioners. That better performance was seen on all measures.

69. These differences are not statistically significant, but they suggest that in any further trial the design should be such as to indicate on a sound statistical basis whether chiropractic treatment is equally effective for common migraine as it is for classical migraine, and whether chiropractors are more effective in treating classical migraine than doctors and physiotherapists using manipulation or mobilisation.

(b) *A Fifth Hypothesis*

70. A hypothesis that was not included in the Parker trial was that chiropractic treatment would be more effective than manipulation by a doctor or a physiotherapist. The figures plainly indicated that the doctors and physiotherapists who manipulated had the least satisfactory results.

71. We considered it right to see whether the *post hoc* hypothesis (hypothesis E) suggested by the figures was supported. It was not supported on the statistical basis used in the Parker trial itself. We have included the results in tables 37.3 and 37.4 from which it will be seen that this hypothesis was not supported on the re-analysis.

(c) *Different Levels of Significance*

72. It occurred to us that it would be useful to consider the results using different levels of significance. The level of significance adopted at the outset of the Parker trial was 0.01 which is relatively stringent. We therefore considered levels of significance of, respectively 0.001, 0.025, 0.05, and 0.1. Any level less stringent than 0.05 would be unlikely to be acceptable in a statistical analysis offered to a reputable medical journal.

73. The results of changing the level to 0.05 are summarised below in table 37.4.

Shortcomings of the Trial

74. Our attention was drawn to some obvious inaccuracies in the data sheets, and to possible inadequacies in the original design. We asked Dr Thompson, as an expert independent statistician, to report to us on these matters. Through the Commission's Secretary, Dr Thompson sought from Dr Parker further information which was supplied. Copies of the relevant correspondence and of Dr Thompson's reports to the Commission were supplied to the organisations principally interested in the inquiry.

Table 37.3

MEAN VARIATE SCORES DURING THE PRE- AND POST-TREATMENT PHASES OF THE TRIAL AND EFFECTS OF TREATMENT

(Table 37.1 amended to remove anomalies arising from coding errors)

Variate	Mean Group Scores for Trial Phase*						F Ratio†				
	Chiropractic Manipulation		Manipulation		Mobilisation		Hypotheses‡				
	I	III	I	III	I	III	A	B	C	D	E
Mean frequency of attacks ...	8.5	5.0	11.2	10.0	8.7	5.7	25.57	0.19	0.87	0.08	1.76
Mean duration in hours/attack ...	23.6	18.5	12.4	12.3	14.9	11.9	4.43	0.01	0.74	0.19	1.12
Mean disability ...	2.8	1.9	2.7	2.4	2.8	2.2	17.50	0.02	1.54	0.65	1.81
Mean intensity of pain ...	4.9	2.8	4.9	4.3	5.3	4.6	20.46	0.65	3.19	2.24	2.55

*I=pretreatment; III=post-treatment phase.

† $F_{0.01}(1,83)=6.95$.

‡The F ratio used in this table should not be applied to hypotheses B, C, D, and E for the reasons stated in the text under the heading "Design of Trial"

For the purposes of this table the F ratio used in the Parker trial has nevertheless been retained.

(a) *Accuracy of Data*

75. It turned out that there were coding errors in the data sheets. On the basis of corrections which Dr Parker supplied, table 37.3 presents a more accurate picture. We have omitted the mean group scores for the "during treatment" phase, which are of no immediate relevance, but have added the fifth hypothesis (E) suggested by the results: that chiropractic manipulation is more effective than non-chiropractic manipulation.

(b) *Design of Trial*

76. It was statistically inappropriate to test any of the hypotheses in the Parker trial except the first (A) by the F test specified. To test the other hypotheses simultaneously, a standard multiple comparison method was needed. Scheffé's S-method is an appropriate method: it covers all possible comparisons, including those suggested by the results. If this method is used a different F ratio is applied to hypotheses B, C, D, and E, the last of which we have added ourselves as one obviously suggested by the results.

77. Applying these methods we achieve the results summarised in table 37.4.

Table 37.4

REVISED F RATIOS APPLIED TO HYPOTHESES IN TABLE 37.3

Variate	Hypotheses				
	A	B	C	D	E
Mean frequency	25.57	0.19	0.87	0.08	1.76
Mean duration	4.43	0.01	0.74	0.19	1.12
Mean disability	17.50	0.02	1.54	0.65	1.81
Mean intensity	20.46	0.65	3.19	2.24	2.55
<i>F: Values for Significance of F Ratios at Different Levels</i>					
0.1	*	2.37	2.37	2.37	2.37
0.05	3.96	3.11	3.11	3.11	3.11
0.025	5.21	3.86	3.86	3.86	3.86
0.01	6.95	4.87	4.87	4.87	4.87
0.001	11.65	*	*	*	*

*Irrelevant.

78. It is therefore seen, on this revision, that hypothesis A (that pre-treatment scores for the whole sample would be less than post-treatment scores) is supported on the most stringent (0.001) test, except as to mean duration. Hypothesis B (that manipulation would be more effective than mobilisation) is not supported on any test. Hypothesis C (that chiropractic treatment would be more effective than the other two treatments considered together) is supported only as to mean intensity on the 0.05 test, less stringent than the 0.01 test used in the Parker trial but nevertheless indicative. Hypothesis D (the Parker trial's *post hoc* hypothesis, that chiropractic treatment would be more effective than mobilisation alone) is not supported. Our own *post hoc* hypothesis E (that chiropractic treatment would be more effective than non-chiropractic manipulation) is not supported except on the 0.1 test, which is clearly insufficient.

79. The fact that none of hypotheses B, C (except in one aspect), D or our own E is supported suggests that the experiment may have lacked sensitivity or (to use a statistical term) "power". The power of a test is the probability that the test will detect as statistically significant, at a stated level of significance, a difference of a given size. In the present case a *post hoc* power analysis is appropriate because the mean differences in respect of chiropractic manipulation in the pre- and post-treatment mean group scores are larger on all variates than the mean differences in respect of manipulation and mobilisation and also on other measures such as those patients with no post-treatment attacks. Also the difference between chiropractic treatment and the other forms of treatment approximates 20 per cent in terms of improvement in the patient's condition. If a 20 per cent improvement is meaningful from the patient's point of view (and we can offer no opinion on this) then the design of the test should have incorporated sufficient sensitivity to enable it to be demonstrated. Without going into a detailed analysis, it is obvious that such sensitivity could have been achieved only by a considerable increase in the number of patients.

80. The results of the trial were perhaps contrary to the experimenters' expectations. It will be remembered that the Webb Committee had already heard from two medical experts who had ridiculed the idea that manual therapy could be effective for migraine. The trial opened up a number of possibilities of major interest to anyone involved in manual therapy.

(c) *Use of an Inappropriate Control*

81. It is easy to be wise after the event. We have already drawn attention to the difficulty of using "mobilisation" as a control technique. That meant that other factors—the placebo effect is an obvious one—could not be excluded as possibly affecting the results. In any future and similar trial it should not be overlooked that the control subject should not be offered any form of the treatment that it is desired to test. In this context "mobilisation" is simply a more time-consuming and a more gentle method of achieving the result obtained by "manipulation". Both are forms of spinal manual therapy.

Conclusions

82. The Parker trial clearly establishes that cervical "manipulation" or "mobilisation" is an effective treatment for migraine. But the results cannot be taken further than that.

83. The Commission holds that there is a real need for further experiments of this kind. That is because the Parker trial results indicate, though not statistically, that chiropractic treatment was more effective *on those patients on which it was used* than manipulation by a doctor or a physiotherapist *on those patients those doctors and physiotherapists treated*, and possibly somewhat more effective than mobilisation *on those patients treated by mobilisation*. The matter should be decided once and for all.

84. We wish to express our indebtedness for the help and advice given to us by Dr H. R. Thompson on statistical matters, and for his arranging for the re-analysis of the data collected for the Parker trial. It is hardly necessary for us to add that Dr Thompson's assistance was given to the Commission as part of his normal work and from an entirely independent standpoint. We have also had the advantage of reading a memorandum from Dr K. D. Bird of Australia, who on Dr Parker's behalf commented on Dr Thompson's report to us.

COMMENT ON THE CLINICAL TRIALS

85. The overall message from the various trials we have mentioned (whether controlled or uncontrolled) appears to be quite clear. It is that spinal manual therapy, even if performed by relatively unskilled and inexperienced practitioners, is more effective in providing quick relief of pain of musculo-skeletal origin than are conservative methods. Furthermore there was no evidence of any harm being done to patients. Thus spinal manipulation, at least for a clearly defined type of condition, appears to be safe and effective.

86. There remains, however, a dearth of hard statistical evidence. This will come only from carefully designed controlled trials requiring close co-operation between the chiropractic and medical professions and, ideally, the physiotherapists. We have more to say on this later.

87. It is important to note that in all of the clinical trials we have discussed, what was being investigated was a particular form of treatment (manual therapy), and not a theory of disease. Now Government subsidies of manual therapy are available but only if the treatment is given by a medical practitioner or by a licensed physiotherapist on referral from a medical practitioner. No "proof of efficacy" has ever been required of these practitioners.

88. We have referred elsewhere to the fact that the chiropractor's training in manual therapy is superior to that of the physiotherapist, and that all but a handful of medical practitioners have had no formal training at all. It seems extraordinary and unjust to us that by a combination of law and of ethical ruling patients desiring manual therapy may obtain a State subsidy for it only if they avoid those most qualified to give it.

THEORETICAL EXPLANATIONS

89. Having considered the evidence for the clinical effectiveness of spinal manual therapy, including that delivered by chiropractors, we turn now to the question of the "chiropractic theory of disease". This may be summarised briefly in the words of the American Chiropractic Association used in their 1979 statement of the "Chiropractic State of the Art", pp. 9-10:

(1) Disease may be caused by disturbances of the nervous system.

(2) Disturbances of the nervous system may be caused by derangements of the musculo-skeletal structure [especially the vertebrae and pelvis].

(3) Disturbances of the nervous system may cause or aggravate disease in various parts or functions of the body. . . . Under predisposing circumstances, almost any component of the nervous system may directly or indirectly cause reactions within any other component by means of reflex mediation.

90. So the logical consequence, according to the American Chiropractic Association, is that mechanical musculo-skeletal derangements (the chiropractic subluxation—see chapter 9) of the vertebrae or pelvis and associated structures can be a contributing factor to functional disorders of organic visceral and vasomotor nature.

91. It is to be noted that there is no claim in this summary of the disease theory that disturbances of the nervous system are necessarily a cause of any or all disease, and, if they are, that they are the only cause or even the main cause. It is also to be noted that there is no reference to the cause of pain in the back, neck, or head, which, as we have reported earlier, is the reason why over 80 percent of the chiropractors' new patients seek their help. Indeed we find chiropractors surprisingly coy about this dominant

aspect of their work. We can only surmise that they regard local pain as just a manifestation of some disease state which may be of a purely mechanical nature and for which the nerve involvement is simple and direct. But we regard statements of the "disease theory" such as those we have given as relevant only to Type O chiropractic which we have earlier discussed, and therefore relevant only to a very small fraction of the chiropractors' patients. We therefore see the final scientific testing of these theories as of much lower urgency than proofs of clinical effectiveness of spinal manual therapy, the matter discussed earlier in this chapter. Indeed if the neurogenic disease theory were conclusively disproved this would in no way, in our view, invalidate chiropractic treatment of Type M disorders, nor would it remove the necessity for more than a small part of the chiropractor's training.

92. It is, however, an important matter because chiropractors set great store by the neurogenic disease theory and in its absence there would be no justification for granting chiropractic the status of a profession distinct from that of the manual therapist. It is important to note that in the ensuing discussion of the chiropractic theory of disease as enunciated we are not implying that chiropractors claim that this is the sole or the main cause of any particular disease but just that it is a possible contributing factor. That is all we understand chiropractors to claim.

Type O Disorders Affected by Chiropractic Subluxation

93. Conclusive scientific testing of the Type O theory is a formidable task indeed. There are two main questions to be asked:

1. Do mechanical dysfunctions of the spine contribute to visceral functional disorders and does removal of the mechanical dysfunctions relieve the disorders?
2. By what possible neurobiological mechanism could such mechanical dysfunctions affect visceral function?

94. It is much more difficult to give a scientific answer to the first (clinical) question than in the case of the simple relief of pain and musculo-skeletal dysfunction which we considered earlier. It would be extremely difficult if not impossible to distinguish between different possible causes and remedies. Dr Haldeman in his submission (Submission 131, pp. 28-33) refers to a number of reported claims by chiropractors, medical practitioners, and others that spinal manual therapy has influenced visceral function. While these claims remain contested, Dr Haldeman concludes: "the important fact remains that practitioners of spinal manipulation throughout the world have documented similar relationships between the spinal column and visceral disease. Since there is no research by critics of chiropractic and spinal manipulation to disprove this relationship, it appears that the most unscientific posture one can take to this subject is to discard, outright by the possibility of a vertebro-visceral relationship."

95. Because of the great difficulties of proof of effectiveness or lack of it, the second theoretical question about possible neurobiological mechanisms assumes greater importance.

The Crelin Paper

96. Early in our proceedings we were referred to a paper published in 1973 by E. S. Crelin entitled "A Scientific Test of the Chiropractic Theory" (*American Scientist*, 61: 574-80). Professor Crelin was Professor of

Anatomy at the Yale University School of Medicine. His paper is frequently relied upon by those who oppose chiropractic. That is because his finding was (p. 580) that “the subluxation of a vertebra as defined by chiropractic—the exertion of pressure on a spinal nerve which by interfering with the planned expression of Innate Intelligence produces pathology—does not occur.”

97. Professor Crelin arrived at this finding by this method: he excised the vertebral columns from six cadavers within 3 to 6 hours after death. Using various pieces of mechanical apparatus, he compressed, twisted, and bent each vertebral column. There did not appear to be any significant interference under any of these manoeuvres with the spinal nerves in their intervertebral foramina.

98. We mention this paper largely because so much reliance seemed to be placed on it. It cannot be regarded as of any great significance. Professor Crelin’s definition of the chiropractic subluxation “the exertion of pressure on a spinal nerve which by interfering with the planned expression of Innate Intelligence produces pathology” would not be subscribed to today by any reputable chiropractor. It is not a useful exercise to state a theory with a view to proving it wrong unless one can be sure that it is stated correctly. Leaving aside Professor Crelin’s quite outdated reference to “Innate Intelligence”, we do not understand chiropractic treatment to be aimed necessarily at the relief of simple nerve compression. Indeed Dr Haldeman in *The Neurobiologic Mechanisms in Manipulative Therapy* (1978), p. 63, lists 13 other mechanisms which have been proposed for the action of manipulative therapy, of which at least 3 are from chiropractors. Also, knowledge of nerve interference in general has progressed markedly since Professor Crelin’s paper was published as we discuss later.

Current Neurophysiological Research

99. Dr Haldeman (Submission 131, pp. 38–40) conveniently identified for us three neurophysiological processes which are commonly discussed when considering the effects of spinal manipulation. They are, he said:

- (a) Pain physiology.
- (b) Nerve compression and axoplasmic flow (flow of cellular constituents along the nerve axon).
- (c) Basic reflex physiology.

In the context of the possible influence of mechanical dysfunction of the spine on visceral function we are interested in (b) and (c). This is not the place to engage in technical discussions on research in these areas but it is important to be aware that they are very active fields as indicated by the documented references given by Dr Haldeman.

(i) *Nerve Compression*

100. Nerve compression is one of the oldest and most controversial theories offered to explain the apparent influence of manual therapy on visceral function. It is now clearly established that even moderate compression of a nerve can block not only the electrical propagation of nerve impulses but also the axonal flow of protein material. This latter topic was extensively reviewed in the recent conference on *Neurobiologic Mechanisms in Manipulative Therapy* sponsored by the National Institute of Neurological and Communicative Disorders and Stroke at Michigan State University (Plenum, New York, 1978). Dr Haldeman was questioned by

the Commission and cross-examined by counsel at some length on this topic (Transcript, pp. 3293-6, 3335-49) and later we were able to discuss it further with members of the medical faculty at the University of Otago by arrangement with Professor G. L. Brinkman, Dean of the Medical School. Following this discussion, Professor A. J. Harris, who has been active in research and publication in this field for many years, was kind enough to write to us with his critical comments. He said:

The major point made in these sections of the transcript is that nerves can affect the tissues they innervate by a mechanism which is independent of the electrical propagation of nerve action potentials. This separate 'trophic' function of nerves depends on axonal transport of materials within nerve axons.

Professor Harris had written a comprehensive review of this field: see Harris, A. J., "Inductive Functions of the Nervous System", *Ann. Rev. Physiol.* 36, 251-305 (1974). Professor Harris's comment continues:

I believe that the statements made to the Commission about the existence of these mechanisms are substantially correct, but with some glossing over of the evidence. . . . Whether the maintained application of very light pressure can block axonal transport while leaving nerve impulses intact is slightly less clear. . . . there is no experimental evidence to support the hypothesis that pressure on a nerve could cause a dysfunction that could be expressed without there being a simultaneous and obvious block of nerve-conduction, causing paralysis and sensory loss.

We are also indebted to Dr M. Pollock of the Otago Medical School for supplying us with valuable comments on the effect of small pressure changes on nerves.

101. Active research continues on this topic and clearly the last word has not yet been said.

(ii) *Reflex Physiology*

102. The other mechanism mentioned by Dr Haldeman involves the possible ability of manual therapy to influence reflex activity in the central nervous system. This somato-visceral reflex, in his view, holds possibly the greatest interest for those trying to establish a role for manual therapy (including chiropractic) for Type O complaints. The suggestion is that sensory input (say a chiropractic vertebral subluxation) to one part of the nervous system can influence almost any function of the nervous system. That such reflex connections exist seems not to be in dispute. Also, as we have already said, changes in visceral function followed by spinal manual therapy have been documented. However neither a causal relation between a vertebral subluxation and visceral function nor a certain mechanism for such a vertebro-visceral reflex has been established. But clearly in the face of all the information available it is not a responsible scientific stance to assert that it is impossible for a vertebral subluxation to affect visceral function.

In General

103. We should like to quote the views of Professor W. Kunert given at the conclusion of a review entitled "Functional Disorders of Internal Organs due to Vertebral Lesions" given at a CIBA Symposium (Vol. 13, No. 3, 1965). Professor Kunert had since 1958 been working as an Oberarzt in the University Medical Polyclinic in Bonn, West Germany, and included in his publications is a book entitled *The Vertebral Column, Autonomic Nervous System and Internal Organs*, Enke, Stuttgart, 1963.

104. We find Professor Kunert's remarks (p. 96) refreshingly objective and balanced:

The situation, of course, is not always as clear-cut as in the case described above. Nevertheless, we have records of numerous cases similar to the one described here, in which a definite connection appears to exist between a functional disorder in an internal organ and a spinal lesion. Despite this, however, we would emphasise in conclusion that the diagnostic importance of spinal lesions must not be overestimated, as it so frequently is, and that, in particular, the origin of disorders of the internal organs should be sought in such lesions only when all other possible explanations have been examined and discarded. Nothing can discredit the inherent diagnostic value of the relationship between the spine and the internal organs more than to insist on finding such a connection where none exists and to seek corroboration in threadbare hypotheses. We have no evidence that lesions of the spinal column can cause genuine organic diseases. They are, however, perfectly capable of simulating, accentuating, or making a major contribution to such disorders. There can, in fact, be no doubt that the state of the spinal column does have a bearing on the functional status of the internal organs.

105. Dr Haldeman (Submission 131, p. 40) remarks that these conclusions follow very closely opinions which have been expressed by chiropractors over the past 20 years.

COMPARISON WITH MEDICAL SCIENCE

106. It has been strongly urged by the opponents of chiropractic, and particularly by the Medical Association, that the scientific status of chiropractic, which we have been discussing, provides an inadequate basis for state subsidised treatment. By comparison, what is the scientific foundation for medical treatment which attracts state subsidy? How can these treatments be assessed in terms of (a) proof of clinical effectiveness, and (b) theoretical biological mechanisms?

107. It was not part of this inquiry to investigate these matters but they are important considerations in the assessment of medical opposition to chiropractic.

108. In the words of Bourdillon (*Spinal Manipulation*, 2nd edition, 1973, pp. 1-2), "only a few generations ago medicine was an art and the large majority of medical and surgical treatments were based on the results of practical experience rather than on firm scientific foundation." Since then and particularly over the last 40 years major advances have been made, for example in the theoretical understanding of the mode of action of a wide variety of drugs. Fundamental advances in the knowledge of human biochemistry and neurophysiology have placed pharmacology on a much firmer basis. Indeed we were told of some of the more recent developments during the inquiry by Professor Hubbard (Submission 90, Addendum). These advances have only been possible with major backing of governments and vast sums have been spent in support of fundamental medical research.

109. However, it would be ridiculous to claim, and we are sure the medical profession does not do so, that the theories underlying all medical treatment as at present administered are fully understood. These theories are continually evolving, old ones being displaced by new ones as more information becomes available.

110. Not only that, but the clinical effectiveness of medical or surgical treatment can rarely be exactly predicted. Certainly for many conditions there will be a very high success rate for some treatments but for others there will be considerable uncertainty and the doctor may have to use a "trial and error" approach. So now, as in the past, much of medicine is not based on sure scientific knowledge and medical practitioners cannot predict with certainty the outcome of their treatment. Indeed the words in an editorial in an issue of the *British Medical Journal* of 1910 (Vol. 2; 639) apply with nearly the same force today as they did 70 years ago:

It must be admitted that medicine is not yet entitled to rank as a science. It does not fulfil the test of a science—that is to say, the power of prediction. The most experienced among us cannot foretell with absolute certainty the issue even of a trivial ailment, or the action of an ordinary drug in a given case, as an astronomer can predict an eclipse.

111. Perhaps these words should be modified by stating that “medicine is not yet entitled to rank *as an exact science*” instead of just “*a science*”.

112. We do not say that medical health benefits should be withheld from patients unless the treatment can be guaranteed to be successful (or is demonstrated subsequently to have been successful) and the basis for its success is scientifically established. That being so, we feel it is unreasonable to oppose benefits for chiropractic treatment on those grounds.

ISOLATION FROM MEDICINE

113. A major plank in the medical profession’s policy of non-recognition of chiropractic is that chiropractic has isolated itself from the mainstream of scientific and medical knowledge.

114. Whatever may have been the position in the past, this argument certainly has no force today. As we shall see (chapter 38), a great part of chiropractic education concentrates on basic science and basic medicine.

115. The point of criticism really comes down to this: that chiropractors believe that certain conditions are partly biomechanical in origin and may be relieved or modified by spinal manual therapy, a proposition which organised medicine does not accept. In the Commission’s view this is not an adequate foundation for a policy of ostracism. Indeed many open-minded people might see it as no foundation at all. They might say that, far from being constructed with the solid materials of scientific research, its construction is made up of the detritus of sheer ignorance about chiropractic and is flawed by great and acknowledged gaps in scientific and medical knowledge in this area.

116. Unfortunately this attitude in organised medicine is not new. We have already referred to the editorial in the Canadian Medical Association Journal (Can. Med. Ass. J., 85, 1056, 1961) which put the matter succinctly (see chapter 25, para. 6).

117. We dismiss the notion that chiropractic is cut off from medical and scientific knowledge. It uses the existing body of medical and scientific knowledge as a foundation. In areas where present medical and scientific knowledge cannot provide any conclusive answer, it relies on its clinical experience. We cannot see anything to criticise in that, or, for that matter, anything that is radically inconsistent with a scientific approach.

CHIROPRACTIC RESEARCH

118. We have already referred to a number of clinical studies of the effectiveness of spinal manual therapy in pain relief, and also to published work relating to possible neurobiological mechanisms which could explain the apparent success of these procedures. Regrettably very little of this work has been originated by chiropractors or has even involved chiropractors. During the inquiry the chiropractors have been frequently criticised for their apparent lack of interest in research and we believe that this criticism is at least partly justified. The New Zealand Chiropractors’ Association, while conceding that chiropractors should be doing more research, said that lack of Government funds (of the kind available to medicine) and lack of co-operation from the medical profession were the main reasons for the relative inactivity. While we do not dispute these

facts we firmly believe that both individual chiropractors and the profession as a whole can and must do more research. There is some research that cannot be done without the co-operation of the medical profession and particularly medical educators. We deal with this later. There is some however which can be done, and in some places is being done, independently of medicine. We consider two distinct types of research:

- (a) Research based on clinical records.
- (b) Fundamental scientific research.

Clinical Records

119. There is useful research which could be carried out using chiropractors' clinical records provided these records were properly kept to nationally or internationally agreed standards. Several of the chiropractic colleges we visited obviously recognised this need and had established their own systems of record-keeping for their own clinics. We also understood that Palmer College, for one, which had acquired a minicomputer to be used partly for clinical record-keeping, was keen to promote a system of record-keeping in practitioners' offices which would be compatible with its own computer based system. It seems to us that standardisation of record-keeping in New Zealand is long overdue and should be a matter to which the New Zealand Chiropractors' Association should give urgent attention. Only when clinical records based on rigorous common standards are available can useful retrospective clinical studies be undertaken.

Fundamental Scientific Research

120. The organised chiropractic profession in the United States has considerable funds at its disposal, but until recent years only a very small proportion has been used for fundamental research. A much higher proportion has been spent on activities which could broadly be described as "political" and this has been criticised, with some justification, by those opposed to chiropractic in this inquiry.

121. The great bulk of the funds allocated to research by the colleges, by the professional associations, and by the Foundation for Chiropractic Education and Research appears to go to the colleges themselves to do work within their own walls. While we accept that it is essential for any higher teaching institution to have its own research programme, we also feel that, where fundamental science is concerned, it is of the greatest importance that research should be conducted in such a way that its objectivity is completely unassailable. This, we feel, can be so only if the work is done in a recognised university and subject to public scrutiny. There are difficulties, however. It is clear that in any university where there is a school of medicine there will be active discouragement of any research directed primarily at the fundamentals of chiropractic. Further, in the United States, the logical place where such research should be carried out, funding has for long been denied by the medically dominated organisations which traditionally support health research. If such chiropractic-directed research is to be done in a university it seems that the chiropractors must fund it largely themselves. It is easy to see therefore why they have preferred to do it themselves in their own institutions. This is understandable but not in the long-term interests of their profession. There are relatively few chiropractors who have research

training in the basic sciences and the research facilities of chiropractic colleges cannot compare with those of large university science departments. So it is essential that chiropractic research should establish a firm presence in the universities.

The University of Colorado Experience

122. An indication of what can be achieved is to be found in a programme of research now running at the University of Colorado. We shall describe this in some detail because, to our knowledge, it is unique in the sense that it is fundamental research being conducted in a prestigious university by research scientists expert in their fields who are not chiropractors, yet the motivating force is an interest in the theoretical basis of chiropractic treatment.

123. The director of this research programme is Dr C. H. Suh, Professor in the College of Engineering and Applied Science and chairman of the Department of Engineering Design and Economic Evaluation. This work was mentioned first in the principal submission of the Chiropractors' Association (Submission 19, p. 51), and the association's principal witness Dr L. C. Mudgway was questioned on its status by counsel for the Society of Physiotherapists (Transcript, p. 1253, and see also p. 1228):

Q: . . . At that particular date there was no particular research being done on the validation of manipulation therapy. Are you aware of any that has been done since September 1975?

A: Most of the research to my knowledge at the present time from a chiropractic point of view, is that being conducted by Dr Suh.

Q: That work done by Professor Suh is concerned with a computer spinal model, and also with examining the geometry of X-rays.

A: That is only part of his research.

Q: What are the other areas he is researching?

A: I cannot answer that.

Q: I put it to you quite simply there are no other areas.

A: I cannot answer that, all I can do is obtain from Dr Suh all the information here, all the material he is researching at the present moment.

124. It is interesting that the principal chiropractic witness did not fully appreciate the significance of the research programme being directed by Professor Suh and indeed the Commission might have been left with the quite false impression left by counsel for the physiotherapists had not one of its members been able to visit the University of Colorado in the course of the Commission's overseas inquiries.

125. Professor Suh, a specialist in biomechanics, explained that the broad goal of his research group is to define precisely what a chiropractic adjustment is, how much and what type of force is applied and for how long. Coupled with that is the desire to establish what the neurological consequences are of such an adjustment. Professor Suh believes, from the clinical evidence, that "something happens" when a chiropractic adjustment is made but neither he nor anyone else knows just what this is. His research is directed towards finding this out in a perfectly open way without prior commitment. His own work has been concerned primarily with developing a mathematical model of the spine, based on known anatomy, and with representing this model using computer graphics techniques. He has also been concerned with precision X-ray methods for the visualisation of biomechanical aspects of subluxation. Considerable progress has been made and the work is continuing. Perhaps of more immediate interest to the layman is the research being conducted by his two principal collaborators, Doctors S. K. Sharpless and M. W. Luttgies, both of whom are neurophysiologists.

126. Dr Sharpless is a Professor in the Department of Psychology and his work on nerve compression, e.g., in *The Research Status of Spinal Manipulative Therapy*, p. 155, had been cited by Dr Haldeman (Submission 131, p. 38). We did not meet Professor Sharpless in person but an account of some of his more recent work was given in a paper "Neurophysiological Research on the Consequences of Joint Fixation" delivered at a Conference on the Biomechanics of the Spine in 1977, at the Cleveland Chiropractic College of Los Angeles, the eighth in the annual series of such conferences sponsored by the University of Colorado Biomechanics Laboratory. Professor Sharpless states (p. 2) "the subject of the research being undertaken in our laboratories is the neurophysiology of plastic changes in nervous tissue resulting from joint fixation".

127. Dr Luttgies is an associate professor in the Department of Aerospace Engineering Sciences. We met him and heard at some length about the work he is doing. He explained that he was interested in attempting "to corroborate that physiological alteration in nerves results from what the chiropractors call a subluxation, to corroborate, if possible some changes in hard and soft tissue relations". He explained that this was easy enough to state but much more difficult to do. There was, he said, a serious absence of fundamental neurophysiological data and he has over the last few years been working in areas where this information was found to be particularly deficient. These have concerned, in particular, the neurochemical consequences of different types of stimulation or damage to nerves in animals: see, e.g., *Experimental Neurology* 50, 706 (1976). While we are not personally competent to assess this work technically it is clearly of high quality. We were very much impressed with Professor Luttgies's systematic professional approach to a fairly daunting topic and with his scientific detachment. It is much too early to say whether or not his findings will lead to a firm theoretical basis for chiropractic but certainly none of the results in any way suggests that there can be no rational theoretical basis.

128. One of Professor Suh's objectives is to involve practising chiropractors in the research programme as much as possible. Evidence of this was a paper in the proceedings of the eighth Annual Biomechanics Conference of the Spine held in December 1977 in Los Angeles and referred to earlier. The paper was entitled "Inflammatory Effects on the Sciatic Nerve Trunk of the Mouse" by J. J. Triano, M.A., D.C., who had been working with Professor Luttgies as a research associate. This was a fundamental study aiming at a "quantification of both constant and intermittent mechanical stimuli effects on the sciatic nerve trunk of the mouse". Dr Triano is back in practice in Colorado and is continuing to collaborate with Professor Luttgies in a clinical investigation of possible objective assessments of pain, a notoriously difficult problem.

129. Also working as a research associate during our visit was a member of the Palmer College faculty, Dr John Grostic, who had been granted 3 months' leave by the college for the purpose. He was working with Professor Suh in the area of the precise analysis of spinal X-rays and, in particular, possible simplified methods which chiropractors could use in their own offices. He was also investigating the best ways to use small computers (such as that now installed at Palmer) in documenting and analysing clinical data.

130. The research activities of Professor Suh's group are being supported financially by both the National Institutes of Health (NIH) and by the International Chiropractors' Association (ICA) and in that

respect appear to be unique. Professor Suh recounted for us the great difficulties he had in convincing the NIH that research primarily directed towards chiropractic was worthy of their support. He told us of a reviewer who, after approving one of the Colorado papers for publication, had second thoughts when he discovered that the work had been sponsored by a chiropractic organisation. Professor Suh however appears to have overcome at least some of these prejudices and in so doing has been a real pioneer.

131. The work of the Colorado group is admirable but three principal research workers, even if they spent the rest of their active lives in these areas, could do no more than scratch a small part of the surface of what needs to be investigated. Professor Suh has demonstrated that fundamental scientific research into chiropractic can be done in a university with chiropractors closely involved. Why is there not more of this activity?

132. We believe there are two main reasons. The first is the prejudiced attitude of organised medicine towards chiropractic and the effect of this attitude on medically dominated federal funding agencies in the health area. This is obvious and needs no further comment. The second reason is associated with the attitude of the chiropractors themselves and, in particular, with the very powerful American Chiropractic Association (ACA). In the early days of Professor Suh's programme, the ACA was a joint sponsor but later withdrew its support leaving the ICA as the only chiropractic source of funding. Professor Suh's view was that the ACA tended to be distrustful of work done in universities and therefore not under their complete control and that they preferred their research money to go into their own colleges. There was also a suggestion that they were not very happy about being involved in a project also being supported by the ICA. This view was confirmed in our minds by the cool and somewhat disparaging reaction we obtained when we mentioned the Colorado work during our later visit to the Los Angeles Chiropractic College, which is, of course, an ACA college. (We note in passing that the 1977 Biomechanical Conference, previously mentioned was held at Cleveland Chiropractic College, Los Angeles, an ICA college.)

133. In our view the attitude of the ACA and its colleges to university research is short-sighted to say the least and it does the profession as a whole no credit. Indeed we find the general attitude of North American chiropractic colleges to universities to be quite ambivalent. On the one hand they would welcome the prestige and improved financial security which would accompany formal association with a university but they fear loss of independence and loss of control by the profession of their education.

134. Now they cannot have it both ways. It is understandable that their attitude should lead to cynicism in the scientific community. A precondition for scientific respectability is a willingness to change if this is shown to be necessary and a willingness to be proved wrong. Fortunately at the Preston Institute in Melbourne we saw little evidence of the North American attitude towards the universities. We are very hopeful therefore that future New Zealand chiropractors will be free of these attitudes and will become actively involved with the New Zealand universities. We note that counsel for the Medical Association in his final submission (Submission 135, p. 86) stated that:

... the one area in which we see some scope in the future for greater co-operation between the professions is in the promotion of research into the value of spinal manipulative therapy. Leaving aside the questions of how much research should be promoted and as to priorities of time and money, there is a willingness on the part of the medical profession to see such research undertaken.

135. This was the only real conciliatory gesture made to the New Zealand chiropractors by the Medical Association in the whole course of the inquiry but it does offer a glimmer of hope. It is a pity that it had to be immediately qualified by counsel for the Medical Association in these words:

At the same time, it is an unfortunate fact that the record of joint medical/chiropractic research does not engender a sense of confidence that future research can be pursued on fully co-operative lines.

136. It seems to us that the Otago Medical School could be an ideal location for any research requiring university facilities. It ought to be possible, with the aid of funds from the Medical Research Council, to set up a fellowship scheme which would enable a suitably qualified chiropractor to move into residence. Other practical research schemes may suggest themselves. But it is clearly essential that active research should be encouraged at once.

GENERAL CONCLUSIONS

137. There is strong clinical evidence that manual therapy as administered by chiropractors is safe and effective in the relief of pain of biomechanical origin. There are also strong indications that such therapy in some conditions is more effective than conservative medical treatment but confirmation of these indications will depend on further properly controlled trials.

138. There is no scientific proof of any theory proposed to explain how a chiropractic subluxation could affect visceral function. At the same time, in the context of current neurophysiological thought, modification of visceral function by mechanical disturbance of the spine is a rational hypothesis.

Recommendations for Future Research in New Zealand

139. That the New Zealand Chiropractors' Association formulate a proposal for a clinical trial or trials on some aspect of chiropractic treatment to be conducted in co-operation with one of the clinical medical schools in New Zealand. This proposal should be submitted to the Medical Research Council. If the council is not prepared to support such a trial, our recommendation is that a special grant of \$200,000 over a 4-year period be made by the Department of Health for this purpose.

140. That the New Zealand Chiropractors' Association sponsor a post-doctoral research fellow to work in a New Zealand university on a topic related to fundamental chiropractic theory. The staff of the Otago University Medical School should be consulted in the formulation of such a topic. The funds required would be approximately \$15,000 per annum.

Chapter 38. CHIROPRACTIC EDUCATION

EDUCATIONAL REQUIREMENTS

1. It is beyond debate that a health care practitioner whom a member of the public may consult directly must meet high educational standards. The matter assumes particular importance when the public may obtain this care from more than one source. If there is just a single professional group permitted to offer primary care the public has no decision to make. If there is more than one group there is an initial choice to be made. But members of the public cannot necessarily be expected to decide for themselves what type of practitioner can best help them. It has been accepted for many years that the general medical practitioner, because of his training, has the knowledge to decide if his patient's condition is beyond his competence to treat and if so, to whom he should be referred. This referral will of course in almost all cases be to another medical practitioner with specialist training.

2. If chiropractors are to continue to function as primary contact practitioners it is essential that they too have sufficient knowledge of general body structure and function and pathology to make similar decisions. Someone may come to the chiropractor believing that his problem can be solved by spinal manual therapy when in fact he has a sinister condition beyond the competence of the chiropractor to treat. It is necessary therefore for the chiropractor to have sufficient diagnostic ability to decide when he should refer a patient for medical treatment. His education must provide this.

3. It is clear also that the chiropractor's training must provide him with the necessary skills to administer his manual therapy safely and effectively to those he decides he is competent to treat.

4. In order to make his preliminary diagnosis the chiropractor may have to use procedures other than manual tests and he must be competent to make these safely and accurately. His main additional diagnostic aid is the use of X-ray. As this is potentially dangerous to the patient, his training in the taking of radiographs and in their interpretation is a vital part of his education. There may also be other diagnostic procedures he needs to use but we shall refer to these later.

5. To summarise, the chiropractor's professional education must equip him to be a diagnostician competent at least to detect contra-indications for chiropractic treatment, a limited-field radiographer, and a skilled manual therapist. Our discussion of chiropractic education has these assumptions in mind.

HISTORY OF CHIROPRACTIC EDUCATION

6. A brief outline of the major developments in chiropractic education may be helpful. The Palmer influence has of course been great and Palmer College in Davenport, Iowa, was the first and is still the largest (1800 students) chiropractic college in the world. Techniques of "adjustment" have been developed at Palmer and elsewhere and while some of these appear to have come and gone like fashions in clothes, and while some colleges emphasise different techniques, there appears now to be a range of techniques which are fairly generally accepted.

7. Aside from the question of technique, a major division occurred fairly early in the development of the profession. This concerned particularly

the use of procedures other than purely manual procedures both for diagnosis and for treatment. As early as 1906, John Howard, a Palmer College faculty member, in strong disagreement with B. J. Palmer, established his National School which 2 years later moved to Chicago and developed quite independently of Palmer. From its early days, some prominence was given to adjunctive procedures (the use of light, heat, electrotherapy, and other techniques which we now in New Zealand usually associate with physiotherapy). These came to be accepted by graduates of this college and some others as a normal part of the armamentarium of the chiropractor. The role of William Carver in this development has been mentioned in chapter 7. This view was strongly opposed by Palmer and some other colleges. What is more, it appears that the Palmer group also resisted the use of adjunctive procedures for diagnosis as well and indeed did not see general diagnosis (i.e., other than a direct spinal examination) as forming a legitimate part of chiropractic.

8. Another topic which has long been given prominence at National but which was never part of the original Palmer training, is nutrition. A total of 90 contact hours is devoted to nutrition in lectures at National College.

9. These differences over what should be included in the chiropractic curriculum still exist in the United States: see chapter 7 as to "straights" and "mixers". Palmer College has, as we shall see, for various reasons, recently extended its teaching to include general diagnosis and nutrition and, on an elective base, the use of adjunctive treatment procedures; but there are a few small colleges, notably Sherman College in South Carolina, which strongly adhere to the original more limited scope and call themselves colleges of "straight chiropractic."

10. It was quite correctly emphasised more than once in the public hearings that whatever the current educational standards of chiropractic colleges from which future New Zealand practitioners may graduate, for some time yet most New Zealand chiropractors will be products of earlier Palmer College years. In fact 46 percent of the present 93 graduated from Palmer before 1970 and of these 30 percent graduated before 1962. It is important therefore to pause to consider what Palmer College was like 20 years ago and before the Council on Chiropractic Education (CCE) came upon the scene. We gain a fascinating glimpse from a 1959 article which was reprinted in the December 1978 issue of the *Journal of the Canadian Chiropractic Association*:

Palmer School Broadens Technique Curriculum

On December 20th, 1957, the change in policy at PSC, outlined on January 4, 1956, by Dr H. M. Himes, Director of the Technique Department at Palmer School, was given further confirmation.

The December 20th report states that, "A new curriculum for the Palmer School of Chiropractic Student Clinic will take effect January in line with the revised technique policy laid down in January, 1956, by the Head of the School Technique Department, Dr H. M. Himes.

"The program will direct students to compare the merits of upper cervical specific technique and lower spine adjusting. 'Upper cervical' will remain the chief area of interest but detailed full spine adjusting will be used where indicated."

"This will lead eventually to integration of the entire spinal column on a specific rather than a 'general adjusting' basis."

This would seem to be a most important step toward unity within our profession. Everyone knows that differences over techniques have been one of the greatest stumbling blocks to chiropractic professional progress. By incorporating full spine adjusting into "the new technic curriculum for PSC", the Palmer School has taken a great step toward solving our technique difficulties. In his historic policy address to the PSC student body on January 4, 1956, Dr Himes said:

"At Lyceum 1946, Dr Hender was empowered to make the statement changing the name H-I-O to 'Upper Cervical Specific' and added that the PSC would stand behind

any chiropractor who adjusted the spinal column for the REMOVAL OF INTERFERENCE, when and where he found it.

"It is time life be given to the 1946 announcement, and the so-called controversy between lower spine and upper cervical be given its death blow."

Many of our readers may not have had the opportunity of hearing Dr Himes' address or of reading a copy of it. We are, therefore, quoting that section dealing with the Conclusions and Propositions in the hope that it will help you to understand the new policy adopted at the Palmer School of Chiropractic."

11. The H-I-O or "hole-in-one" technique was evidently a relic of the times when Palmer College was dominated by B. J. Palmer, and this account of events in the 1950s makes us somewhat cynical when we read in the *Palmer College Bulletin* of 1978-79 that "Palmer College of Chiropractic has maintained its eminence in chiropractic education. B. J. Palmer . . . stood for more than a half-century as the recognised leader of the chiropractic profession. He was the author of 18 books, which form the basis of chiropractic understanding . . . His teachings and writings form a strong base of tradition on which the college will continue its growth and service." Throughout this bulletin there are indications that the influence of B. J. Palmer is still strong: for instance, included in the section on "Chiropractic Philosophy" is the statement "The state or organization found among the body organs and systems is maintained through the nervous system, and indicates the presence of an intellectual guiding entity—an inborn or innate intelligence." Such a statement would not be found today in the publications of colleges affiliated to the CCE.

12. Again we have reservations about the following section of the bulletin headed "The Profession of Chiropractic":

A subluxated vertebra, disturbing the normal nerve supply of an organ, brings about functional disease which may be followed by pathological disease.

The chiropractor, having established that a disease has been caused by a subluxated vertebra, directs his efforts to determining which vertebra is subluxated, and to the adjustment of this vertebra back to its normal range of movement. Following the adjustment, the normal nerve supply is restored to the organ or system of organs, and their normal function may be re-established.

Chiropractors, through careful analysis of the entire spine, may not only locate the subluxated vertebra, but through knowledge of nerve fiber distribution, may locate the region of the affected organ. They may then advise the patient about the nature of his symptoms, and suggest methods of care for the body while it is being restored to a normal state of health.

13. It is against this traditional background that most New Zealand chiropractors have been educated. For various reasons future New Zealand chiropractic students are unlikely to train at Palmer or at any other North American college. However, at least for the next two decades the contrast between the Palmer traditions and the new-look Australian training (as to which see below) could be a source of tension in the profession. In his address to the 1979 chiropractic graduating class at Preston Institute, Professor R. R. Andrew (a former Dean of Medicine at Monash University) drew attention to this problem. He expressed the confident hope that these tensions would not be allowed to damage the profession or to adversely affect patient care. We cannot do better than to quote his words:

... I do hope that . . . the proper recognition will be given to the vast clinical experience of many older generation chiropractors who may not have any great understanding of, e.g., immuno-suppressive pathology, but can do their professional job with skill and effectiveness. This is a watershed which all professions face as they progress and become more demanding of their practitioners. But your profession I hope will be animated by an appropriate degree of pragmatism and a generosity of spirit in its recommendations and that the Registration Board will react and determine in a similar way.

14. Professor Andrew was of course referring to a particular Australian problem which does not apply in New Zealand, but we think that the sentiments he expresses should be taken very much to heart by the New Zealand profession in respect of the different educational backgrounds (Palmer and Preston) of the two main groups of chiropractors over the next 20 years or more.

THE COUNCIL ON CHIROPRACTIC EDUCATION

15. Until well into the 1930s there was effectively no national control of educational standards in chiropractic colleges in the United States and apparently little interest in the setting of such standards. Moves were begun in the 1930s to establish a chiropractic education programme which culminated in 1974 with the formal recognition by the United States Office of Education of the Council on Chiropractic Education as the accrediting agency for chiropractic colleges. In its *Educational Standards for Chiropractic Colleges* (June 1978) the CCE states its purpose as follows:

The Council on Chiropractic Education is a national organization advocating high standards of quality in chiropractic education, establishing criteria of institutional excellence for educating primary health care chiropractic physicians, inspecting and accrediting colleges through its Commission on Accreditation, and publishing lists of those institutions which conform to its standards and policies.

16. While federal recognition of the CCE does not necessarily indicate any Government opinion on the value of chiropractic relative to other types of health care it does mean that colleges duly accredited by the CCE, and only such colleges, are eligible for Federal assistance both in the form of guaranteed student loans and loans towards new college buildings. In January 1979 only six colleges had been accredited by the CCE—Los Angeles College, National College, Northwestern College (St. Paul, Minnesota), Texas College (Pasadena, Texas), Logan College (Missouri), and New York College. Three others, including Palmer College, which has now become fully accredited, had the status of recognised candidate for accreditation indicating that the institution “has given evidence of sound planning, the resources to implement these plans, and has an intent to work towards accreditation.” (*The Council on Chiropractic Education and the Accreditation Process for Chiropractic Colleges*, 1979). In addition, three chiropractic colleges outside the United States are affiliate members, meaning that they subscribe to the policies and regulations of the CCE. These colleges are Anglo-European (Bournemouth), Canadian Memorial (Toronto), and International College (Preston Institute, Melbourne).

17. A number of the “straight” chiropractors of the original Palmer view are suspicious of the CCE and believe that it is imposing curriculum requirements that are unacceptable to them. While we do not wish to go into the finer details of the history of the establishment of the CCE, one aspect is important. This concerns its relations with the two chiropractic professional bodies, the American Chiropractic Association (ACA) and the International Chiropractors’ Association (ICA). In the 1930s there was only one professional body, the National Chiropractors’ Association (NCA) and this was involved in the early moves towards an accreditation programme. A rival body, the International Chiropractors’ Association (ICA), based on Palmer College, was later set up. In the 1960s the NCA disbanded and most of its members, together with some from the ICA, formed the ACA which continued to support the CCE. The ACA currently has about three times the membership of the ICA. However, the

ICA, based at Palmer College, did not fund nor support the CCE presumably because it disagreed with some parts of the curriculum (e.g., laboratory diagnosis, physical therapy) which the CCE was promoting and because it thought Palmer College might lose some of its autonomy. However, when the CCE obtained federal recognition Palmer College saw the advantages of accreditation and formally sought such status. It is quite clear that in an effort to satisfy CCE requirements, Palmer College's educational standards have been very considerably raised in the last 5 years: for instance, the number of full-time teaching staff has been almost doubled during that period. The CCE announced that Palmer College had received full accreditation in July 1979 just as we were completing this report.

18. We should like to emphasise at this point that Palmer College today, from the evidence of our visit, must be a very different place from what it was 20 years ago or even 5 years ago. While deficiencies remain in some educational facilities, notably in anatomy and in the basic sciences, there are some very strong sections. We were particularly impressed with the X-ray department and with its new director, Dr G. DeWet. We were also pleasantly surprised by the library which is now well housed in new quarters, adequately stocked, and professionally organised by the new librarian. Generally we sensed that Palmer College was now looking to the future rather than dwelling over much on its past history. This is a healthy sign for the chiropractic profession in general.

19. The publications of the CCE plainly indicate that its concern is not so much with the detailed curriculum of chiropractic colleges as with how it is taught and by whom, what laboratory and library facilities are available, and what opportunities there are for staff to do research. This view was certainly confirmed by the executive secretary of the CCE, Dr R G Miller, ED.D (who incidentally is not a chiropractor), whom we met in Des Moines, Iowa. Thus, while National and Los Angeles colleges certainly teach physiotherapy techniques, this is not a requirement of the CCE and indeed at Palmer this topic is available only as an elective. Some topics not required by the CCE may nevertheless be required by many state chiropractic licensing boards so that, for example, any Palmer student who intended to practise in a state which required competence in physiotherapeutics would need to take that elective. Responses to the various requirements of the CCE and state licensing boards have inevitably led to some tensions within Palmer College between the traditionalists, who would prefer the chiropractor to limit his diagnosis and treatment strictly to palpation and manipulation of the spine (with the help of diagnostic X-rays), and those with a broader approach to chiropractic health care who would include laboratory tests, nutrition, physiotherapeutics, etc., within the curriculum. We see this as a healthy situation at Palmer and we have no doubt that when all the dust has settled there will be a much greater unity in the profession as a whole with full support of the CCE by the ICA.

RELATIONS WITH UNIVERSITIES

20. None of the North American chiropractic colleges has formal affiliation with a university and this has undoubtedly counted against them and their graduates because the university has traditionally been the guardian of academic standards and in some cases professional standards. Agreements are now being made by some colleges to establish formal association with a university. A notable case is that of Canadian

Memorial Chiropractic College (CMCC) whose negotiations with Brock University in Ontario appear to be at an advanced stage. It is important to note that it was a firm recommendation of the 1973 report of the Ontario Council of Health (*Scope of Practice and Educational Requirements for Chiropractors in Ontario*) that CMCC be brought within the public educational system of Ontario and to this end be joined to a university. Presumably the CMCC Board would have been strongly influenced by this recommendation.

21. There are, however, obvious obstacles in the way of a formal association between a chiropractic college and a university. It would clearly be very difficult to combine with a university which possessed a medical school: so most large universities are eliminated immediately. We also gained the impression that most chiropractic colleges in the United States would regard a university association as a mixed blessing, particularly because they fear they would lose control over their teaching and would gradually become absorbed into medicine as osteopathy appears to have been. This attitude we find understandable but at the same time most regrettable. We cannot see that chiropractic can ever become accepted into the mainstream of health care until its practitioners are educated at publicly financed tertiary institutions which are open to full public scrutiny: and see also on this point chapter 37. However, at the colleges in Great Britain, Canada, and Australia there does appear to be a clear acceptance of the desirability of formal university association.

DEVELOPMENTS IN AUSTRALIA

22. It is in Australia that the most promising developments have been made towards integration of chiropractic courses into a recognised tertiary institution. A full professional course, including clinical training, is now established at the International Chiropractic College (ICC) which uses the facilities of the Preston Institute of Technology, Melbourne. The first graduates from the ICC received their diplomas in May 1979. ICC has made a formal submission to the Victorian Institute of Colleges for approval and accreditation of their course as an integrated degree course leading to B.App.Sc. (Chiropractic). This proposal has the full support of the Preston Institute, and decisions on this submission and a consequential submission to the Australian Tertiary Education Commission are anticipated at the time of writing. We shall have more to say about this development later but note at this point the encouraging convocation address at the May graduation ceremony of the ICC. This address was given by a member of the Course Advisory Committee, Emeritus Professor R. R. Andrew, Director of Medical Education, St. Francis Xavier Cabrini Hospital, and formerly Dean of Medicine, Monash University. Professor Andrew said:

This is the commencement of a career which has as its central motive service to the community through one aspect of the health services now properly recognised by the State largely because of the high standards of your College and the excellent integration and co-operation with the Preston Institute of Technology . . . I have not the smallest doubt that the College as it becomes more and more integrated with and part of the total life of the Institute will go from strength to strength.

EDUCATIONAL BACKGROUND OF NEW ZEALAND CHIROPRACTORS

23. Licences to practise as chiropractors in New Zealand are granted by the New Zealand Chiropractic Board, set up under the Chiropractors Act 1960. The board requires that the licensee hold a doctor of chiropractic

degree or diploma (D.C.) from one of a small number of chiropractic colleges it recognises, and that he or she pass a qualifying examination set by the board. Of the licensed chiropractors practising in New Zealand at the time of writing only 4 have been trained outside North America (at Anglo-European College, England) and 64, or 69 percent of the total, have obtained their qualifications at Palmer College. At present there are 17 students at Palmer at various stages of their course. The remaining students at present under training are at ICC (17), Anglo-European College (2), and Sherman College (4). Of these colleges, only Sherman has no status with the CCE.

SUMMARY OF PRESENT SITUATION

The CCE and Its Requirements

24. Throughout the world the dominating influence in chiropractic education is the United States Council on Chiropractic Education. In the United States, as the single federally recognised agency, it is clearly going to be the determining force in chiropractic educational standards in the foreseeable future. While its establishment and early backing came largely from the ACA, it now has significant support from the ICA. Also Palmer College, the largest chiropractic college of all and the main bastion of the ICA, made strenuous efforts to qualify for full CCE accreditation and has now done so.

25. As the United States is dominant in chiropractic education, so its standards have become the standards aspired to by colleges in other countries. It is clearly in the interests of non-United States colleges to produce graduates whose education would qualify them to practise in the United States and elsewhere. CCE requirements are therefore to the forefront in the planning of Anglo-European College, Canadian Memorial College, and International College in Melbourne, and there is continuing formal consultation between the CCE and these colleges.

26. It is important to emphasise again that the prime concern of the CCE is not with what is taught but how it is taught. In its *Education Standards for Chiropractic Colleges* the CCE states thus what it considers the course should contain:

Curriculum

The purpose of the curriculum is to provide the means for giving a student a thorough understanding of the structure and function of the human organism in health and disease. A well-balanced presentation should give the student an understanding of the essential features of the life processes; digestion, excretion, physical and mental growth, nutrition, metabolism, energy, nervous control, the significance of developmental defects, behavior, and other elements which are fundamental of the understanding of pathological conditions. An understanding of structure and function should make it possible for students to identify deviations from the normal and should provide the essential facts required later for the diagnosis, prognosis, and the treatment of disease.

Length of Course

The curriculum shall be presented over a minimum period of eight semesters or the equivalent for a total of not less than 4200 hours.

Sequence

The course must be presented in a proper sequence of subjects to insure proper prerequisites.

Offerings

The offerings should include the following disciplines: Human anatomy; biochemistry; physiology; microbiology; pathology; public health; physical, clinical and laboratory diagnosis; gynecology; obstetrics; pediatrics; geriatrics; dermatology; otolaryngology; roentgenology; psychology; dietetics; orthopedics; physical therapy; first aid and

emergency procedures; spinal analysis; principles and practice of chiropractic; adjustive technique; and other appropriate subjects.

Courses offered in the curriculum shall be taught in sufficient depth to fulfill *sic* the concept of the chiropractic physician as set forth in the first two paragraphs of the Foreword of these Educational Standards.

27. Two points need to be made regarding this curriculum statement. The first point is that it is not a mandatory requirement of the CCE that a college teach all of the subjects mentioned under "Offerings". This was made clear to us by the CCE officers we met. Nevertheless all the North American colleges we visited offered this complete range of subjects, even though at Palmer physical therapy was not a course requirement but just an elective. The second point is that we see the value of some of the offerings not as a means of producing a practitioner in the field—say gynaecology or orthopaedics—but as part of the training of a chiropractor in the exercise of his judgment on whether or not his patient should be referred to another health practitioner. What the CCE does insist on is that all subjects are taught by adequately trained staff.

28. Another important mandatory requirement is the making of "provisions for a research program by making available adequate time, space and resources". We have already dealt with research in chiropractic colleges in chapter 37.

29. We can usefully sum up the stance of the CCE by giving its statement on objectives of chiropractic colleges:

The objectives of each institution shall be clearly defined. A measure of the merit of the institution is the degree to which its stated objectives are fulfilled. In the broadest terms these objectives shall embrace:

1. The preparation of the chiropractic doctor as a primary health care provider, as a portal of entry to the health delivery system, well educated to diagnose, care for the human body in health and disease and to consult with, or refer to, other health care providers.
2. The development of postgraduate education for the profession.
3. The conduct of research.

Comparison with University Standards

30. As the North American chiropractic colleges are outside the university system it is not easy to relate their standards to those of universities, especially as a major part of the subject matter is not taught at any university. Entrance requirements are a guide, however. The CCE requirement as from 1979 is that all candidates for admission must have completed at least 2 years of a bachelor's degree course in arts or sciences with C+ grade average and not less than C grade in laboratory courses in biology and chemistry. This in turn is not easy to relate to the New Zealand scene. Our impression is that the minimum CCE entry standard would be sufficient to gain a student entry to a New Zealand university without credits. The minimum required level of attainment in biology and chemistry would be about equivalent of New Zealand University Entrance level.

The Common Scientific Base

31. While the specifically chiropractic material is of course not taught outside chiropractic colleges there is much other material that is. Indeed, considerably more than half the contact hours in the 4-to 5-year course offered are concerned with just those topics which are to be found in any

standard preclinical medical course. The chiropractic student is therefore well exposed to anatomy, physiology, pathology, micro-biology, human biochemistry, and diagnosis (including laboratory procedures) and in a CCE college he will probably be taught these subjects by a non-chiropractor using standard medical texts. He is therefore exposed to the whole range of scientifically based factual material that medical students are.

Comparison with Medical Standards

32. Although the content and generally the level of treatment of the non-chiropractic subjects is comparable with what a university medical school might offer, most CCE colleges inevitably suffer by comparison in respect of the calibre of teaching staff and especially in laboratory facilities. This is a general statement but there are some notable exceptions. For example, the facilities at National College especially in anatomy and laboratory diagnosis would stand comparison with those of the New Zealand medical schools. We feel that Dr T. Tran, the Academic Dean at Los Angeles College, to name just one we met, would be welcome in the faculty of any university department of anatomy. Certainly we are satisfied from what we saw that graduates of the colleges we visited reach standards in anatomy and in the other basic medical sciences comparable with medical graduates.

33. In our list of non-chiropractic subjects where there is a common scientific base with medicine we include the subject of diagnosis. It was made clear to us at both the New Zealand medical schools that diagnosis as such is not taught as a separate subject but that students acquire diagnostic skills within the framework of other subjects such as pathology and especially through their contact with large numbers of patients in hospital wards. It was suggested to us that chiropractors could not possibly possess diagnostic skills comparable with those of a medical graduate simply because they had not had clinical experience in hospitals.

34. We put this point to the faculty at National College and received a most interesting reply from Dr L. E. Fay, the Executive Vice-President. Dr Fay drew a clear distinction between patients in hospital and patients who "come through the practitioner's office door". The hospital patient, he said, was presumably where he was because his condition had gone beyond the stage where the general practitioner could cope with it and he had some kind of advanced pathology. The patient in the second category, he said, was much more the legitimate concern of the chiropractor and it was towards this patient that the chiropractor's diagnostic training was primarily directed. He maintained, and we are inclined to agree, that the chiropractor's training fits him as well and possibly better than does a medical training for diagnosis at the general practitioner level. He agreed that hospital access for chiropractors would be an added benefit but in no sense a substitute for the diagnostic training they already receive. If the chiropractor has been adequately trained to identify conditions which are beyond his powers to treat—and we believe he does receive such training at CCE colleges—then he is actually at an advantage over his medical opposite number when it comes to conditions which are biomechanical in origin. He is trained to treat such cases whereas the medical practitioner—except in a few cases—is trained only to administer drugs for pain relief. Having said all this, however, we are quite certain that the chiropractor's diagnostic skills would be significantly improved through access to hospitals.

Developments at Preston Institute of Technology

35. Because of the strong influence it is likely to have on the education of New Zealand chiropractors of the future, we consider at some length the present and likely future status of the International College of Chiropractic (ICC) at the Preston Institute of Technology (PIT), Melbourne.

36. During 1979 the first group of students completed the course of training provided by this college. The students will have been taught partly by staff of PIT and partly by fully trained chiropractors who have either been educated at or have taught at American colleges fully recognised by the American CCE. These students have been awarded a diploma of the ICC. If, as appears likely, the proposed integrated course leading to B.App.Sc. (Chiropractic) at PIT is approved by the Victorian Institute of Colleges (of which PIT is a member) and thence by the Australian Tertiary Education Commission, these students would retrospectively be awarded the degree, as the course would have been equivalent to that now formally proposed. It should be noted here that degrees awarded by Australian Colleges of Advanced Education (CAE) of which PIT is one, are comparable with university degrees. They differ mainly in that a CAE course will place greater emphasis on breadth of coverage and less emphasis on depth of coverage of a principal subject.

37. If and when formal approval is given, those chiropractors contributing to the degree course will be appointed by the PIT as full members of the staff.

38. The B.App.Sc. (Chiropractic) will require 5 years of full-time study of which the final two-thirds of a year will be full-time supervised clinical work. The course is stated to consist of three broad divisions. We give these below with the total contact hours (lectures and laboratory work) allocated to each.

	<i>Hours</i>
<i>1. Basic Sciences and Humanities</i>	
Anatomy (including neuroanatomy)	660
Chemistry and biochemistry	320
Physiology (including neurophysiology)	350
Humanities (general philosophy, psychology, sociology, communication skills)	200
Natural sciences (biology, applied physics, genetics, physical anthropology)	165
<i>2. Chiropractic Sciences</i>	
Chiropractic principles and theory	240
Psychomotor skills (mainly principles and techniques of palpation and manipulation, including extremity joints and soft tissues)	460
Spinal studies (spinal anatomy and biomechanics)	320
<i>3. Clinical Sciences</i>	
Diagnosis and practice	910
Pathology	230
Microbiology and community health	180
Radiology and radiography	*140

*A further 185 hours of radiological interpretation are included under diagnosis.

Following this formal course work a further 8 months of full-time supervised clinic work must be undertaken in order to complete all requirements for the degree.

39. The progression of material through the 5 years of the course is set out in appendix 2. This course should also be viewed against the background of the objectives which are stated and elaborated in the excellent document *Chiropractic Undergraduate Programmes* issued in December 1977 by the Australasian Council on Chiropractic Education. This document is reproduced in full in appendix 3. The course content and standards are aimed to match those of chiropractic colleges having status with the American CCE. Competence of staff is assured by the fact of the course being integrated into the VIC system. Likewise the physical facilities can be expected to come up to at least a satisfactory basic level.

40. Future chiropractic graduates of PIT can therefore be expected to have received a training closely comparable with D.C. graduates of an American CCE college. They will, however, have one great advantage. They will have been trained in an internationally recognised tertiary institution alongside students studying a range of academic disciplines, especially scientific disciplines, and should therefore have a more balanced academic outlook. With 250 students (of whom 17 are New Zealanders) currently enrolled the course is unquestionably viable.

41. The Commission was favourably impressed with the two representatives of the ICC who appeared before it in public hearings, Dr A. M. Kleynhans, the Principal, and Dr T. R. Yochum, Head of the Roentgenology Department. This favourable impression was maintained on our visit to Preston where we met most of the staff, talked to a number of students (including six from New Zealand) and saw all the facilities. Our general impression was that the chiropractic college is fully accepted as an integral part of the institute both by staff and students.

42. The non-chiropractic institute staff who teach the basic science and medical science subjects have no reservations about teaching chiropractic students and indeed appear to find them a particularly stimulating group ready and willing to challenge traditional thinking. Generally these staff are well qualified with advanced degrees in their teaching subjects. There is one exception and that is in microbiology. While the particular teacher in charge seemed highly motivated and efficient her highest qualification was a B.App.Sc. Further, a deficiency in our view is that diagnosis is taught almost entirely by chiropractors with no additional medical qualifications. We have no doubts that in the teaching of diagnosis at ICC particular emphasis is placed on identifying situations where the chiropractor should not treat (contra-indications)—this was emphasised to us several times—but we are still firmly of the view that it would be in the best interests of the college for medically qualified staff to be involved in this teaching.

43. Dr Kleynhans, in his evidence, spoke of the problem thus (Transcript, p. 3226):

The problem we have is to break down barriers that have been set up for many years. We would be very happy to employ immediately medical practitioners to teach in the department of diagnosis. We would be happy to appoint a medical physician as head of the department of diagnosis if it were not unethical in terms of AMA rules in Victoria for them to do so.

44. Having had discussions with officers of the Victorian Branch of the Australian Medical Association (though not on the specific point mentioned by Dr Kleynhans) we are not convinced that the association's ethical position is necessarily inflexible. The general attitude seems certainly more liberal and open-minded than the official medical attitude in New Zealand, and we do not overlook the fact that some very respected

members of the Victorian medical community have expressed themselves as not opposed to the greater use of chiropractic treatment.

45. The existing laboratory facilities range from very good (e.g., in chemistry and physics) to barely adequate (e.g., anatomy, pathology, chiropractic technique). We did, however, see partly completed facilities for human dissection and for the teaching of technique to large classes which indicated to us that the major deficiencies will shortly be overcome.

46. Generally the college must reach and maintain the standards laid down in the document *Accreditation Procedures and Standards for Chiropractic Education* published by the Australasian Council on Chiropractic Education, May 1978. This document is concerned particularly with administrative and management procedures and with general educational facilities. It was of interest to the Commission to read subsequently this council's report (dated November 1978) to the Chiropractic Board of New Zealand on an inspection of the ICC carried out at the board's request. We found this a most thorough report and generally concur with its findings bearing in mind, however, that there had been developments between the time of the council's report and the Commission's visit.

ATTITUDE OF NEW ZEALAND EDUCATORS

47. In view of the criticisms by the New Zealand medical witnesses of chiropractic education, especially the standards of teaching in diagnosis, it seemed to us that we should explore the possibility that chiropractic students should receive an element of formal medical education from one of the New Zealand medical schools as part of the qualification for registration. We already had the submissions and evidence of Dr D. S. Cole, Dean of the University of Auckland Medical School, but Dr Cole did not appear to have directed his mind to this particular question. We invited, and received, further comment from Dr Cole, the Medical Association, the Society of Physiotherapists, the Chiropractors' Association, and the Department of Health.

48. It appeared to us that there was at least the possibility that any deficiencies found to exist in chiropractic education could be remedied by a prospective chiropractor attending medical school for training in some areas common to both the medical and chiropractic courses either (a) before attending a chiropractic college (in which event he might expect to receive some cross-credits, thus shortening the period he would be required to remain overseas), or (b) by attending medical school on his return as a chiropractic graduate.

49. The first alternative was rejected by the Chiropractors' Association on the ground that, though clearly advantageous, it was impractical. The association told us this:

Further education of chiropractors in anatomy, neurology, physiology and pathology would necessarily be at undergraduate level prior to entering chiropractic college. The Association recognises that there could be clear benefits in the teaching of these basic sciences in New Zealand including control of curriculum, savings of cost to students, and, on the supposition made, an improved education in vital areas of curriculum. However, the Association also recognises that, before any such programme could commence, considerable disadvantages and practical difficulties would have to be overcome. It is well recognised throughout the health professions today that there is a need to introduce the student to clinical practice from the commencement of his studies in order that he may relate his study to its practical significance and in order that his motivation for his chosen career is not lost. It would be essential that students attending a basic science course such as is under consideration, be it for one year or two, have the opportunity to receive some introduction to chiropractic and some tuition in palpation and adjustment techniques. This would require suitably qualified academic staff and appropriate facilities, and the provision of these raises practical difficulties given the extremely small number of New Zealand chiropractic students.

50. We accept that objection. Agreeing as we do that the training of a chiropractor must throughout include a practical element which can be expected to confer on the graduate chiropractor the necessary degree of skill in diagnosing and correcting spinal dysfunction, it is quite clear that such a practical element could not be introduced into any New Zealand undergraduate "pre-chiropractic" course. There is not the manpower. However, we do not lose sight of the great advantages to a chiropractic trainee of existing New Zealand university medical science subjects (such as physiology and biochemistry) which are not restricted to medical students.

51. But Dr Cole, the Medical Association, the Physiotherapists' Society, and the Department of Health objected to any such ideas on quite different grounds. We mention their objections because their nature is important.

52. The Medical Association, through Dr J. S. Boyd-Wilson, wrote as follows:

In the final analysis . . . we have serious doubts as to the value of the teaching of neurology and basic science subjects to the chiropractic students at Medical Schools so long as the clinical training of those students takes place at a chiropractic college against a background of belief in the chiropractic subluxation. We see the result as leading to confusion and conflict between the orthodox and the unorthodox teachings. It is inevitable that the clinical and philosophical training of students at chiropractic colleges would be directed towards requiring those students to reject the orthodox beliefs acquired by them at Medical School.

53. The Physiotherapists' Society in its comment drew particular attention to what its members saw as the need to upgrade New Zealand education in physiotherapy and manual therapy, and we have dealt with this important topic already. On the question of some degree of medically oriented training for prospective chiropractors the society said this:

Nothing in this Inquiry to date [November 1978] has caused the New Zealand Society of Physiotherapists to change its view that, chiropractic and medicine depend upon entirely different ideas concerning the causation and treatment of *disease*. Physiotherapists are already trained in methods consonant with medicine; as partners in their subscription to the ethics of science they co-exist. However *sincere* may be the chiropractor, his refusal to conform to *science* (not medicine) makes co-operative educational programs an Utopian aspiration. The basic tenets of chiropractic education remain questionable and thus, regardless of the quality of that education, it is the 'fundamentals' of chiropractic that cannot be overlooked, however conveniently harmonious an answer this might appear to be.

The manipulative sciences are young and at this formative stage there is no room for doctrinal teachings in accordance with any one philosophy of spinal manipulative therapy.

54. The Department of Health provided the following comment:

In our view, it would not be practicable to graft . . . elements of medical education on to existing chiropractic education . . . The differences in philosophy and practice as understood by graduate medical practitioners and graduate chiropractors respectively are so fundamental that any additional education for graduate chiropractors would have to be given at a non-medical institution. In our opinion, there is no way of combining the two in any meaningful manner. We therefore return full circle to the fundamental impediment to any true dialogue or co-operation between chiropractors and practitioners of orthodox medicine—namely, the philosophy of chiropractic set against the science of medicine. As long as chiropractors claim to offer an alternative health care service, we believe that the Government should *not* facilitate the provision of educational facilities for chiropractors. The result could be most confusing and it could be expected that there would be implications in respect of other alternative health care providers.

55. The Department of Health's comment conveniently sums up those of the Medical Association and the Society of Physiotherapists. The crux is what is seen as the difference between medical and chiropractic "philosophy"; the alleged refusal by chiropractors to conform to science.

56. We have already made it clear elsewhere in this report that the Commission cannot accept this reasoning. However apt such an argument may have been in the past, it is difficult to apply it realistically in the present day. Alleged difference in "philosophy" is in reality a red herring. The real difference between medical practitioners and physiotherapists on the one hand and chiropractors on the other is that the former will not accept that spinal manual therapy can bring about the results which even moderate chiropractors claim. The difference is not one of philosophy at all. It is a difference of opinion about the results that may follow from a particular form of treatment.

57. We have left Dr Cole to the last. His attitude, speaking as a medical educator, was rather different. It emerged very clearly during his cross-examination. He was asked whether, as a teacher, he would be prepared to participate in the medical education of chiropractors. The following passages (Transcript, pp. 2833-4) are significant:

Q: . . . I would ask you whether you would be prepared to teach them if it was a requirement that they do for example a year in a hospital studying, taking in this very essential which you say is wrongly absent. You are telling us you would not be prepared to teach them.

A: No, I would not be prepared to teach them because of the basis of their belief and I come back to that time and time again.

Q: You say because they don't agree with your belief you are going to see that they don't get the training in this country, the lack of which you complained about?

A: Mr Craddock, teaching clinical students involves teaching them on patients and I am talking about the clinical side. No clinical teacher will take a student and teach him on a patient if he does not believe that that student is on the same wave length, to put it commonly, in terms of his background to medicine. You cannot ask—You might equally ask a Church of England clergyman to teach a black magic man counselling. He won't do it if they have different beliefs. We are not just teaching on objects on solutions, possibilities, we are teaching on patients for whom we are accepting responsibility.

Q: And you are going to say, 'Very well, if the chiropractic profession continues to function in this country as a primary health service, in the interests of the patient—which is your criterion—you are going to see that they don't get access to hospitals'.

A: In the interest of their patient we are going to fail to teach them ourselves in hospitals. If they can get into hospitals in other ways that is their problem but they will not get into hospitals to be taught by medical practitioners in my view.

58. As we listened to these answers, given under the stress of cross-examination, they seemed inconsistent with what might normally be regarded as the duties and functions of a university teacher. It occurred to us that Dr Cole might wish to have an opportunity to reconsider the views he was expressing. He later, at the Commission's invitation, supplied us with his considered memorandum on the question of medical education for chiropractors or prospective chiropractors. It contained much information for which the Commission is grateful. The following extract conveys Dr Cole's considered views on the topic he was asked about under cross-examination:

. . . the clinical teaching of chiropractic students hinges on the willingness of medical practitioners to do this teaching.

It is my opinion, based on discussion with colleagues, that no medical practitioner in his public capacity either in a hospital or university will be willing to teach clinical medicine to chiropractic students or postgraduates except as bona fide medical students.

I believe there is ample evidence from the medical submissions why this is so.

For myself, I have under cross-examination on 16 November, made it clear that it hinges on:

- (a) No teacher in a professional school will be willing to teach his subject, involving the use of patients under his care, to a group of students who have not been prepared adequately for this teaching. In this respect the preparation has two aspects
 - (i) The adequacy of the scientific factual content of basic sciences.
 - (ii) The basic beliefs as to causation of disease, physiological mechanisms and the accepted pharmacological background for therapy.

While (i) may be satisfied by some chiropractic course, (ii) is not. Everything I understand (and the Commission has been informed at length on this), everything suggests this preparation is inconsistent with orthodox clinical teaching.

- (b) It must be re-stated that clinical teaching in vocational courses differs very significantly from other university courses . . . The main reason is that, not only must there be a commonality of basic belief by the teacher and pupil, but the third person, the patient, is in a position of trust with the teacher (Doctor) and the pupil must do nothing to endanger that trust.

It is my view that to teach students from an unorthodox section of the health group would breach that principle.

59. It is clear to the Commission that the outlook which Dr Cole so clearly expresses is based on a misunderstanding of the real differences between the medical and chiropractic professions. The Commission has already canvassed that question, and there is no need to repeat our findings on it. Suffice it to say at this point that current chiropractic education does not reject "basic [medical] beliefs as to causation of disease, physiological mechanisms and the accepted pharmacological background for therapy". What it does is to emphasise the role of biomechanics as an additional cause of disease and the correction of mechanical defects by manual therapy—this is where chiropractors part company with orthodox medicine. But the fact that chiropractors are not trained to administer drugs and discourage their use if at all possible should not be taken as indicating that they reject *in toto* drug therapy and the chemical explanations for drug action.

60. But even if it were to be assumed that everything Dr Cole said about those differences was right, the Commission would find it impossible to accept Dr Cole's approach.

61. The Commission sees the need to say this: if a prospective medical student satisfies university requirements (which may include a personal interview) and is admitted to the course, it is the obligation of the university to teach that student. It should be of no concern to the teacher or to the university that the student may hold beliefs the teacher does not share, or may intend to make use of his training in a manner of which the teacher disapproves. The contrary view is entirely inconsistent with the basic purpose and functions of a university.

62. The Commission is not satisfied that clinical teaching should be exempt from this rule. Naturally a student engaged in clinical training must be expected to accept the conventions which necessarily apply in such a situation. But to say that a student cannot have clinical training as part of a university course because he has beliefs which the teacher does not share, is in the Commission's view to state a proposition which is completely untenable.

63. The Commission repeats that it cannot accept that the university medical degrees and courses are to be considered as somehow exempt from the basic and fundamental academic conventions which apply in all other areas of the university community, and which mean that a student who is academically capable is freely accepted into the community regardless of his personal philosophy and beliefs.

TRAINING FOR WHAT?

64. In the course of their comments on the possibility of some medical education for chiropractors in New Zealand the Department of Health stated that "What is at issue is not so much the standard of chiropractic education, and the remedying of any deficiencies, as the use to which that education is put". We agree that this is an important point. We have dealt

with current educational standards and we are satisfied that the academic standards set by the American CCE (which are also the standards of the Australasian CCE and the Canadian CCE) are good. If we accept that what chiropractors are taught is of an acceptable standard we must then consider whether the material covered is appropriate and sufficient to fit them for their current role of primary contact health practitioners.

65. The requirements for this primary role may be very simply stated and they are two-fold:

1. The chiropractor must be fully competent and equipped to make his biomechanical examination and to administer his manual therapy.
2. He must be able to identify conditions which lie outside his scope of treatment and/or which contra-indicate manual therapy.

66. To satisfy the first requirement he must have intensive training in manual techniques based on a sound knowledge of human anatomy, with special emphasis on musculo-skeletal aspects. He must have a good general knowledge of human physiology and training in radiography. To satisfy the second requirement he must have a good general knowledge of human pathology and of visceral disorders and should be familiar with and be able to carry out the most frequently used basic medical tests of the type which may be performed in a general medical practitioner's surgery. He must thus be taught how to make a preliminary medical diagnosis. Only if he has this training should he be permitted to function as a practitioner of primary contact.

67. We therefore see the kind of basic medical training provided in CCE colleges (more than half the total course) as essential. We are satisfied that it is adequate for the purpose but are in no doubt, as we have suggested elsewhere, that it would be very usefully consolidated if chiropractors could have access to hospital wards.

Possible Extension of Scope of Practice

68. Most New Zealand chiropractors, appear to limit themselves to manual therapy of the spine and its immediate articulations. So their scope of practice is rather more restricted than that of many of their North American counterparts and this almost certainly is a reflection of their traditional Palmer College background. The main additional areas where American chiropractors operate are:

- Extremity joints and associated structures;
- Physiotherapeutics; and
- Nutritional counselling.

69. National College and Los Angeles College have long given emphasis to these topics and we have no doubt that their graduates are competent in them. Canadian Memorial College gives due attention to extremity joints and to nutrition, but places less emphasis on physiotherapeutics (called auxiliary therapy) than does National. Palmer does not teach physiotherapeutics other than as an elective and still gives less attention to the extremities and to nutrition than the other CCE colleges or Canadian Memorial.

70. The situation at the International College in Melbourne is what interests us most. Here there is no teaching in physiotherapeutics, probably for political reasons. However, extremity joint techniques and nutrition appear to be given due attention, more than at Palmer and somewhat as at National.

71. The question arises as to what use the New Zealand chiropractor should be entitled to make of the training he has received in topics other than spinal manual therapy. It seems to us that the three areas we have mentioned represent a natural extension of the chiropractor's drugless, non-surgical practice and that if he has been adequately trained it is in the public interest that he should be allowed to practise. It is our view that current courses at the American CCE colleges, at Canadian Memorial, and at International College, Melbourne, adequately equip their graduates to treat extremity joints and associated structures by manual therapy and to offer basic nutritional and dietetic counselling (at least at the level of a general medical practitioner). We make this point because during the inquiry it was suggested that New Zealand chiropractors go beyond their area of competence when they manipulate extremity joints and when they offer dietetic advice. The older Palmer graduates may not have been taught adequately in these areas and would probably have no desire to move into them. We believe however that these deficiencies have now been made good, and that it is quite proper for a recently graduated chiropractor to manipulate extremity joints and to offer basic dietetic advice.

72. The matter of physiotherapeutic treatment could become of greater substance. It is not at present an issue in New Zealand because New Zealand licensed chiropractors (with possibly two exceptions) have received no training in these methods and we have no evidence that they wish to become involved. It could become an issue if chiropractors who have received training in physiotherapeutic procedures apply for licenses. They may wish to function as do many of their North American colleagues—as chiropractors *and* physiotherapists. Our view is that this should not be encouraged, that it is better for the chiropractor and physiotherapist to co-operate rather than to compete (see chapter 26.) It is a matter which the Chiropractic Board will have to take into account when licensing such practitioners.

FUTURE OPTIONS FOR THE EDUCATION OF NEW ZEALAND CHIROPRACTORS

73. We consider the following possibilities:

- (1) Complete education in New Zealand.
- (2) Complete education in North America.
- (3) Complete education in Australia at Preston Institute of Technology.
- (4) Basic science and medicine in New Zealand followed by 2 to 3 years at either a North American chiropractic college or Preston Institute.
- (5) New Zealand medical degree followed by 1 year intensive course in manipulative therapy at a chiropractic college.

We also note, for the first four options, the possibility of supplementing the chiropractor's training in diagnosis with post-graduate access to New Zealand hospital wards by arrangement with the two medical schools.

(1) *Complete Education in New Zealand*

74. While this might be an ideal solution, the relatively small numbers of students (say up to 20 new entrants per year) would not be sufficient to make such a complete course economically or academically viable, even if associated with an existing tertiary institution, and even if the numbers doubled or trebled. We therefore reject this possibility.

(2) *Complete Education in North America*

75. If prospective New Zealand chiropractors wish, for personal reasons, to obtain their qualifications in North America they should not be discouraged from doing so but neither should they receive any financial support from the New Zealand taxpayer. It is our firm view, however, that only CCE approved colleges and Canadian Memorial should be recognised by the New Zealand Chiropractic Board.

76. It should be noted here that we feel that Anglo-European College in Bournemouth, while its aspirations are commendable, suffers from some severe deficiencies which were pointed out in the Webb report. These deficiencies appear to remain and until they are removed we feel that no new students from New Zealand should be given approval to train there. That is not to say, however, that British graduates of the College should not be eligible to apply for licences to practise in New Zealand.

(3) *Complete Education in Australia at Preston Institute*

77. Bearing in mind the high quality of the course, the fact that it is integrated with a recognised tertiary institution, and the general similarity of attitude to health care in Australia and New Zealand, we believe that the Preston Institute is the most appropriate place for intending New Zealand chiropractors to obtain a full training. We also feel there should be incentives and these we deal with at the end of this chapter.

(4) *Basic Science and Medicine in New Zealand Followed by Overseas Chiropractic Training*

78. While this option seems attractive on paper there are major organisational difficulties. We accept the view of the Chiropractors' Association that it would be important to include some chiropractic material in the first 2 years of the course and, in the present climate of mistrust between the medical and chiropractic professions, this would clearly be impossible. We therefore reject this as a possibility at least for the immediate future.

(5) *New Zealand Medical Degree Followed by Intensive Course in Manipulative Therapy*

79. We include this option because it appears to be the only route for a person who wishes to practise as a primary contact chiropractor and be accepted by the medical profession. Dr Haldeman, in the course of his evidence, said that 12 months' full-time training in spinal manipulative therapy following a medical degree would be appropriate. No such course appears to be offered by any chiropractic college and indeed, as Dr Haldeman indicated, there would be very little demand from physicians for it. This appears not to be a practical option.

RECOMMENDATION

80. We **recommend** that the New Zealand Chiropractic Board encourage New Zealand students to obtain their chiropractic education at the International College of Chiropractic at the Preston Institute of Technology, Melbourne. Furthermore, in recognition of the fact that no Government subsidised training is available in New Zealand, we recommend that a system of bursaries should be established, to be administered by the Department of Health or Department of Education,

to provide support for New Zealand chiropractic students at the Preston Institute. (The analogy is with the former veterinary bursary scheme operated at a time when veterinary training was not offered in New Zealand.) Such chiropractic bursaries should be tenable only at the Preston Institute. The scheme should be conditional upon full accreditation of the proposed B.App.Sc. (Chiropractic) degree by the Victorian Institute of Colleges and subsequently by the Australian Tertiary Education Commission.

Chapter 39. CHIROPRACTIC PHILOSOPHY AND LIMITS TO PRACTICE

PHILOSOPHY

1. In the criticisms of chiropractic on the grounds of its inadequate scientific base (chapter 37), and in the criticisms of chiropractic education (chapter 38), there was frequent reference to "chiropractic philosophy". We believe that many of the critics who have given evidence have been unclear in their distinction between "philosophy" and principles or theory. That is not entirely their fault. The chiropractors themselves very often appear to be unclear both in their writings and, in the case of those who gave evidence, in their oral explanations. Because "chiropractic philosophy", real or imagined, has been such a stumbling block to inter-professional co-operation, we deal with it now in the light of our previous consideration of chiropractic science and education.

2. The original chiropractic philosophy can be summarised in the words of D. D. Palmer himself (*The Science, Art and Philosophy of Chiropractic*, 1910):

The amount of nerve tension determines health or disease. In health there is normal tension, known as tone, the normal activity, strength and excitability of the various organs and functions as observed in a state of health. The kind of disease depends upon what nerves are too tense or too slack.

Functions performed in a normal manner and amount result in health. Diseases are conditions resulting from either an excess or deficiency of functioning.

The dualistic system—spirit and body—united by intellectual life—the soul—is the basis of this science of biology, and nerve tension is the basis of functional activity in health and disease.

Spirit soul and body compose the being, the source of mentality, Innate and Educated, two mentalities, look after the welfare of the body physically and its surrounding environments.

Chiropractors correct abnormalities of the intellect as well as those of the body.

3. B. J. Palmer further stressed the idea of "Innate Intelligence" and the idea of disease resulting from impairment of its flow from the brain through the nervous system.

4. These ideas first formulated 80 years ago have of course been greatly modified, some indeed completely discarded. We do not understand them to be taught now except out of historical interest at any of the chiropractic colleges likely to produce New Zealand practitioners of the future. A. E. Homewood in his book *The Neurodynamics of the Vertebral Subluxation* (2nd ed., p. 80) written in 1962 made the following comments on D. D. Palmer's concept of Innate Intelligence:

Many ingenious approaches to the health problems have been thought out carefully, but none seems to be as all-encompassing as the teachings of D. D. Palmer. The chiropractor needs to experience no twinge of inferiority as he views the mottled array of theories. The founder of the science of chiropractic appreciated the working of Universal Intelligence (God); the function of Innate Intelligence (Soul, Spirit or Spark of Life) within each, which he recognized as a minute segment of Universal; and the fundamental causes of interference to the planned expression of that Innate Intelligence in the form of Mental, Chemical and/or Mechanical Stresses, which create the structural distortions that interfere with nerve supply and thereby result in altered function to the point of demonstrable cellular changes, known as pathology.

5. These were quoted in the Medical Association's principal submission (Submission 26, pp. 3-4) and were used, understandably, to derogate

chiropractic in the 1968 Cohen Report to the United States Congress, *Independent Practitioners Under Medicare*, pp. 152-4. While in the later edition of his book Homewood points out that the Cohen committee used his words out of context, and that they were later more fully explained, he did not retract them (see 3rd ed., pp. 88-89). Homewood's words do strike us as verging on the irrational and we were concerned that his book was on the list of those used at some of the chiropractic colleges we visited. In no case, however, did we find it to be anything more than one of a number of possible references and invariably we found that present teachers had strong reservations about parts of the book. Certainly we do not accept the passage we have quoted from Homewood as representing the official view of these colleges and we found the reservations expressed by Dr Haldeman (Transcript, p. 3394) about Homewood's status as a chiropractic theorist to be representative of the views of the chiropractic educators we met.

6. In its section headed "Chiropractic Philosophy" the 1978-79 Palmer College Bulletin makes reference to "innate intelligence" and we have already expressed (chapter 38) our reservations about that part of the Palmer tradition. However, most of that section of the bulletin deals with the various hypotheses which are proposed to explain the influence of mechanical dysfunction on various body systems via the nervous system—this is scarcely philosophy. We find on page 25 of the bulletin under "Chiropractic Defined" a statement which we regard more strictly as an expression of a distinctive philosophy.

Chiropractic is that science and art which utilises the inherent recuperative powers of the body and deals with the relationship between the nervous system and the spinal column, including its immediate articulations, and the role of this relationship in the restoration and maintenance of health.

7. In this statement we see a clear distinction being drawn between chiropractic on the one hand and allopathic medicine on the other. The essence of allopathy is the determination of the pathological state and the choice of some kind of intervention—usually chemical—to oppose that state. We see nothing objectionable or irrational in the distinctive chiropractic philosophy expressed in this way so long as chiropractors recognise the clear limits of their approach and we believe the great majority of them in New Zealand do.

8. While the chiropractor uses exclusively a modality which the medical practitioner normally does not use, it is not so much this modality which makes chiropractic distinctive from medicine as a health care system but rather its emphasis on the use of the inherent recuperative powers of the body. This emphasis we see as the essence of chiropractic philosophy:

LIMITS TO PRACTICE

9. As with the question of "chiropractic philosophy", the "limits to practice" of chiropractors have been a constant bone of contention between chiropractic and the other health professions. Many medical practitioners grudgingly concede that chiropractors, through spinal manual therapy, may provide effective relief for back pain sufferers. "The trouble is", they say, "the chiropractor doesn't know where to draw the line and will treat conditions which don't exist or which are outside his area of competence".

10. The Chiropractors Act 1960 is of little help here. All it states is what a chiropractor does, not what he may treat. It is very understandable that the medical profession in particular is anxious to know what, if any, are the limits the chiropractor imposes on himself in this respect. It is also a

matter of vital public interest. Both the Department of Health and the Medical Association expressed grave concern at this lack of definition and the principal witness for the Chiropractors' Association was cross-examined at length on the subject. No really satisfactory answers emerged. This is not surprising for the profession as a whole has been very reluctant to address itself to this problem.

11. Dr Haldeman, in an article quite critical of the chiropractic profession (*Journal of Canadian Chiropractic Association*, October 1976, p. 7), states that "Despite the numerous attempts to define chiropractic and the scope of practice there is as yet no international definition which is ascribed to by all chiropractors".

12. The Canadian Chiropractic Association appears to have addressed itself more seriously to the scope of practice problem than its United States counterparts and does indeed have a policy statement as reproduced by H. J. Vear (*Journal of Canadian Chiropractic Association*, March 1977):

"Practice of Chiropractic" means any professional service usually performed by a chiropractor, the aim of which is to restore and maintain health and includes:

- (i) The diagnostics, treatment and prophylaxis of functional disturbances, pathomechanical states, pain syndromes and neurophysiological effects related to the statics and dynamics of the locomotor system, more particularly the spine and pelvis.
- (ii) The treatment thereof by adjustment and/or manipulation of the spine (and other anatomical structures).
- (iii) The use of X-ray for diagnostic purposes.

13. The Chiropractors' Association's principal witness accepted (*Transcript*, pp. 698-9) statements (i) entirely, (ii) with the exception of the words in parenthesis, and (iii) with some qualifications.

14. These statements, however, are inclusive—there is nothing to indicate any limitation in terms of the nature of the condition presented. This is a matter the chiropractic profession has chosen to run away from and the New Zealand chiropractors in particular must face up to it in the interests of the profession and of the public.

15. A brief statement which was used in a Canadian chiropractic publicity film, *The Chiropractors*, appealed to us as a very useful basis for an acceptable, simple statement on scope of practice. It was that "chiropractic is concerned with the remedying of biomechanical derangements and their consequences".

PART VI: CHIROPRACTIC AND THE GENERAL HEALTH TEAM

Chapter 40. THE HEALTH DEPARTMENT SUBMISSION

INTRODUCTORY

1. The Department of Health provided us with a background paper (Submission 3), formal submissions (Submission 41), and a final statement (Submission 133). The Commission is grateful indeed for the willing and courteous assistance offered to it by the department at various stages of the inquiry. We hope we will not appear ungracious when we say that in its formal submissions and statements to us the department appeared to have been considerably influenced by the views of the medical establishment—perhaps understandably, because it is to the medical establishment that one would usually turn for advice about matters of public health. In the proceedings before this Commission, however, the degree of expertise ordinarily to be attributed to the medical establishment has been limited by its general ignorance of chiropractic, and the department's papers would therefore have been of greater assistance to us if they had demonstrated a rather more independent stance.

2. In this respect we wish to comment on the different attitude demonstrated by senior officials of the United Kingdom Ministry of Health and Social Security whom we met while we were in London. For reasons mentioned elsewhere in this report the position regarding chiropractic in the United Kingdom is distinguishable from the position in this country; but the attitude of the ministry officials who were in the process of examining how chiropractic services might develop in the United Kingdom in the context of a general health service structure, was one of scrupulous fairness and open-mindedness. It was plain to us that they had gone to considerable trouble to inform themselves about chiropractic as it is presently practised, and were prepared to weigh up with some sympathy and understanding both its good and its bad points. We found our meeting with the ministry officials (Mr A. G. Saville and Dr T. W. Modle) constructive and helpful. We wish to record our appreciation of their courtesy in arranging to spend some time with us.

3. Because our own Department of Health's attitude was largely based on that of the New Zealand medical establishment, we do not need to canvass at any length the department's objections to chiropractors except to the extent that is required to enable us to deal with the department's important suggestion that health care should ideally be a matter of teamwork.

4. But before we do this we should mention one point raised by the department. We mention it so that there can be no misunderstanding about the Commission's position or its proper function.

5. In its final statement, presented to us by the Director-General of Health in person, we were told (Submission 133, p. 4) that the department remained:

... opposed to the proposal that Government funds should be utilised to subsidise chiropractic services, and that it would be obliged to advise the Minister of Health to take a similar stand should such a recommendation be made.

6. The Commission must disregard this comment. The Commission, having been set up to make an impartial inquiry into the question whether chiropractic treatment should be subsidised from public funds, cannot allow itself to be influenced by the department's premature statement on what it will recommend on that very question. The Commission has had very much wider opportunities to investigate the matter from an independent standpoint.

7. With that preface we now deal with the important issue of the chiropractor's place in the health care team.

THE HEALTH CARE TEAM

The Department's Views

8. We begin by setting out in the department's own words its views on chiropractors in the context of a general health care team.

9. The department introduced the topic by stating in its first formal submission to us (Submission 41, p. 1):

... the department, as guardian of the standards of health care provided to the community, would not wish to oppose the development of any additional health service which was of proven benefit to the public and which could be combined satisfactorily with the services provided by medical and other health professionals within the New Zealand system of comprehensive health care.

10. It then went on to say (*ibid.*, pp. 11-12):

Reference has already been made to the *comprehensive* care which a good primary health care service should provide, and to the inter-relating system of health care delivery made possible by medical practitioners and other health professionals working in association. As the department's background paper explained, "There are limitations on the work of each profession whether by specific legal restraint or by an ethical code of conduct and, in practice, each profession recognises its limitation and refers patients to other professions as required. Working together in this way, the various health professions can each contribute their specialised knowledge and experience as part of the health team. The beneficiary of this pattern of service is, of course, the patient"

11. The Commission readily accepts this statement as expressing the ideals of general health care teamwork. We see no good reason why the chiropractic profession cannot be incorporated into such a concept of a general health care team, and we consider it in the public interest that this be accomplished.

Suggested Obstacles to Chiropractors Becoming Health Team Members

12. Nevertheless the Department of Health argued that there were obstacles to chiropractors becoming part of the general health care team. In dealing with this aspect we first set out the department's views as presented to us and then state our own findings.

(a) *Chiropractors Must Cease Being "Separate and Distinct"*

13. In its final submission the department said (Submission 133, p. 10):

In brief, the department believes that if chiropractic is considered to be a valid healing art it should ideally be provided not as a "separate and distinct" system of health care but

as an integral component of the existing pattern of health services. Chiropractors are not able to provide a comprehensive service, or an alternative equivalent in scope or quality to that provided by the medical profession. In the view of the department, the overall benefit to patients would be increased if chiropractors were to abandon their "separate and distinct" stance and come to an accommodation which would enable their specialised manipulative skills and their humane approach to patients to be made available by them as members of the health team, and on the basis of medical referral. Herein lies the essential dilemma for the chiropractors. For such a development requires the giving up of chiropractic philosophy and of chiropractors' claims to status as primary health physicians. In the light of the considerable, and growing, similarities which appear to exist between responsible chiropractors and medical practitioners in respect of patient care, we do not believe that an accommodation as described above should be impossibly hard for chiropractors to accept.

14. We find ourselves unable to accept this reasoning. It is based on two persistent misconceptions: first, of chiropractors as providers of a separate, distinct, and comprehensive system of health care, and secondly, of the medical profession as generally qualified to assess when the kind of treatment in which a chiropractor specialises is indicated.

15. In spite of the statement in the Chiropractors' Association's principal submission (Submission 19, p. 6), chiropractors cannot hold themselves out as providing a separate, distinct, and comprehensive system of health care: see chapter 12. They acknowledge the multifactorial causation of disease. They rely on their special expertise in a field generally neglected by medicine, and their view is that unless patients have direct access to chiropractors those patients would be denied relief which chiropractic treatment can give. That seems to us to be a compelling argument, in the public interest, for allowing chiropractors to retain their position as primary contact practitioners.

16. The Commission is therefore of opinion that the department's views on this point are misconceived, and that chiropractors should remain primary contact practitioners. We add that there is no obstacle, nor has there ever been any, to medical practitioners taking proper steps to inform themselves of the benefits of spinal manual therapy, and learning about the way in which chiropractors administer it. Their neglect and ignorance of an important area of health care are surprising.

(b) *Chiropractic Care is Incomplete*

17. In its first formal submission to us the Department of Health said this (Submission 41, p. 12):

... The Department of Health would not be able to view chiropractic as a comprehensive alternative health care system. Limitations on the ability of chiropractors to diagnose and treat the wide range of modern illnesses and disease, the absence of a working partnership with medical and other health professionals whose combined skills and experience are so important for patient care, and the lack of legal access to certain medicines which may, in some cases, be essential to the patient—these and other deficiencies point to the fact that the health care provided by chiropractors must necessarily be incomplete. If it should be accepted by the Commission that chiropractic is a separate and distinct healing art, the reality is that as long as it continues to be practised in a way which deprives the patient of the full range of facilities provided by medical science and the separate contributions which the various members of the health care team are qualified to make, it can only be a limited art. Incomplete care must always be to the disadvantage of those the health care system is intended to help.

18. We dismiss this argument as well. Chiropractors do not hold themselves out as providing a "comprehensive alternative health care system". They do not deprive patients of the full range of facilities provided by medical science, because they are trained to direct patients who require other than purely chiropractic treatment to the proper quarter so that they can receive such other treatment.

(c) *Difficulties in the Relationship Between Chiropractors and the Medical Profession.*

19. In its final submission (Submission 133, p. 11) the department stated:

The department considers the continuing hostility between orthodox medicine and chiropractors to be most unfortunate, but also inevitable. It does not however believe that the blame can be laid at the door of the medical professionals. While it can be admitted that the medical profession has sometimes appeared slow in accepting new advances in health care, it is also necessary to emphasise that orthodox medicine, with its serious responsibility for patient safety, has always needed to await sufficient evidence of the advantage, or balance of advantage, of new developments before adopting them.

20. We agree that any "hostility" that exists is unfortunate. We do not agree that it is inevitable. Nor do we accept that it exists to any really significant degree outside what we venture to describe as those active in medical politics. We consider that the department, in its description of the medical profession's attitude, overstates the matter.

21. In our opinion the medical "political" attitude to chiropractors, which some doctors and others have tended to accept uncritically, is based on misinformation and ignorance. We are satisfied that some ordinary general practitioners already recognise the benefits of spinal manual therapy. They have seen for themselves what chiropractors can accomplish, and regard those chiropractors as skilled practitioners in the art.

22. The Commission considers, in the light of the evidence it has received, that the suggestion that the medical profession, "with its serious responsibility for patient safety, has always needed to await sufficient evidence of the advantage . . . of new developments before adopting them" is, in this instance, no more than an attempt to rationalise organised medicine's inactivity and lack of interest in this area. The position is that the medical establishment has never taken spinal manual therapy seriously. We have dealt elsewhere with the evidence for the effectiveness of spinal manual therapy: see chapter 37. In the face of that evidence it is unreasonable for the medical establishment to maintain its attitude of hostility towards chiropractors.

Chiropractors as Members of the Health Care Team

23. It is now convenient to return to the two principal qualifications which the department suggests should be possessed by a prospective entrant to the health care team (see para. 9):

- (1) The additional health service should be of "proven benefit to the public";
- (2) It should be capable of being "combined satisfactorily with the services provided by medical and other health professionals within the New Zealand system of comprehensive health care".

The analysis is very reasonable and the Commission agrees with it.

24. We see no reason in principle why chiropractors should not be regarded as qualifying under both these heads.

25. In the first place we consider, for reasons already discussed at length in this report, that spinal manual therapy as practised by chiropractors is of "proven benefit to the public". That does not mean that we accept all that some chiropractors have claimed for spinal manual therapy. But we consider it now beyond argument that spinal manual

therapy is an effective and beneficial form of treatment for many Type M disorders. The question of scientific explanation for its effectiveness in these and other disorders is another matter, already dealt with. We do not believe that lack of scientific explanation is any more than an excuse put forward by those looking for reasons to justify not recognising chiropractic.

26. In the second place there is nothing in principle to prevent the chiropractor's skilled spinal manual therapy being combined satisfactorily with the services provided by other New Zealand health professionals, and every reason why that combination should be encouraged. Indeed the Commission's view is that the chiropractor's training and skill ought to be used as a part of the general system of health care as a matter of important public interest, and that the practice of spinal manual therapy by other health professionals, including doctors, who have no adequate training in the art should be actively discouraged. We have already noted elsewhere that it would take at least a year's full-time training to bring a fully qualified medical practitioner up to the standard of a qualified chiropractor in spinal manual therapy. This may be bitter medicine, but it must be accepted.

27. The true—as distinct from the imagined—obstacles to the incorporation of chiropractors into the health team are, first, the medical establishment's refusal to accept them, and secondly the unprofessional activities and claims of some chiropractors. It is clear that the chiropractors must act decisively to impose proper ethical and professional standards on those guilty of unacceptable conduct, and we suggest (chapter 43) means by which they should be helped to do this. Once the few maverick chiropractors have been brought under control, there can be no rational ground for any medical opposition to the inclusion of the chiropractic profession in the general health team.

28. Having written the above we were encouraged to find that during a debate in the House of Lords (*Hansard*, 370/72, 12 May 1976), Lord Winstanley, a medical practitioner in a group general practice in an urban and mining area in the industrial north of England, had put forward views which are much the same as those we have endeavoured to express. The House was debating the means by which chiropractors and osteopaths should be encouraged to apply for registration under the United Kingdom Professions Supplementary to Medicine Act 1960. Lord Winstanley pointed out (*ibid.*, col. 1030) that every day in his practice he was conscious of the fact that the work he was doing could very often be done better by someone else, and he mentioned back pain in particular (*ibid.*, col. 1031):

It is a subject which we understand very little about. . . . But the fact remains that there is a great deal of it; and the fact also remains that it is utterly clear—and I cannot always understand why—that many so-called osteopaths or chiropractors (call them what you will) very often deal with this effectively when I cannot deal with it at all. If this is a fact, if it is established that these practitioners are able to give relief to patients suffering in this kind of way, then surely we must take some kind of step to see they are enabled to give that relief within the orbit of the National Health Services, and to give it free.

Lord Winstanley pointed to the need to ensure that such practitioners were properly trained so that they could practise safely, and continued (*ibid.*, col. 1032):

All I want to do is to make it clear that I believe the bulk of my profession would now approach this subject with a much more flexible, a much more liberal, attitude than they might have done in the past; and I hope that in the future we will have the open-door kind of policy . . .

29. Our inquiries in Great Britain indicated that there could be some sympathy among the general medical profession with Lord Winstanley's views. That may explain why chiropractors seem to have attracted some sympathy and interest in the Ministry of Health and Social Security. What we have learned simply confirms our clear opinion that chiropractors must become accepted as members of the New Zealand general health care team.

30. The Department of Health has a public duty to assist in this process. The interests of public health cannot be allowed to be hindered by the untounded obstruction of organised medicine in New Zealand. In particular the Department of Health ought not to allow it to be suggested that it could be a party to any such obstruction.

CONCLUSIONS

31. The Commission accepts the Department of Health's concept of a general health care team, and the ideal of full co-operation between members of that team. Once the chiropractic profession has established firm discipline over those of its members who tend to act unprofessionally, there can be no reason why chiropractors should not be accepted as members of that team. It is in the public interest that this acceptance be encouraged, and that the Department of Health play an active role in this development.

32. There can be no question of chiropractors being limited in their right to practise as primary contact practitioners.

Chapter 41. CHIROPRACTIC AND MEDICAL ETHICS

INTRODUCTORY

1. One of the complaints about chiropractors is that they practise in isolation from other health services. That is largely true, although it is clear that New Zealand chiropractors do not hesitate, where necessary, to send patients to medical practitioners.

2. The complaint about isolation comes from the New Zealand medical profession. This is surprising. For it is the New Zealand medical profession itself which in this country has brought about that state of isolation by a deliberate policy of ostracism of chiropractors. It was made clear to us throughout our sittings that the policy would be continued. The organised medical profession saw no reason to alter its policy of ostracism.

3. This policy is put into operation in a most effective way. The medical profession naturally has no control over chiropractors. But it does have control over its own members, and by a powerful weapon. By the use of its disciplinary powers it is able, in bad cases, to deprive a medical practitioner of his qualification and his livelihood. It controls its own code of ethics. A breach of the ethical code—which does not necessarily have anything to do with a breach of the general law—can be and is punished. To a medical practitioner it is a professional disgrace to be found guilty of a breach of the ethical code.

THE ETHICAL RULING

4. The present ethical ruling applicable to New Zealand medical practitioners appeared for the first time in the 1978/1979 *New Zealand Medical Association Annual Handbook* (at p. 50). It reads:

It is unethical for a doctor to refer a patient to a chiropractor for treatment.

THE EARLIER POSITION

5. It is of interest to consider what the position was before the above ruling was first published in 1978. We will work backwards.

6. In 1974 the Accident Compensation Commission ruled that it would pay the cost of chiropractic treatment of patients covered by the Accident Compensation Act, but only if such treatment were given on medical referral. The Chiropractors' Association inquired of the Medical Association under what circumstances such referrals would be made. The Medical Association's answer, dated 13 September 1974, was short and to the point. It said:

The MANZ advise the Chiropractors' Association that it is contrary to the ethical code of the Medical Association of N.Z. for medical practitioners to refer patients to chiropractors . . . and that the Chiropractors' Association also be advised that medical practitioners should not practice in collaboration with, or act as consultants for chiropractors.

7. Now it is quite clear that in 1974 there was nothing in the Medical Association's handbook about the matter. The principal Medical Association witness, Dr. J. S. Boyd-Wilson, told us so (Transcript, p. 1768). Where, then, was it stated in express terms that it was part of the

Medical Association's ethical code that doctors must not refer to chiropractors, act as consultants for chiropractors, or practice in collaboration with them? According to Dr Boyd-Wilson (Transcript, p. 1767) the ruling was not for many years in written form. He told us it was an unwritten ruling of very long standing in general terms that doctors should not deal with people who are not medically qualified (Transcript, pp. 1767, 1809, 1838). It follows, then, that when the Medical Association wrote to the Chiropractors' Association on 13 September 1974 the basis for its attitude could only have been what Dr Boyd-Wilson referred to as the unwritten rule of very long standing that doctors must not associate professionally with practitioners who are not medically qualified.

8. We are, with respect, unable to see how the Medical Association's interpretation of its "ethical code" in 1974 was justified. For, as we discovered when we consulted the General Medical Council and the British Medical Association during our visit to London, the "unwritten rule" has not been interpreted as precluding a doctor from referring a patient to a heterodox practitioner for treatment as long as the doctor is satisfied, in the individual case, that the practitioner is competent to carry out the treatment, and as long as the doctor retains ultimate responsibility for the patient's management: see General Medical Council's handbook *Professional Conduct and Discipline*, January 1979, pp. 9-10. A statement to this effect was first published in 1974, but we were told that it represented the common understanding of the medical profession for at least 40 or 50 years before that.

9. We refer to the ethical position in great Britain in greater detail at a later stage.

10. It is clear that medical referrals to physiotherapists, which no one has suggested could be regarded as unethical are, and have been, based on the principles we have just outlined.

11. It is also clear that the N.Z. Medical Association's express statement in its 1978/79 handbook must be seen as a significant change in the ethical code, because it expressly excludes chiropractors as practitioners to whom referrals may ethically be made. If it were not for that express ruling, it must be doubtful whether any disciplinary action could have been maintained against a doctor who, complying with the previous "unwritten rule", referred patients to a chiropractor. It is possible that the Medical Association, when it wrote to the Chiropractors' Association in 1974, misunderstood the ethical code. If this is so it is unfortunate, because it means that accident compensation patients who could legitimately have been referred for chiropractic treatment have had to pay for that treatment when the cost of it could have been met by the Accident Compensation Commission. At all events the Medical Association no doubt felt it was sensible to make the ethical position regarding chiropractors crystal clear by inserting an express new ruling in its 1978/1979 handbook before this Commission started its investigations.

THE PRESENT POSITION

12. It is worth repeating the Medical Association's 1978 ethical ruling:

It is unethical for a doctor to refer a patient to a chiropractor for treatment.

13. So the position we are faced with is that no medical practitioner, on pain of disciplinary proceedings, may in this country refer a patient to a chiropractor for treatment. He may not collaborate or associate with a chiropractor on a professional basis. No matter how convinced a doctor

may be that a particular patient will respond to chiropractic treatment, he may not refer that patient to a chiropractor. The collective wisdom of the medical profession prohibits him from doing so. That is ostracism of chiropractic by the organised medical profession. Not only that: each individual doctor is forced by professional ethics to ostracise chiropractic.

14. There are of course ways of evading the new rule. We are satisfied that many doctors in fact do so. They simply tell the patient that he ought to consider consulting a chiropractor and leave the rest to the patient. That is not a referral. It is of course a breach of the spirit of the rule.

15. But why should a doctor, whose experience tells him that chiropractic treatment is likely to give his patient relief, be forced to evade the rule? What justification is there for the rule? We heard a good deal of evidence from the Medical Association on this point. It seemed to us to amount less to a justification for the rule than an attempt to rationalise it.

16. It cannot be based solely on the proposition that chiropractors do not have a formal medical qualification. Physiotherapists are not medically qualified but it is recognised that a medical practitioner may refer a patient to a physiotherapist for treatment without any risk of being thought to be behaving unethically. So the lack of a chiropractor's medical qualification is not in itself a bar to collaboration. Nor is collaboration barred because chiropractic is not a regulated or recognised profession: as we have seen, chiropractic is in this country a regulated and legally recognised profession, and has been for 18 years.

17. The real basis for the operation of the rule as it affects chiropractors can therefore only lie in the fact that the organised medical profession regards chiropractors as health practitioners who are beyond the pale. The position is that the medical profession can decide for itself in terms of its disciplinary procedure which health services it is prepared to recognise and which it is not. So the fact that chiropractic has had the statutory status of a recognised health profession in this country for the past 18 years can be treated by the medical profession as completely irrelevant.

18. The position was explained to us by Sir Randal Elliott, the immediate past President of the New Zealand Medical Association. He put the matter in this way (Submission 109, p. 3):

An essential requirement for successful interprofessional referral is the acceptance both by the referring doctor, on the one hand, and the practitioner to whom the patient is referred, on the other, of the same professional tenets, the same philosophy, the same scientific infra-structure upon which to base their forms of practice.

And it was pointed out to us that if a patient were referred to a chiropractor, the chiropractor would no doubt take his own history, take his own radiographs, and make his own diagnosis. Very likely he would interpret his findings differently from those of the medical practitioner concerned; he might demonstrate to his own satisfaction that a subluxation was present at a level different from the originally diagnosed site of the disorder. Far from accepting the referring doctor's diagnosis, the chiropractor might well (it was said) take the decision to make the adjustment at a site different altogether from that intended by the referring physician.

19. "These", Sir Randal Elliott continued (Submission 109, p. 4)—are the considerations which make it impossible for scientifically-trained medical practitioners to refer patients to chiropractors in good faith, whether for separate or "concurrent" chiropractic treatment.

20. Now it seems to us that the reasoning lying behind that attitude is essentially this: that patients must be protected from the risks of treatment which is not regarded as acceptable by medical science generally. In a

case of that kind, so it is reasoned, the matter cannot safely be left to the judgment of the individual doctor because that would be ineffective, for instance, to safeguard the patient from the dangers of some unorthodox miracle treatment which the doctor is led to favour by enthusiasm rather than discretion. We find nothing to criticise in that reasoning:

21. But does it apply to chiropractic treatment on reference from a medical practitioner? We think there are distinguishing factors.

22. In the first place, chiropractors in New Zealand are far from being unlicensed, uncontrolled, casual health practitioners with widely differing levels of health education. They are by statute a profession. Each is licensed to practise. To secure his licence to practise each must meet minimum educational standards.

23. Each must pass examinations set by the New Zealand Chiropractic Board. These include testing the candidate's knowledge of the limitations of his therapeutic procedures, his knowledge of the multi-factorial nature of the causes of disease, and his knowledge of those conditions which do not fall within the scope of chiropractic practice.

24. Further, chiropractors in this country are entitled, as a matter of legal right, to accept patients direct and to treat them. The treatment they offer, provided it does not infringe the provisions of any other statute, is perfectly legal. Chiropractic is part of the legitimate health services in this country. Parliament laid that down 18 years ago. That is one of the realities in this inquiry.

25. Next, chiropractic as practised in this country is established to our satisfaction as a safe form of treatment. We heard much from those opposed to chiropractic about the risks to patients. Those fears appear to us to be without any factual foundation which we could regard as convincing. We have dealt with this topic at greater length elsewhere in this report: chapter 15.

26. Finally, we have concluded that chiropractic can be an effective form of treatment, certainly for some types of disorder, possibly for others. This topic, too, is dealt with in greater detail elsewhere: chapters 31, 32, 37.

27. Now, since chiropractic treatment is generally safe, and since it is known to have effective potential to relieve some types of disorder, we are simply unable to understand how referral from medical practitioners can be precluded on the ground that medical and chiropractic philosophy differ. If a form of treatment can in some cases be effective, how can it possibly matter whether the medical profession agrees or disagrees with the philosophy behind it? The philosophy becomes irrelevant; the reality is the effectiveness.

28. That is in effect the view that has long been accepted by organised medicine in the United Kingdom. In its 1979 *Handbook on Professional Conduct and Discipline*, the General Medical Council stated the position in this way under the heading, "Improper delegation of medical duties" (pp. 9-10):

The Council recognises and welcomes the growing contribution made to health care by nurses and other persons who have been trained to perform specialised functions, and it has no desire either to restrain the delegation to such persons of treatment or procedures falling within the proper scope of their skills or to hamper the training of medical and other health students. But a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility.

For these reasons a doctor who improperly delegates to a person who is not a registered

medical practitioner functions requiring the knowledge and skill of a medical practitioner is liable to disciplinary proceedings. Accordingly the Council has in the past proceeded against . . . doctors who by signing certificates or prescriptions or in other ways have enabled persons who were not registered medical practitioners to treat patients as though they were so registered.

29. This statement is cautiously worded. But it is quite clear what it means. Correspondence produced by the Medical Association confirms the position. The Secretary of the Central Ethical Committee of the British Medical Association (Dr John Dawson) supplied the following commentary on the ethical statement:

We believe that a doctor should be free to treat his patients with what he considers to be the most suitable techniques and drugs. Manipulative techniques may be a valuable treatment for some conditions.

If a doctor wishes to use another person's skills in manipulation it is ethical for him to delegate that part of the patient's treatment to a person the doctor is satisfied is capable of safely performing the manipulation. Delegation to a chiropractor [sic] can only be based on the doctor's *personal* knowledge and assessment of the chiropractor's skills *not* on the general grounds of his possession of any qualifications.

And the Secretary of the British Medical Association (Dr E. Gray-Turner) wrote this:

An individual doctor if he knows of, and is satisfied with the competence of, certain specific manipulative skills in an individual chiropractor [sic], would not be acting unethically if he sought the use of such skills for the treatment of a patient, by delegation, while retaining overall responsibility for the patient.

30. We record our indebtedness to the Medical Association which, once the matter had been drawn to our attention by the 'Chiropractors' Association, provided us with this material.

31. While we were visiting London we took the opportunity to confer with officers of the British Medical Association and the General Medical Council. We understood from them that the position as stated above had been the generally accepted position for more than 40 or 50 years, though it was not reduced to written form until 1974.

32. Now chiropractors in the United Kingdom are not registered as they are in New Zealand. There are therefore in the United Kingdom no statutory standards to which a practising chiropractor must adhere. The practical effect of this is that a doctor in the United Kingdom who is brought up on a disciplinary charge arising out of his referral of a patient to a chiropractor would be obliged to show that he had personally satisfied himself, and had reasonable grounds for being satisfied, of the competence of that individual chiropractor to administer the treatment for which the patient was referred. The position is obviously different where the doctor delegates the patient's treatment to a person belonging to a "profession supplementary to medicine", a category of recognised ancillary professions which exists in the United Kingdom and which consists of nurses, X-ray technicians, physiotherapists, and the like: in such a case, we were told, the competence of such a person to carry out the delegated treatment would ordinarily be taken for granted.

33. We were anxious to discover how these principles might be applied in practice. The representatives of the British Medical Association and the General Medical Council were good enough to allow themselves to be questioned on the matter. We have no reason to believe that the views they expressed were other than the official views of their respective organisations. After some discussion it emerged that in the United Kingdom a doctor would not be considered to be acting unethically in referring a patient to a chiropractor for treatment if:

- (a) He was personally satisfied of the chiropractor's competence to administer the treatment;

(b) He was personally satisfied that the chiropractor would not go outside the area of referral except with the doctor's express consent;

(c) He retained ultimate responsibility for the patient's management.

34. On the first of these matters we understood the position to be that the referral might legitimately extend to allowing the chiropractor to decide on the exact modality of treatment to be used and to allowing the chiropractor to use such diagnostic aids for that purpose as would be appropriate.

35. On the second of these matters, we understood the view to be that a doctor's assertion of his personal satisfaction that the chiropractor would stay within the terms of the referral would be more likely to be accepted in the United Kingdom context if it were shown that chiropractors themselves, as a body, regarded it as unethical to go outside the terms of a referral. The example was given to us of the willingness of the physiotherapists' professional body to discipline any physiotherapist for any breach of the referral ethic. This view of the matter is of course both logical and pragmatic.

36. Having stated the principles, as we now understand them, which would be applied in considering disciplinary action in the United Kingdom in regard to a referral to a chiropractor, it is now useful to translate them to a New Zealand context. That is an important exercise, because there can be little doubt that those would have been the principles which would have applied in New Zealand at the present day if the New Zealand Medical Association had not chosen to enact its specific rule against referral to chiropractors in 1978.

37. Prior to 1960 the position of New Zealand chiropractors was no different from that of United Kingdom chiropractors today. But since 1960 the situation in New Zealand has been significantly altered. For since 1960 all New Zealand practising chiropractors have been required to be registered under the Chiropractors Act which provides minimum standards of competence and provides for disciplinary action.

38. That means, in terms of the principles applied by the Central Ethical Committee in the United Kingdom, that the referral by a New Zealand doctor to a New Zealand chiropractor would have to be regarded as a referral to a practitioner whose professional competence in his field was ordinarily to be taken for granted. It is therefore seen how significant a difference it was that the New Zealand Chiropractors Act brought about.

39. So if the United Kingdom principles were still applicable in New Zealand, the only question a New Zealand doctor would have to consider in deciding to refer a patient to a chiropractor would be whether the particular chiropractor would stay within the area of the referral. The referral could of course be made only on the basis that the doctor retained ultimate responsibility for the management of his patient.

40. Therefore the position is that until the New Zealand Medical Association adopted its rule in 1978 expressly prohibiting referrals to chiropractors, it seems highly likely that such referrals could neither effectively have been prevented in this country nor punished by disciplinary action, provided the United Kingdom principles were observed.

41. We feel bound to comment that it is unfortunate that we had to wait until our meetings in London to discover the history of the ethical position.

42. Before we consider the New Zealand situation further, we will refer briefly to the ethical position in Australia, the United States, and Canada.

AUSTRALIA

43. As recently as June 1978, and no doubt as a response to the report of the Webb Committee, the Australian Medical Association produced a comprehensive ethical ruling dealing with the relationship of doctors to other health professionals. That ruling contains the following statement:

The Australian Medical Association does not recognise any exclusive dogma such as homeopathy, osteopathy, chiropractic, and naturopathy. It is unethical for doctors to associate professionally with practitioners of such dogmas.

It is noted that this is based purely on "philosophical" grounds. It appears to be something of a rearguard action, and it remains to be seen how long it will be sustained once the Australian State registration systems become fully operative.

44. While we were in Australia we noted that the medical attitude seemed rather less rigid than the above ruling might suggest. And Professor R. R. Andrew, formerly Dean of the Medical School at Monash University, in addressing the first chiropractic graduates at the Preston Institute, said:

I hope, I expect, that the Australian Medical Association will be animated by a generous and co-operative attitude towards your profession which now has amply demonstrated its unimpeachable standards of education and its unexceptionable statutory control through the Victorian Chiropractors Registration Board. This group of laymen, medical doctors and chiropractors is closely modelled on the Victorian Medical Registration Board, and will jealously guard proper standards of education practice and ethics.

There is thus a need now for the A.M.A. to recognize, in a realistic way, the contribution which chiropractic makes to total health care. There is no longer room for the older attitudes of the medical profession, although in the past there were defensible reasons maybe. A.M.A. ethical guidelines should provide for close collaboration between the professions so that what we all know is happening now, and with increasing frequency on a somewhat dubious basis of professional propriety—that is the referral by medicos of patients to chiropractors—will receive the official recognition and approval it deserves.

THE UNITED STATES

45. From material produced to us during our public sittings we would have been entitled to conclude that the American Medical Association's attitude was that it was ethically wrong for a physician to associate professionally with any person who offered treatment which had no scientific basis and was dangerous, was calculated to deceive the patient by offering him false hope, or which might cause the patient to delay in seeking proper care until his condition became irreversible. Chiropractors, it was said, fell into this category because chiropractic was an "unscientific cult" which "constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation".

46. But events have moved since these opinions were expressed. The relationship between chiropractors on the one hand, and medical practitioners, hospitals, and those providing diagnostic services on the other hand has become the subject of litigation. The American Medical Association, during our visit to its headquarters in Chicago, was kind enough to provide us with copies of the relevant court documents and other materials, including a kit of materials it had issued to its members on 3 November 1978. We were able to discuss the position at some length with Mr William B. Smith, the association's legal officer.

47. Three legal actions were commenced by chiropractic interests in 1976 and 1977. It is necessary to understand the nature of these actions in order to assess the current medical ethical position.

48. The first action (*Wilk & others v. American Medical Association and others*, U.S. District Court, Illinois, No. 76C3777) was commenced on 12 October 1976. It is an anti-trust suit in which it is alleged that the American Medical Association and other bodies associated with the medical establishment have acted unlawfully in attempting to boycott chiropractors in restraint of interstate trade and commerce, and in attempting to monopolise in the United States the taking, reading, and performing of radiological X-ray services, and the performing of health care services through the use of "physical manipulation and spinal adjustment". The action is designed to enjoin the medical establishment from acting in any way so as to prevent professional co-operation and association between medical practitioners and chiropractors.

49. This action is still in its preliminary stages, and it would be wrong for the Commission to comment or speculate on what might be the outcome. However, it is clear that the United States laws relating to competition and monopoly provide the plaintiffs with feathers to fly with, and it is also clear that until the courts have decided the action one way or the other there are good reasons why the United States medical establishment should not wish to add fuel to the plaintiffs' fire by any overt activity suggesting an attempt to defeat or interfere with chiropractic interests.

50. The second legal action is *New Jersey Chiropractic Society and others v. Radiological Society of New Jersey and others* (Superior Court of New Jersey, C-886-76). It is still pending and covers much the same ground as the third legal action.

51. The third legal action (commonly called "the Pennsylvania case") is *Slavek and others v. American Medical Association and others* (U.S. District Court, Eastern District of Pennsylvania, No. 77-1726). It has been settled by agreement, despite opposition from parts of the medical establishment. The effect of the settlement (which technically relates only to the position in Pennsylvania) may be summarised as follows:

- (1) Medical specialists, including those in radiology or clinical pathology, may ethically choose to accept or decline patients sent to them by licensed chiropractors;
- (2) It is declared that there is no policy against hospitals or members of hospital staff taking and furnishing diagnostic X-rays and reports thereon in regard to chiropractors or chiropractic patients, or making and furnishing clinical laboratory tests and reports thereon to chiropractors or chiropractic patients. Each hospital may decide for itself, or allow associated individual pathologists and radiologists to decide for themselves, whether or not to provide such services and the circumstances under which such services should be provided.

52. Except to the extent that the Pennsylvania settlement has clarified some issues, the question of the extent to which medical practitioners in the United States may deal with chiropractors on a professional basis cannot be answered with certainty. It is however, plain that some degree of professional association is permissible. It is also plain that it is impossible to assert at the present time that there is in practice a blanket ethical ban on any professional association between medical practitioners and chiropractors in the United States.

CANADA

53. As far as we have been able to ascertain there is in Canada—at least in the major provinces of Ontario and British Columbia—no express ethical rule forbidding medical practitioners to refer patients to chiropractors. In both provinces the relationship between medical practitioners and chiropractors on an individual basis seems on the whole to be good.

54. In the discussions we had with the Ontario College of Physicians and Surgeons we were impressed with the pragmatic and realistic approach that was adopted. Although it was clear that there were strong reservations about some aspects of chiropractic activity, it was also clear that the question of professional relations with chiropractors was being dealt with in a spirit of moderation and compromise.

A NEW ETHICAL RULE

55. We have no hesitation in concluding that the position adopted by the British Medical Association and the General Medical Council, suitably adapted to New Zealand conditions, is the appropriate ethical stance.

56. We will restate it.

57. A medical practitioner commits no breach of professional ethics in referring a patient to a registered chiropractor for treatment if:

- (a) He is personally satisfied of the chiropractor's competence to administer the treatment;
- (b) He is personally satisfied that the chiropractor will not go outside the area of referral except with the medical practitioner's consent; and
- (c) He retains ultimate responsibility for the patient's management.

A medical practitioner will normally be justified in taking for granted the competence of a registered chiropractor. If the Chiropractors' Association accepts and enforces the ethical position inherent in the referral system, a medical practitioner will normally be justified in taking for granted that a registered chiropractor who is a member of the association will not go outside the area of referral without consent.

58. And we would add the following: that a medical practitioner should not be thought of as committing any breach of professional ethics in conferring or collaborating with a registered chiropractor on any question of diagnosis or management of a patient or in undertaking, in collaboration with a chiropractor, the concurrent management of a patient.

59. So we have reached the clear conclusion that the present New Zealand ethical rule is wrong. It cannot be justified. It should be abandoned. In the public interest a doctor who desires to do so must be free to refer a patient to a chiropractor. He must also be freely available for consultation by the chiropractor on any medical matters which the chiropractor believes may be relevant. These factors are so important that the present ethical rule must give way. That will be small consolation to any doctor who has already been penalised by his own profession for referring his patients to or collaborating with chiropractors. But it will enable a doctor, if he believes that a particular chiropractor could help his patient, to do what he believes is in his patient's best interests.

60. What standards and practices of referral are therefore to be adopted? Here again we have had no difficulty in coming to a clear conclusion. We therefore now discuss what has come to be called the "referral ethic".

THE ETHICS OF REFERRAL

61. The point made by Sir Randal Elliott was that a doctor who refers a patient to a chiropractor cannot be certain that the chiropractor will provide his treatment in the area contemplated by the doctor. This of course assumes that chiropractors are going to insist, once a patient has been referred, on acting completely independently of the referring doctor and regardless of his wishes or instructions. It also assumes that a referring doctor is going to know enough about spinal manual therapy (an assumption not at all justified by the evidence) to be able to tell the chiropractor exactly what he should do.

62. Now it is true that the chiropractors have made it clear that they are not prepared to accept a health benefit which is conditional on medical referral. Because of the attitude of the medical profession that stance is perfectly understandable. But the chiropractors do not preclude referral. There is nothing inconsistent in accepting patients direct, and also treating patients on referral. We think that chiropractors understand that although they have a free hand with their own patients, a patient accepted on referral remains the doctor's patient and the doctor's responsibility and can be dealt with only in terms of the referral.

63. The possibility was put to us that a patient, having been successfully treated by the chiropractor on referral, might at a later stage himself approach the chiropractor direct for further treatment for the same complaint. We consider it would be unethical for the chiropractor in that situation to deal with the patient without first consulting the doctor who referred the patient in the first place. The chiropractor should if necessary refuse to treat the patient if to do so would involve a breach of the good faith necessary to make a referral system work.

64. We consider that chiropractors have a very simple method of making it quite clear that they accept the "referral ethic". They should amend their code of ethics so as to provide in express terms that a referred patient is to be treated as the responsibility of the referring medical practitioner, and the treatment offered, or any treatment thereafter offered, is not to go outside the terms of the referral except with the medical practitioner's agreement. It must be clearly understood that the patient remains the doctor's patient. Any breach of this "referral ethic" should be dealt with as professional misconduct.

65. The matter is very much in the hands of the chiropractors themselves. If the medical ethical rule against referral to chiropractors is abandoned—and it is obvious that it must be abandoned—referrals cannot be expected to be made except on the basis we have just explained. The chiropractors must be ready to adopt the referral ethic themselves and be positive and active in condemning any breach of it.

66. In the course of our inquiry we invited the New Zealand Chiropractors' Association to state in positive terms on what basis its members would accept referrals. The association accepted that invitation by stating to us what is described as its "preliminary views" in this way:

1. A chiropractor should be prepared to accept a patient on referral from a medical practitioner (general practitioner or otherwise) and should treat that patient if in his opinion chiropractic treatment is indicated.

2. On such a referral the chiropractor should regard the patient as primarily the patient of the referring physician and:

- (i) If a specific form of treatment is directed by the referring physician the chiropractor should carry out that treatment unless he thinks it is inappropriate. In that case he should make his opinion known to the referring physician and seek agreement on what is to be done.
- (ii) If no specific form of treatment is directed by the referring physician, treatment should be at the discretion of the chiropractor and should be carried out in accordance with the information furnished by the referring physician and the chiropractor's own clinical findings.
- (iii) At the completion of the treatment the chiropractor should send the patient back to the referring physician and supply a report (written or verbal as arranged between them) as to the course and result of treatment.

3. If a previously referred patient later came direct to the chiropractor for treatment for the same condition the chiropractor should communicate with the physician who originally referred that patient unless that is quite impracticable.

4. If a patient previously referred later approached a chiropractor for treatment for a different condition the Association can see no ethical bar to the chiropractor treating the patient without communication with the medical practitioner. If, however, the patient required medical assessment the Association would regard it as proper for the chiropractor to refer that patient to his known general practitioner.

5. The N.Z.C.A. hopes that the N.Z.M.A. would regard the approach set out above as generally appropriate in the case of referrals in the opposite direction.

67. There are three comments we would make on the Chiropractors' Association's statement. In the first place we consider it an acceptable basis for referral. It is carefully worded, and we consider that the medical profession would be perverse if it did not accept it. Secondly, we would expect to see the ethical standards so recognised by the association firmly enforced, by disciplinary action if necessary. Finally—and we mention the point because it was raised in the cross-examination of the association's President, Dr L. C. Blackburn—we wish to say that point 4 of the association's statement is quite reasonable from an ethical viewpoint. We would, however, expect that the chiropractor in such a situation would take proper steps to inform the patient's doctor of the position, but as we see it, that is a matter of necessary courtesy rather than a matter of ethics. If the normal courtesies are preserved such a referral system should work smoothly and to the benefit of patients.

CONCLUSIONS AND RECOMMENDATIONS

68. In summary, then, our clear view is the existing ethical ruling in New Zealand prohibiting referral by doctors to chiropractors cannot be justified and must be jettisoned. But to make any referral system work, chiropractors must accept the referral ethic themselves and enforce it.

69. We consider these matters to be of substantial importance. They affect the interests of the patient. In our view the New Zealand Medical Association should reverse its ruling preventing referral to registered chiropractors. This will not open the door to homeopaths, naturopaths, iridologists, or faith healers, for the simple reason that those groups are not organised health professions recognised by statute, as the chiropractors are.

70. We should like to think that the Medical Association would act promptly in accordance with the opinion expressed above. But in view of the association's general attitude expressed very firmly during the inquiry, Parliament should act in any event, and we **recommend** that the Medical Practitioners Act 1968 be amended by inserting the following provision:

Notwithstanding any rule to the contrary, it shall be lawful and ethical for any medical practitioner—(a) to refer a patient to a registered chiropractor for treatment provided the medical practitioner retains overall responsibility for the patient and first personally satisfies himself that the chiropractor concerned is capable of safely carrying out such treatment; and—(b) to collaborate and associate with a registered chiropractor concerning the diagnosis or management of a patient's disorder.

Chapter 42. USE OF THE TITLE "DOCTOR"

1. The great majority of chiropractors at present practising in New Zealand have graduated from chiropractic colleges in the United States. Those colleges award the degree of doctor of chiropractic (D.C.) to graduates who have completed the full chiropractic course. In the United States the degree of doctor of chiropractic is not necessarily a "spurious" degree. Accordingly chiropractors who have graduated from some chiropractic colleges cannot be criticised if they elect to prefix their names with "Dr" if they prefer that to "Mr", "Mrs", or "Miss".

2. It is necessary to understand that in the United States a doctoral degree is not necessarily a post-graduate research degree, as it is in New Zealand. In New Zealand the universities will award doctorates (other than honorary doctorates) only to a candidate who already has a degree and only in respect of a programme of research undertaken over a period of some years, and under supervision except in the case of the higher doctorates. That is the normal pattern throughout the British Commonwealth. Many United States doctorates follow that pattern. However, in some United States universities including some leading universities, a doctorate may be awarded on the basis of advanced course work, not necessarily including research, e.g., M.D., J.D., D.D.S.

3. That is why most medical courses in the United States lead to the degree of doctor of medicine (M.D.). The courses are not necessarily more onerous than the New Zealand medical courses; it is simply that the United States universities consider that a proper academic training in medicine is at a level that requires greater recognition than a bachelor's degree. But the New Zealand universities do not take this view: the normal medical course leads to a bachelor's degree, and a doctorate will be awarded only as a research degree.

4. The great majority of medical practitioners in New Zealand therefore do not have a doctorate. Their title "doctor" is a courtesy title. But it is a courtesy title hallowed by long usage. It is accepted by the general public. Even though it may be strictly incorrect for a medical practitioner who has graduated M.B.Ch.B. to label himself "Dr", no one doubts that the level of his education and expertise makes it an appropriate courtesy label; and of course the word "doctor" has for most people become synonymous with "medical practitioner".

5. Now the chiropractor who has graduated from a recognised chiropractic college with the degree of doctor of chiropractic is entitled to label himself "Dr". He has a doctorate. That puts the matter beyond question. If he does not care to use the label, that is his affair. Some New Zealand chiropractors prefer not to use the label, but many do use it.

6. The Commission, in the course of this inquiry, invariably adopted the practice of addressing chiropractors who had graduated as doctors of chiropractic, and who wished to be so addressed, as "Dr". The usage we adopted is not to be taken as a suggestion by us that chiropractors are to be regarded as medically qualified. We simply adopted proper courtesy.

7. But of course the use by New Zealand chiropractors of the title "Dr" creates understandable problems in the field of health care. There is no doubt that the chiropractors' usage of the title is a severe irritant to the

medical profession who throughout the course of this inquiry, but with one exception, discourteously, as we think, addressed chiropractors as "Mr". The discourtesy was underlined when Dr Peter Modde, a chiropractor called to give evidence for the Medical Association, was addressed throughout as "Dr". He was the only chiropractor whom the Medical Association so addressed.

8. But while we are of opinion that a chiropractor who has graduated as a doctor of chiropractic is entitled to the courtesy of use of the title associated with his degree, we are nevertheless satisfied that a number of chiropractors in New Zealand misuse the title "Dr". We have dealt with this topic in a general way earlier in this report (chapter 18), and we now deal with it more specifically.

9. There can clearly be no objection to a chiropractor putting up a nameplate outside his rooms reading for example:

John Doe, D.C.
Registered Chiropractor

But we do see objections to nameplates reading, for instance:

Dr John Doe, D.C.
Doctor of Chiropractic

or:

Dr John Doe, D.C.
Chiropractor

10. The objectionable feature is that members of the public may quite easily be misled into believing that the chiropractor practising behind the last two nameplates is in fact a medical practitioner who practises, or specialises in, chiropractic. The example we have given of a nameplate containing the words "Doctor of Chiropractic" has the additional objection that the term suggests that chiropractic is a medical specialty. But in any event the fact is that the use of the term "Dr" or "Doctor" on any public nameplate must inevitably be associated in the public mind with medical qualification and medical expertise.

11. It is not a question of how a chiropractor or a medical practitioner would see it. It is a question of how the members of the general public might reasonably see it. We consider that the use of the term "doctor" in this context must create public confusion.

12. Nameplates are not the only means of public communication which create a problem. In some instances the advertisement of a chiropractor's name and his occupation goes beyond a mere nameplate. We have ourselves seen large signs carrying the same information: in one case the words "Doctor of Chiropractic" were more prominently displayed than the chiropractor's name.

13. Letterheads and professional cards create a similar problem. There are other factors as well. In one chiropractor's waiting room we inspected there was a movable sign, conspicuously placed, reading "Doctor is In/Out". And some chiropractic publicity material and literature speaks of the "doctor of chiropractic" in a way that strongly suggests that chiropractors prefer to project their public image, not as chiropractors, but as "doctors". That is not the use of the word "doctor" in any academic sense, but a more general use of the word as it is understood by the public in a context of health care. It is the image of a practitioner whom the public should feel free to consult in the first instance for any health problem.

14. We have reached the clear view that, in New Zealand conditions any nameplate, notice, letterhead, professional card, or any other material which could mislead the general public into believing that chiropractors possess general medical qualifications should be banned and made illegal. The description "registered chiropractor" and the appropriate letters denoting the chiropractor's educational and professional qualifications are all that is necessary or desirable.

15. This may seem hard to some chiropractors. During one of our public sittings the Commission asked a very experienced chiropractor what he thought the reaction of chiropractors would be if the use of the term "doctor" were banned. His reaction was one which we are sure was sincere: it was one of hurt surprise that anyone should consider stripping a qualification from someone who had earned it. The qualification represents perhaps more to a chiropractor than it would to anyone else because of the continual ostracism and opposition by the medical profession. We can completely understand why a chiropractor who has spent years of hard work and sacrifice achieving his qualification should want to insist on its public recognition.

16. In our formal recommendation which follows we have recognised these factors. We do not suggest that a chiropractor who has graduated doctor of chiropractic should not be addressed as "Dr" if he wishes to be so addressed.

17. We do not suggest that chiropractors should take down their chiropractic college diplomas, or that they should stop using the letters "D.C." after their names. (We should point out the usage "D.C. (U.S.A.)" which we have noticed on several occasions is incorrect: the proper way of denoting the origin of a degree is to use the initial letters of the particular institution which awarded the degree, not the country in which the institution is situated. So the correct usage would be "D.C. (Palmer)", "D.C.(P.C.C.)", "D.C.(L.A.C.C.)", etc.)

18. What we do suggest is that the terms "Dr", "Doctor", or "Doctor of Chiropractic" must not be used or displayed in any notice, sign, letterhead, or other material designed for public information. That is because that particular use of the term "doctor" can plainly convey a misleading impression, and the Commission finds it contrary to the public interest that it be allowed to continue.

RECOMMENDATION

19. The Commission therefore **recommends** that the Chiropractors Act 1960 be amended by inserting the following provision:

Any chiropractor who displays or causes to be displayed, or produces or causes to be produced for display or circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material which contains, in relation to any chiropractor who is not a registered medical practitioner, any of the terms "Dr", "Doctor", or "Doctor of Chiropractic", commits an offence . . . Provided however that nothing in this section shall be read as prohibiting a chiropractor from displaying in his professional rooms any diploma or certificate relating to himself or to any other chiropractor with whose practice he is associated, or from using after his name letters denoting an academic or professional qualification.

AN ALTERNATIVE POSSIBILITY

20. An alternative way of achieving the same object would be to amend the Medical Practitioners Act 1969 so as to make it an offence for any person who is not a registered medical practitioner to display or cause to be displayed, or produce or cause to be produced for display or

circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material, in which the terms "Dr" or "Doctor" are used in such a way as to lead members of the public to believe that such person is qualified to practise medicine.

21. We do not consider that such a general statutory prohibition would cause unnecessary hardship to people who hold non-medical doctorates, but we have not heard any submissions or evidence on this general point. For that reason it would not be right for us to make a firm recommendation; but we should add that it could be regarded as unfair to single chiropractors out for special attention when the same problem could arise in regard to dentists, psychologists, or any other person with a doctoral degree who is not medically qualified and who practises in one of the areas of health care.

Chapter 43. CHIROPRACTORS AND PROFESSIONAL DISCIPLINE

THE PROBLEM

1. In earlier sections of this report we have said that chiropractic professional discipline must be tightened up. The reasons are clear. The chiropractic profession as a whole tends to be brought into disrepute by the actions of a few. But worse than that, the activities of the few may be contrary to the public interest. It is not in the public interest for people to be encouraged to believe that they should see a chiropractor in the first instance for any health problem. Some chiropractic publicity material is plainly designed to achieve that result. Furthermore it is not in the public interest that members of the public should be led to understand that spinal manual therapy by a chiropractor is necessarily capable of relieving a wide variety of disorders. Some chiropractic publicity material which the Commission has seen creates that impression and was designed to create it. These are serious matters.

2. At a slightly less serious level, cases have come to the Commission's attention where treatment has been continued long after the point when it should have been obvious that it was not going to achieve the desired result. The Commission takes the view that at the end of a limited period of chiropractic treatment it should in most cases be clear whether or not the patient is responding. In the absence of good reasons it is wrong to continue with the patient's treatment after that.

3. The Commission is also concerned at cases which have been brought to its attention where chiropractic treatment has been proceeded with against medical advice. The Commission sees some element of justification for this in the fact that the doctor who has given the medical advice is probably ignorant of the niceties of chiropractic treatment and what it can achieve. But what the Commission finds hard to understand is the lack of any attempt by the chiropractor to discuss the patient's problem with the doctor. If the doctor refuses to discuss the matter that is his responsibility. It is the chiropractor's responsibility to make the attempt. And where the patient is already under medical care it is essential that he or she be encouraged by the chiropractor to continue with medical care, if not by the patient's original doctor then by some other doctor. Nothing should be said or done to induce the patient to believe that the chiropractor has taken sole charge of the case in such a situation.

4. The Commission is satisfied that most New Zealand chiropractors act in a responsible and professional manner. We are satisfied that the Chiropractors' Association has tried to control the content of publicity material, but unsuccessfully. We are not satisfied that either the Chiropractic Board or the Chiropractors' Association is always able sufficiently to control standards of professional behaviour.

5. What is to be done? Regardless of whether health and accident compensation benefits are to be paid for chiropractic treatment, the Commission considers that the chiropractic house must be put in order. Only a few chiropractors offend. Sometimes they do so more because of

bad judgment or lack of experience than from deliberate intent. These few chiropractors must be brought under proper professional control.

6. The first question we must ask is what is the present position.

THE PRESENT POSITION

7. The disciplinary provisions in the Chiropractors Act 1960 are in the Commission's opinion quite inadequate. We will explain why.

8. The disciplinary provisions can be invoked only in three instances: first, where the chiropractor has been guilty of gross negligence or malpractice; secondly, where he has been convicted of an indictable offence punishable by 2 or more years' imprisonment; and thirdly, where he has been guilty of "grave impropriety or misconduct, whether in respect of his calling or not" (section 22).

9. So the position is that the chiropractor is liable to have the statutory disciplinary procedure invoked against him in respect only of the gravest kind of misconduct, whether in his professional capacity or otherwise. Yet, as anyone knows who deals with disciplinary matters in other professions, the professional rot sets in not so much with grave offences, but with relatively minor classes of unprofessional conduct. There is no way under the Act by which relatively minor breaches of standards of professional conduct can be controlled.

10. That situation needs to be remedied. The whole disciplinary structure in the Act, obviously designed to cope with serious breaches, needs to be recast.

11. There is, however, another present means of imposing proper professional standards. The New Zealand Chiropractors' Association has power under its rules to enforce discipline as an internal matter. But this power is inadequate because it applies only to members of the association. Chiropractors need not be members of the association. The relevant rules of the association are reproduced as appendix 4, together with the association's statements on standards of practice, the law and ethics of chiropractic and the code of ethics. These rules and statements are reproduced as revised and reissued as at May 1978.

12. It is encouraging to see that the Chiropractors' Association has taken steps to declare professional standards and to adopt means to enforce them by internal discipline. Nevertheless the Commission considers that the situation is unsatisfactory. There are two reasons.

13. In the first place, as we have said, the association's disciplinary procedures apply only to its members. A chiropractor who is not a member may be disciplined only for serious misconduct in terms of the Act. A chiropractor who is a member and is guilty of relatively minor misconduct can evade discipline altogether by resigning from the association.

14. Secondly, the total number of members of the association practising in New Zealand is relatively small. That in itself leads to problems. For if everyone knows everyone else, the formal correction of minor professional misconduct becomes embarrassing; and informal advice on proper conduct may be ineffective. It is difficult for anyone outside the association to be sure that justice is being done, unhampered by personal considerations.

15. The Commission proposes to recommend a new disciplinary procedure and structure. It will require amendments to the Chiropractors Act. We now set out our proposals and our reasons for making them.

ONTARIO DRAFT LEGISLATION

16. During our visit to Canada the Ontario Ministry of Health supplied us with copies of draft legislation now being considered. It is reproduced as appendices 5 (Draft Health Disciplines Amendment Act) and 6 (Draft Chiropractors Regulations). We have found it most helpful. If a complete overhaul of the Chiropractors Act 1960 were contemplated, the above materials would provide an excellent working basis.

17. However, we limit ourselves to specific recommendations as to disciplinary procedure. In doing so we have drawn on the Ontario draft legislation to some degree.

A NEW DISCIPLINARY PROCEDURE

18. It is clear that a profession must to a major degree control its own destiny. But in the public interest, when the profession is a health profession, there must be a measure of public control. It follows from this that although the chiropractic profession must settle much of its own code of ethics, certain essential ethical and professional standards must be laid down by Parliament.

19. Furthermore, the enforcement of ethical and professional standards should not be a matter of internal domestic housekeeping. It is in the public interest, and in the chiropractors' own professional interests, that all disciplinary procedures should be established by statute. In that way the public can be assured that there is proper machinery for the investigation and disposal of complaints, and that the interests of any chiropractor against whom disciplinary proceedings may be brought are properly protected.

20. While, as we have said, chiropractors should themselves in the main develop and declare their own ethical standards, they cannot do it effectively within the framework of an association to which not all belong. It is clear that the Chiropractors' Association should be the body principally responsible for laying down ethical standards and it should assist in their enforcement. The Commission therefore **recommends** that the New Zealand Chiropractors' Association be expressly recognised by statute as representative of all chiropractors practising in New Zealand, and that membership of the association be compulsory for every practising chiropractor. That will mean that the present rules of the association as to membership will require statutory modification.

21. The general course we **recommend** is that the Chiropractors' Association be reincorporated as a statutory body under the Chiropractors' Act 1960, with its membership, objects, and powers defined by the Act. All disciplinary proceedings, including the investigation of any complaints, would be undertaken in terms of the Act. As far as chiropractors are concerned, therefore, the entire disciplinary procedure should be statutory and the association's rules for internal discipline would no longer be needed.

(a) A New Complaints Committee

22. The present Chiropractic Disciplinary Committee is set up under section 7 of the Act as a statutory committee to investigate complaints about chiropractors. Its powers are specified in section 22. They are limited to serious offences. Under the system we suggest, we see no need for this committee and therefore **recommend** that the Chiropractic Disciplinary Committee be abolished.

23. However, we do see a need for complaints against a chiropractor to be investigated in a preliminary way. We consider that this is best achieved within the framework of the Chiropractors' Association in its suggested new statutory form. Our **recommendation** is that a Complaints Committee be set up whose membership shall be the association's president and first vice-president, two other persons who shall be chiropractors holding current practising certificates and who shall be appointed by the association's council, and one further member who shall be a senior officer of the Department of Health to be nominated by the Director-General of Health. The quorum of the Complaints Committee should be not less than three members, one of whom should be the nominee of the Director-General of Health.

24. The purpose of including a nominee of the Director-General of Health is to ensure that at least one person involved in investigating complaints is not a chiropractor, yet is generally familiar with the discipline of health services.

25. The secretary of the Complaints Committee should be the secretary for the time being of the Chiropractic Board. The Commission so **recommends**.

26. We **recommend** that the functions of the Complaints Committee be:

- (a) To make a preliminary investigation of any complaint against a chiropractor and to determine whether the chiropractor should be charged with a disciplinary offence before the Chiropractic Board; and
- (b) In relatively minor cases, to hear and determine the complaint itself.

In the latter instance we **recommend** that the Complaints Committee's disciplinary powers should be limited as follows:

- (a) The imposition of a fine not exceeding a total of \$500 in respect of all charges;
- (b) Suspension for not longer than 3 months;
- (c) Censure; and
- (d) Ordering the chiropractor concerned to pay the costs, or part of the costs, of the investigation and hearing.

27. It will be seen that we recommend that the Complaints Committee should in any event have power to suspend a chiropractor from practice for a limited period—a period not exceeding 3 months should be adequate—if from the nature of the complaint and in the circumstances it considers it in the public interest to do so. In such a case the chiropractor concerned should have the right to apply to the board for rescission of that suspension. In other cases both the complainant and the chiropractor should have a right of appeal to the board.

28. The Complaints Committee should, on receiving a complaint, have power to require the chiropractor concerned to supply the committee with a written explanation. It should have the further power to require the explanation to be furnished within a reasonable time, not less than 7 days. Failure to supply such an explanation within the time required should in itself be declared to be a breach of professional ethics and punishable as such.

29. The Commission so **recommends**.

(b) *The Chiropractic Board*

30. The Chiropractic Board is at present the general supervisory and disciplinary authority. It is an important body. In the Commission's **recommendation** it should be reconstituted as follows:

- (a) The chairman should be a barrister of not less than 7 years' standing.
- (b) There should be six other members; four to be registered chiropractors of not less than 7 years' standing to be nominated by the association, one to be the Director-General of Health or his nominee, being a senior officer of his department, and one to be a registered medical practitioner nominated by the New Zealand Medical Council (or, failing nomination by the New Zealand Medical Council, by the Director-General of Health).

The purpose of enlarging the board to include a registered medical practitioner is to ensure that the principal health service is involved in chiropractic affairs. The present isolation of chiropractors is not in the public interest.

31. A board reconstituted as suggested should have a quorum of four, not three as at present (section 4 (2)), at least one of whom, aside from the chairman, should be a non-chiropractic member. We so **recommend**.

(c) *Grounds for Disciplinary Action*

32. We have already set out the existing statutory grounds for disciplinary action. We **recommend** that they be enlarged so that the full list would read as follows:

- (a) Gross negligence or malpractice in respect of his calling;
- (b) Conviction of an indictable offence punishable by two or more years' imprisonment;
- (c) Grave impropriety or misconduct, whether in respect of his calling or not;
- (d) Use of the title "doctor" on any notice or sign or in any publicity material other than in the form of the letters "D.C." following his name; and
- (e) Conduct unbecoming a member of the chiropractic profession.

The last two grounds for disciplinary action are new. It is clearly necessary that the board (or the Complaints Committee under our proposals) should have power to deal with disciplinary offences outside the range of and less serious than those specified in the first three grounds. Ground (d) is self-explanatory (see chapter 42). For the reasons stated earlier in this chapter the Commission takes the view that what may be included in the new ground (e) should be spelled out so that everyone can understand what "conduct unbecoming" can involve. The following formula is **recommended**:

Without limiting the meaning of the expression "conduct unbecoming a member of the chiropractic profession", the following conduct shall be deemed to be included in that expression:

- (a) By words or conduct inducing any person to believe that a chiropractor should be consulted in the first instance in preference to a registered medical practitioner, in respect of any disease or disorder; or

(b) By words or conduct inducing any person to believe that chiropractic treatment will necessarily cure or alleviate any organic or visceral disease or disorder; or

(c) When consulted by a patient who he knows or ought to know is suffering from a disorder requiring medical care, failing to take reasonable steps to advise the patient to consult, or to continue consulting, a registered medical practitioner; or

(d) Exhibits or publishes to the public any circular designed for general publication which has not been approved by the association.

(d) *Penalties*

33. The existing penalties are (section 23 (2)):

- (a) Removal from the register;
- (b) Suspension for not more than 1 year; and
- (c) A fine of not more than \$100.

34. By any modern professional standards these penalties are unrealistic. They should be enlarged, bearing in mind that in terms of the Commission's proposal a Complaints Committee would have power to impose moderate penalties for relatively minor disciplinary offences.

35. The Commission **recommends** that the penalties which may be imposed by the Board be reframed as follows:

- (a) Removal from the register;
- (b) Suspension for such period as the board thinks fit;
- (c) A fine of not more than \$5,000 in respect of each charge;
- (d) Censure; and
- (e) An order that the chiropractor concerned pay the whole or part of the costs of the investigation and hearing.

(e) *Appeal from the Board*

36. The present appeal procedure is to a special appeal board consisting of a magistrate and two assessors (section 24). The Commission notes that the present chairman of the Chiropractic Board is a magistrate. That being so, an appeal to another magistrate and two assessors seems singularly inappropriate, but the Commission would in any event have considered the existing appeal procedure inappropriate.

37. Even under the legislation as it is at present, removal from the register or suspension mean that the chiropractor concerned loses his livelihood. That is a very serious consequence. The Commission considers that an appeal ought to lie from the board to the Supreme Court, without assessors, and so **recommends**.

CONCLUSIONS

38. The Commission sees it as most important that chiropractic discipline should be put on a proper footing. Under the present system there is the temptation to deal with relatively minor disciplinary offences on an informal basis. The whole matter of discipline should be covered by statute. In particular the statutory bodies dealing with disciplinary matters should include persons from outside the chiropractic profession in order to reduce its present isolation from other professions.

39. The range of offences subject to disciplinary action should be enlarged and the present statutory penalties increased to a more realistic

level. There should be a right of appeal to the Supreme Court from any disciplinary determination of the Chiropractic Board as reconstituted. The present appeal board procedure is quite inappropriate as a final appeal court for a health profession.

40. The Chiropractors' Association should be reconstituted as an association under the Chiropractors Act and its membership, objects, and powers regulated by that Act. That is necessary because all practising chiropractors should belong to the one professional body.

41. The changes we have recommended may be seen by some as radical. But in fact they do no more than recognise what could be regarded as the minimum standards for the regulation in the public interest of a professional body which has wide-ranging responsibilities to the community at large.

Chapter 44. RECOMMENDED BENEFITS FOR CHIROPRACTIC TREATMENT

INTRODUCTORY

1. We have now come full circle to the question of the desirability of providing health benefits under the Social Security Act 1964 and medical and related benefits under the Accident Compensation Act 1972 in respect of the performance of chiropractic services.

2. We are left in no doubt that health benefits ought to be provided for chiropractic treatment.

3. We hold the same view about accident compensation benefits for chiropractic treatment but of course, as we have seen, they are already provided but only on medical referral. That means that the public do not get them because the medical profession have declared such referrals unethical. We have already strongly recommended that the medical profession's ethical rule be struck down, by Parliament if necessary. But even so it will be some time before the medical opposition to chiropractic diminishes to an extent that referral to a chiropractor becomes general rather than exceptional. It is therefore a matter, not of recommending that a benefit be created, but of making sure that it is made available despite medical obstruction.

4. To bring about that result an amendment to the Accident Compensation Act will be required. Similarly an amendment will be required to the Social Security Act so that health benefits can be given for chiropractic treatment. We set out at the end of this chapter the statutory amendments we recommend.

5. We are required to consider the extent of such benefits. Our conclusions on this point appear later in this chapter.

6. We now propose to set out the factors which have led us to the clear conclusion that benefits ought to be provided. We will do so in a general way, dealing first with those provided under the Social Security Act.

WHY BENEFITS SHOULD BE PROVIDED

Health Benefits

7. At all stages of this inquiry we have reminded ourselves of the fact that not all human ailments or types of human repair work are covered by benefits under Part II of the Social Security Act. Spectacles and adult dental services are examples of services not covered.

8. In our view, however, chiropractic treatment is essentially no different from forms of treatment recognised by the medical profession and covered by the benefit scheme. A simple example will demonstrate the point.

9. Let us suppose a patient develops severe low back pain. He consults Dr A. Dr A prescribes bed rest and analgesics. Dr A's fee is partly covered by a health benefit. So is the cost of the prescription.

10. The patient finds that bed rest and analgesics do not relieve his condition. So he goes to Dr B. Dr B practises manipulative therapy, and in accordance with his diagnosis he manipulates the patient's spine. Dr B's fee is partly covered by a benefit.

11. Dr B's treatment is ineffective. The patient transfers himself to Dr C, who, having diagnosed what he believes to be the problem, formally refers the patient to a physiotherapist trained in spinal manual therapy. The patient's spine is again manipulated. Again the fees are covered by a benefit.

12. That treatment does not work either. So the patient, still disabled by his severe lower back pain, consults a chiropractor. The chiropractor examines him, adjusts the relevant vertebral joints, and the pain and disability disappear. For these last services the patient must meet the whole of the fee.

13. That is an extreme example. We do not say that every patient goes through that number of consultations. But some hundreds of patients who wrote to us, and some who gave evidence, told us of experiences with features similar to one or another chapter in our hypothetical patient's saga.

14. The point is this. There is no difference in principle between the services provided to the patient in our example by the three doctors, the physiotherapist, and the chiropractor. Each is a qualified and recognised health practitioner. Each has treated the patient for precisely the same disorder. The purpose of the benefit is to ensure that a patient can get this kind of service without undue cost to himself. The State has undertaken to subsidise the cost of curing, relieving, or treating his ailment. The only reason the cost of the chiropractor's treatment is not subsidised is, not because the ailment is different, but because the practitioner who treated it is a chiropractor.

15. That is the way the general public sees the situation. And we can well understand the public concern and resentment, so clearly reflected in the correspondence we received and in the submissions of the Patient's Association for Chiropractic Education (Submission 42), that a form of treatment believed to be effective in many cases cannot come under the health benefit scheme.

16. And the resentment is fuelled by the very kind of instance we have referred to, where benefits are freely available in respect of forms of treatment which were not effective, but not available for the very treatment which put the patient back on his feet. It is only too easy to see such an example as a case where public money has been wasted on ineffective treatments, but not made available to subsidise an effective treatment.

17. The Commission has reminded itself that public demand for a benefit does not necessarily mean that there is a public need for it. But we also remind ourselves of some of the pathetic cases we have seen—people of limited means who have given evidence before us, who have been struggling for years with persistent back problems, who have found that only the chiropractor could give them relief, and who have had to scrape and save and go without to meet the unsubsidised cost of the treatment they find they need.

18. We remind ourselves too of the people who gave evidence before us who, because of their jobs or because of their recreational interests, had to remain active, and who had found that chiropractic treatment was the best way of ensuring that they did remain active. We remind ourselves of the carrier who double-parked his truck outside our hearing room so that he could come and give his evidence in person at a public sitting about this very point.

19. Weighing up all these and many other factors it has become clear

that health benefits ought to be made available for chiropractic treatment, and that there is a genuine public need for them. We find no good reason in principle why the health benefits scheme should not be extended to cover chiropractic treatment.

20. The cost of extending benefits to cover chiropractic treatment (which we discuss later in this chapter) is not likely to be great, and it will need to be set off against what we consider could in the long term be a significant saving in benefits for medical, physiotherapy, and pharmaceutical charges. We will deal with the question of cost separately, and will suggest ways in which, at least initially, costs could be controlled.

21. We should at this stage mention a point made by the Department of Health (Submission 41, pp. 25-7). It is perhaps a philosophical point. It is said that a major feature of New Zealand's health services is a "dual system" with public and private services functioning side by side. The importance is emphasised of a patient having a true choice between obtaining the care he needs in the free public sector or seeking it in the subsidised private sector. It is pointed out that there is not a single example of a health benefit being available in the private sector for services not available in the public sector. Because chiropractic treatment as such is not available in the public sector, the subsidy of private chiropractic treatment would infringe the principle of a "dual system".

22. We appreciate the point of principle involved, but we do not see it in this instance as providing any obstacle to what we propose. There is nothing to prevent hospital boards from employing chiropractors for either inpatient or outpatient services, and indeed we consider this to be a development on which hospital boards might well seriously reflect. But apart from that, if a particular patient requires spinal manual therapy he can, presumably, already get it in the public sector from a physiotherapist. If he prefers the therapy to be delivered by a chiropractor, then for the present he must move into the private sector.

Accident Compensation Benefits

23. The position in terms of the Accident Compensation Act is technically somewhat different because, as we have explained, chiropractic treatment is already included in the accident compensation scheme but only on medical referral. We have seen how the actions of organised medicine have unjustifiably stultified the scheme in this respect. The solution is a simple one: to amend the Act so as to do away with the requirement for medical referral. In the Commission's view a medical referral is not needed in any event. An appropriate amendment is suggested later in this chapter.

Rehabilitation

24. The Accident Compensation Commission is expressly charged by the Accident Compensation Act 1972 with the duty to "promote a well coordinated and vigorous programme for the medical and vocational rehabilitation of persons who become incapacitated as a result of personal injury by accident" (section 48 (1)).

25. We consider that chiropractors have an important role to play in rehabilitation, particularly in regard to back problems of a musculo-skeletal nature. Advantage should be taken of their particular skills and training in this area.

26. The Act does not mention chiropractors, but clearly it is in the

public interest that they be included in the Accident Compensation Commission's rehabilitation programme. The Act should be amended accordingly, and we so **recommend**.

DISORDERS TO BE COVERED BY BENEFITS

27. For reasons fully expressed elsewhere in this report we consider that health and accident compensation benefits should be payable only in respect of a limited range of disorders. Many disorders we have classified as Type M (musculo-skeletal) disorders are known to respond to spinal manual therapy. Type O (organic and/or visceral) disorders, on the other hand, sometimes appear to respond to chiropractic treatment, but unpredictably. Not enough is known about the relationship of cause and effect in the latter cases to enable us to say that, in general, spinal manual therapy is much more than an experimental form of treatment. But we see no reason why a benefit should not be available in a Type O case where chiropractic treatment is given on medical referral.

28. It may be said that a good deal of medical treatment is experimental in the above sense, and we think that may be true. It might therefore be argued that it is unjust that a solely chiropractic patient should be deprived of a subsidy for his successful or unsuccessful treatment in such a case while a medical patient is not. We consider that the answer lies in the development of chiropractic research in the future which may, in the end, mean that the outcome of treatment for a Type O complaint will become more scientifically predictable. In the Commission's view any process of trial and error which is a feature of medical treatment must for the present be regarded as proceeding on a more scientifically informed basis than the trial and error involved in chiropractic treatment of Type O disorders. That is the distinction which makes the difference.

29. We emphasise that we do not in the least attempt to discourage chiropractic clinical experimentation. All we are saying is that for the present it should not attract a health subsidy in the Type O area unless a medical practitioner judges that in a particular instance chiropractic treatment may bring about a significant improvement in the patient's condition, and a referral is made accordingly.

30. It has been impressed upon us by various parties that once a chiropractic benefit is introduced there is no way of limiting it. The argument is that a chiropractor treats a subluxation, not a specific ailment, and that therefore there is no way of specifying the range of ailments which may attract a chiropractic benefit. We do not agree. The formula which we recommend below depends on the identification of a disorder within a defined category. Doctors are accustomed to thinking in these terms. Chiropractors are not. But for benefit purposes chiropractors must be prepared to document their findings in this way. It is true that, as in any attempt to classify, there may be cases falling within a grey area. But this is a situation familiar enough to anyone who has to make a decision on whether a situation falls within a particular category, and we see no unusual problems in the process.

31. We considered at one stage that there could be a case for benefits for "preventative" treatment for people whose normal occupations or duties rendered them particularly vulnerable to back complaints, the chiropractic care being designed to keep spinal problems from arising. We still think this is an important area and that there is a case for a benefit in this situation, but on balance take the view that it would be premature to think of introducing it at present. It is best, we think, to regard

“preventative” chiropractic as a possible extension to a chiropractic benefit to be considered once it is seen how the proposed benefit systems operate in practice.

Range of Disorders to be Covered by Benefits

32. What we now recommend applies to benefits under both the Social Security and Accident Compensation Acts in respect of chiropractic treatment given by a chiropractor on direct consultation by the patient and without medical referral.

(a) *Musculo-skeletal Symptoms*

33. We consider that the benefit schemes should operate in regard to chiropractic treatment aimed at the relief of specific symptoms which are generally accepted as having their origin in biomechanical dysfunction of the vertebral column, pelvis, and the extremities, including their associated soft tissues.

34. Inherent in this concept is the requirement that any claim for a benefit for chiropractic treatment must be justified by specific reference—

- (a) To the symptoms at the relief of which treatment is aimed;
- (b) To the specific biomechanical dysfunction diagnosed as giving rise to the symptoms;

and must include the chiropractor's assessment of how many treatments are likely to be required and over what period of time.

35. In order to avoid doubt we consider that in any legislation or regulations designed to bring chiropractic benefits into effect it should be specifically stated that, without limiting the range of symptoms or disorders at the relief of which chiropractic treatment which will attract a benefit may be aimed, such symptoms or disorders are to include migraine (classical or common), headache, and all cases of referred pain which can reasonably be attributed to biomechanical dysfunction. In explanation of this we should make it clear that there is sufficient evidence for the view that migraine and other forms of headache can respond to chiropractic treatment in enough instances to justify a benefit being paid for chiropractic treatment to relieve those conditions. We are concerned to create qualification for a benefit which depends, not on any rigid Type M/Type O classification, but on a test which turns ultimately on general acceptance of the effectiveness of chiropractic treatment in regard to the relief of specific symptoms. On the evidence we have received, cases which in our recommendation should attract a chiropractic benefit clearly satisfy this test.

(b) *Organic and/or Visceral Symptoms*

36. We cannot recommend generally that benefits be paid for chiropractic treatment aimed at the relief of symptoms outside the range of symptoms we have just discussed. We have already stated our reasons.

37. But we have also stated our reasons for finding that one exception should be made. If a patient seeks chiropractic treatment on medical referral for relief of symptoms which would normally indicate a Type O disorder, then we can see no reason why a benefit should not be paid in respect of that treatment.

(c) Chiropractic Radiological Benefits

38. We hold, as already stated, that the chiropractor's X-ray is an important, if not essential, diagnostic tool. In addition to other evidence we have already noted, to the effect that spinal manual therapy should not in general be attempted unless an X-ray examination has been made, we add that at St. Thomas' Hospital in London this is the standard practice.

39. We consider that a radiological benefit for chiropractic X-rays is amply justified.

(d) Possible Restrictions on Radiological Benefits

40. We have already drawn attention to the lack of co-operation between medical radiologists and chiropractors, and in particular to the reluctance of medical radiologists to make their plates available to chiropractors. In the present situation this means that if a chiropractor is to do his job effectively the patient must in some cases within a short period be exposed to more radiation than is necessary.

41. We do not doubt that according to their own standards medical radiologists sincerely believe that they have proper grounds for their reluctance to co-operate. But assessing their attitude by the most charitable independent standards we can only say that many people might accuse radiologists who will not co-operate of being irresponsible.

42. The situation clearly calls for urgent and sharp correction. One method of providing chiropractic patients with protection against unnecessary radiation is to provide in all cases that the radiological benefit is to be paid direct to the radiologist; that the patient is to be liable only for that part of the radiologist's fee not covered by the benefit; and that it be an express condition of payment of the radiological benefit that the radiographs be made available on request to the patient's chiropractor.

43. The lack of co-operation is by no means one-sided. We have learned of instances where chiropractors have been reluctant to make their radiographs available to the patient's doctor. Precisely the same criticism applies. A radiological benefit for chiropractors should be subject to the same set of conditions.

THE MCKINLAY GUIDELINES: NEED TO MONITOR SUBSIDISED HEALTH SERVICES

44. In arriving at the conclusions expressed in this chapter we have been considerably assisted by submissions made by Professor John B. McKinlay (Submission 41, addendum). Professor McKinlay was called as a witness by the Department of Health. He is a New Zealander, visiting professor at the Wellington Clinical School of Medicine, Otago University, and consultant to the Department of Health. His permanent appointments are at Boston University and the Massachusetts General Hospital (Harvard Medical School). We were impressed by his submissions which were presented from an entirely neutral standpoint.

45. Professor McKinlay's main point was that the nature and magnitude of existing health expenditure were in no way related to any of the traditional outcome measures of the nation's health, such as mortality and life expectancy. "Moreover", he continued (p. 1), "many of the services and procedures contributing to health care cost inflation during this period of fiscal crisis either (a) are known to be ineffective but persist in the face of this knowledge, or (b) have never been evaluated at all in terms of commonly accepted criteria."

46. Professor McKinlay is not the only person who has expressed concern that subsidies for health care are given in this country without any noticeable attempt to monitor whether all the treatments subsidised by public money are effective, or whether alternative and more economic treatments are available. Mr D. A. Preston, Director of the Social Services Division of the Treasury, only a year earlier had drawn attention to the problem ("*The Health Expenditure Problem in New Zealand*", N.Z. Med. J. 1977, 85: 480-3);

Since the late 1960s the upward creep in health costs has changed into a gallop. Between 1969-1970 and 1975-1976 Government current spending on health costs has risen at an average compound rate of 20 percent each year. Much of the rise was inflation—price increases in the total economy averaged about 10 percent a year over the period—but a very large part represents a real shift of national resources into additional health care activity.

A spending surge of this magnitude raises . . . fundamental questions. The first is whether we have got value for our money. I would welcome evidence to the contrary, but a layman's perusal of New Zealand's health statistics since the late 1960s shows no discernible change in trend in such indicators as life expectancy, infant mortality, or disease incidence. It seems we are not getting much extra value for our greatly increased spending. . . .

As medical science advances the results show an increasingly sophisticated and elaborate medical technology. The technology involves ever more expensive costs to pay for equipment, buildings and the incomes of highly trained health professionals. Early advances in public health such as provision of clean water supplies or the development of inoculation resulted in major improvements in health standards for relatively moderate costs per head. In most respects we are now well past this era and moving into a situation where we spend more and more to obtain progressively less dramatic improvements in medical care.

Allied with this advance is the problem of rising expectations. We now want for all of us the level of medical services available only to a North American millionaire half a generation ago.

47. The problem, then, is that the magnitude of the public contribution to existing subsidised health services leaves little room for the introduction of a new benefit. It is a problem of available financial resources.

48. Professor McKinlay suggested this solution (Submission 41, Addendum, p. 2):

... [T]here is a clear need for the establishment of a set of principles or criteria with which to inform government upon priorities for the allocation of whatever resources may become available. Such principles should be methodologically sound, clearly formulated and workable, and widely discussed by at least human service workers, researchers, educators, prospective clients and the general public, with a view to their being adopted by Government. The following guidelines are a first attempt to set down such a set of principles.

The underlying premise in the submission which follows is that Government should *not* support through public funding any service or procedure, the effectiveness of which was not, or cannot, be demonstrated. For Government to consider the cost and/or social acceptability of a service or procedure without first ascertaining its effectiveness is as irrational as a City Council which, confronted with the prospect of a new exterior paint, haggles over cost and colour preferences, without first determining the quality of the product.

49. On this basis Professor McKinlay puts forward three principal criteria which ought to be employed to determine whether a particular procedure or service ("intervention") should be publicly funded. It is to be noted that the three criteria are not regarded by Professor McKinlay as applicable only to "newly proposed interventions for public funding": they are applicable to "interventions" which are already publicly funded. He points out with some emphasis (*ibid.*, p. 9):

Firstly, there is *no* suggestion that the criteria of Effectiveness, Cost Efficiency and Social Acceptability should be applied only to interventions newly proposed for public funding. Clearly, interventions already ensconced in our publicly funded health system should be subjected to the same scrutiny. Moreover, it is likely that a large proportion of established

procedures or services would not meet these criteria and should therefore be excluded from further public funding if we are to truly receive value for money in health care.

Secondly, there is *no* suggestion that the criteria . . . should be applied only to particular interventions, or to interventions proposed by particular groups. Any intervention (whether cardiothoracic surgery, chiropractic, homeopathy, psychiatry or social work) should be subject to the same basic criteria. A situation must be avoided where, as at present, double standards exist regarding the criteria to be met, depending on the relative power of interested groups proposing or supporting some intervention.

50. The three criteria, presented in order of their importance, may be summarised as follows:

- (a) *Effectiveness*. "Whatever the intervention, it must demonstrate some ability to *beneficially* alter the natural course of a clearly defined condition or set of conditions" (ibid., p. 3).
- (b) *Cost Efficiency*. "Where two or more proposed interventions of approximately equivalent effectiveness are available, that one should be preferred which involves the least cost" (ibid., p. 4).
- (c) *Social Acceptability*. "This criterion recognises that a proposed intervention which is both effective *and* cost efficient is of no value unless it is appropriate for and acceptable to all the relevant subsections of the society into which it is being introduced" (ibid.).

51. The logic of Professor McKinlay's propositions is difficult to fault. The criteria he presents are clearly the ideal. Yet they need to be applied broadly. Not every "intervention" involves a simple cause and effect mechanism the predictability of whose response can be precisely measured. The ultimate "intervention" may not be possible until the patient's condition has been positively identified: the process of diagnosis, itself involving "interventions", may be lengthy and complex and in the end perhaps largely a matter of informed guesswork. As we have already pointed out, not all of medicine is based on sure scientific knowledge. And we said (chapter 37, para. 112):

We do not say that medical health benefits should be withheld from patients unless the treatment can be guaranteed to be successful (or is demonstrated subsequently to have been successful) and the basis for its success is scientifically established.

In making that point we recognised that ideal standards of effectiveness cannot be applied in an absolute way to any form of health treatment. What we believe Professor McKinlay was saying was that, to qualify for a subsidy, any form of treatment must be shown to possess a reasonable level of effectiveness in the light of present knowledge. So on that basis a form of treatment whose effectiveness cannot reasonably be predicted and which is, in essence, experimental, ought to be excluded from any subsidy by way of health benefit.

52. In considering whether chiropractic treatment aimed at the relief of musculo-skeletal symptoms on the one hand and organic and/or visceral symptoms on the other, should attract subsidies, we have accepted and followed Professor McKinlay's criteria as we understand them. In considering the criterion of effectiveness, we find as a fact that chiropractic treatment aimed at the relief of musculo-skeletal symptoms does demonstrate an ability to provide such relief. It has, not only a reasonable, but a convincing, level of effectiveness in the light of present knowledge. In considering the second criterion of cost efficiency, we have taken into account the direct and indirect economic benefits that are gained by the patient being put back quickly on his feet and kept on his feet. The third and least important criterion, social acceptability, is clearly met.

53. It is not part of our terms of appointment to consider whether some

forms of medical "intervention" are ineffective or unduly costly on Professor McKinlay's criteria and should therefore not be subsidised by health benefits. The Commission can, however, see the plain sense in the position that there should be some limit to the extent of public funding of ineffective or extravagant forms of treatment. The difficulty in the present situation is that under the health benefit system as it operates virtually all forms of medically-approved treatment attract a subsidy. All the Commission wishes to say is that chiropractic treatment of musculo-skeletal symptoms ought clearly to have priority in the health benefit system over ineffective forms of medical treatment if Professor McKinlay's criteria were to be adopted.

54. In the end we come back to a point already made. It is compelling and decisive.

55. The chiropractor's training in spinal manual therapy is superior to that of the physiotherapist. All but a handful of medical practitioners have had no formal training in it at all. As we have said, it is extraordinary and unjust that, by a combination of law and of medical ethical rulings, patients desiring spinal manual therapy may obtain a health benefit in respect of it only by avoiding those most qualified to give it.

EXTENT OF BENEFITS

(1) HEALTH BENEFITS

56. Subject to what we have said in the preceding sections of this chapter, we consider that there should be a benefit for chiropractic treatment under Part II of the Social Security Act, and that it should be equal (subject to the limitations which we will shortly specify) to the general medical services benefit. There should also be a radiological benefit in respect of chiropractic X-rays (subject again to limitations).

57. It was at one stage suggested to us that if any health benefit were to be recommended for chiropractic treatment it should be no more than that paid for physiotherapy treatment. We cannot accept that suggestion. Physiotherapy patients are medically screened before they receive any physiotherapy. The chiropractor, on the other hand, will in most cases have the responsibility of making a detailed diagnosis, first to exclude contra-indications, secondly to determine whether the patient should be referred for medical treatment, and thirdly to determine the precise nature of the chiropractic treatment required. All this involves a degree of training, skill, and responsibility which is much more nearly comparable to that of a medical practitioner than to that of the average physiotherapist.

58. We are indebted to the Department of Health for drawing to our attention a problem in providing any radiological benefit for chiropractic X-rays. The problem arises because, by the very nature of a chiropractor's practice, he provides his own X-rays (Submission 41, p. 17). The point is made that the initiating practitioner should have no financial interest in the investigation involved.

59. The point is a valid one. We felt it justified us in recommending financial limitations on any chiropractic radiological benefit.

Limitations on Health Benefits

60. We consider that a limitation should be placed on the total amount of chiropractic benefits payable in respect of any one patient in any one

year. We consider also that there should be a limit on the period of treatment for which the benefit should be payable. But we do not recommend inflexible limits.

(a) *Limit on Period of Treatment*

61. It seems to us, on the evidence, that in most cases, if chiropractic treatment is going to work at all, it will have some effect within the first 21 days. We consider therefore that a benefit should be available for no more than the first 3 weeks of treatment, but should be continued after that if more than 3 weeks' treatment is shown to be justified: that is, if the chiropractor is able to satisfy the appropriate authority that continued treatment is necessary. In such case the question whether and for what period further treatment continues to be justified should be reviewed at regular intervals.

62. Any arbitrary and inflexible limitation would, we are satisfied, result in hardship to those people who are kept on their feet only by continuing or periodic chiropractic treatment. We saw a number of such people who gave evidence. Some of them clearly found it difficult to manage the full chiropractic fees. They should not be deprived of a benefit for treatment that keeps them going, any more than a diabetic should be deprived of a benefit for the continuing medical attention and medication which he needs.

63. We think that at least in the initial stages of a chiropractic benefit a measure of control is desirable. It may turn out later from experience that such control can be relaxed. It means, however, that some data processing system for recording the patient's chiropractic treatment will need to be introduced by the Department of Health. Such a system must include provision to draw attention to the expiry of the 21 days' period, or to the occasions on which a review will be required. We have been greatly impressed by the administrative procedure used by the Workmen's Compensation Board in Ontario, and we consider that it could readily be adapted to New Zealand conditions. The Ontario board's office manual is reproduced as appendix 7.

(b) *Financial Limit on Benefit*

64. For the same reasons we consider that the total amount payable by way of benefit should be limited, but that the limitation should not be inflexible and should be waived in circumstances similar to those in which the suggested limitation on the period of treatment may be waived. In other words the financial limit should be waived if continued chiropractic treatment involving benefit payments above the limit is shown to be justified.

65. The current schedule of general medical services benefits is as follows:

1. Ordinary patients:		\$
(a) Normal consultation/visit	... ..	1.25
(b) Urgent consultation (at night, weekends, and public holidays)	... ..	3.00
(c) Urgent visit	... ..	4.00
2. Special group patients:		
Beneficiaries, pensioners, dependents, and chronically ill:		
(a) Normal consultation	... ..	3.00
(b) Normal visit	... ..	4.00

	\$
(c) Urgent consultations	6.00
(d) Urgent visit	7.00
Children and young persons:	
(a) Normal consultation	4.75
(b) Normal visit	6.00
(c) Urgent visit	8.00
(d) Urgent consultation	7.00
3. All plus for each 15 minutes in excess of 30 minutes ...	0.75

66. Bearing in mind all the matters we have mentioned we consider that the financial limits on chiropractic benefits should be as set out in the following table:

Table 44.1

SCHEDULE OF PROPOSED CHIROPRACTIC BENEFITS

Chiropractic benefits shall be payable according to the scale prescribed for general medical services benefits, but the maximum amounts payable by way of chiropractic benefit in respect of any patient in any one year shall be as follows. The limits stated in this table may be exceeded at the discretion of the Director-General of Health only if chiropractic treatment attracting a benefit in excess of the limits stated is shown to be justified.

	<i>Maximum Amount Payable in Any 12-month Period Without Waiver</i>
	\$
1. Ordinary patients	25.00
2. Special group patients (including children and young persons)	80.00

These figures include the benefit payment of \$0.75 for each 15 minutes in excess of 30 minutes.

67. These financial limits are of course arbitrary, but we consider them to be fair and reasonable. Any possible hardship is taken care of by the proposal that the limits may be waived in suitable cases. In any event we consider it likely that most cases will be caught by the proposed limit on the period of treatment rather than by the financial limit.

68. In cases where the waiver of either limit will be justified there will obviously be administrative convenience in considering whether both limits should be waived simultaneously. That will avoid unnecessary duplication of effort.

(c) Limit on Chiropractic Radiological Benefit

69. We consider that a chiropractic radiological benefit should be confined strictly to the diagnostic process on initial consultation. It should not be payable in respect of further X-ray plates, taken within a period of 12 months from the initial X-ray, which are used to check patient progress or are used for routine checks in a preventative health care context.

70. We consider that the benefit for X-rays used in the diagnostic process on initial consultation should be limited to three plates, the cost of any additional plates being met in full by the patient.

71. The benefit per plate should be fixed at \$5, providing for a maximum radiological benefit of \$15 in any 12-month period.

(2) ACCIDENT COMPENSATION BENEFITS

72. The position in regard to accident compensation benefits is different. We have already explained why. The Accident Compensation Commission will meet the full cost of chiropractic treatment if it is on medical referral. If the requirement as to medical referral were done away with, as we recommend, the result would be that payment for chiropractic treatment under the scheme would be limited only by the Accident Compensation Commission's normal monitoring procedures.

73. For reasons already stated in this chapter we do not think such a situation would be satisfactory. We think there should be stated and specific limits on the total amounts that may be paid for chiropractic treatment and the period of such treatment.

74. Taking into account all the matters we have mentioned earlier together with what we have learned as a result of our discussions with the relevant authorities in Ontario and British Columbia, we have arrived at the conclusion that total payments in respect of any one patient's chiropractic treatment in terms of the accident compensation scheme should be limited to \$200 in any 12-month period, that sum to include the cost of chiropractic X-rays. The total period of chiropractic treatment of any one patient in respect of which payment is made should be limited to 21 days from the date of the first consultation.

75. These limits should be waived in any case where it can be shown that a continuation of chiropractic treatment beyond the financial or time limits would be justified.

COST OF PROPOSED BENEFITS

76. It is impossible to give any more than a very approximate estimate of the cost of the proposed benefits. There are imponderable factors. However, experience overseas suggests two things: first that it is unlikely that there would be any major increase in the number of chiropractic treatments administered in cases where a benefit would be paid; and secondly that it is likely that the average pay-out per patient under either the health benefit or accident compensation schemes will be significantly less than the financial limits prescribed. But we have no way of knowing whether there will be an increase in the number of practising chiropractors in this country. Nor have we any way of predicting to what extent there would be a reduction in benefits paid in respect of other health services once chiropractic were put on a more truly competitive basis.

Health Benefits

77. We base the following estimates of cost on the survey of 4609 new patients conducted by the Chiropractors' Association and presented in evidence in this inquiry (Submission 19, Part II, pp. 98-120). The survey covered a period of 3 months (see chapter 16). Sixty-one chiropractors responded. We extrapolate from these figures the total number of new patients which the 96 chiropractors practising at the time of the survey could be expected to see in one year as follows:

Total number of new patients seen in 1 year:

$$(4609 \times 4 = 18\ 436)$$

$$18\ 436 \times 96 \div 61 = 29\ 014 \quad \dots \quad \dots \quad 29\ 014$$

78. We note, however, that in a second survey (*ibid.*, pp. 121-49) 55 chiropractors reported that in a whole year they had received 20 965 new

patients (p. 138). The total number of new patients in 1 year for 96 chiropractors may therefore be estimated as 36 593 ($20\,965 \times 96 \div 55$). We will use the latter figure so as to take account of a reasonable margin for error, and assume for the purposes of the exercise that all such patients would qualify for the proposed chiropractic health and radiology benefits under the Social Security Act.

79. There is no value in including existing, as distinct from new, patients. Most existing patients could be assumed to be outside the limits of the maximum payable or the maximum period of treatment.

80. Based on the survey of the 4609 new patients it was found that approximately 95 percent were X-rayed (p. 115); and from the table showing the ages and status of the new patients (pp. 104, 109), health benefits could be expected to fall approximately in the following proportions:

	<i>Percent</i>
Normal consultation	77.6
Beneficiaries:	
Pensioners	11.3
Children and young persons	11.1

A table referable to those 4609 new patients shows how many visits it was anticipated each would have to make (p. 117). We have adjusted the patient numbers in that table so as to relate them proportionately to the assumed 36 593 new patients.

81. In the following table (44.2) we will assume that X-rays will be taken in 95 percent of cases and that in each of such cases the full radiology benefit (\$15) will be claimed. We will also assume that the health benefit entitlement will follow the proportions shown in the preceding paragraph.

Table 44.2

AMOUNTS PAYABLE IN RESPECT OF CHIROPRACTIC PATIENTS UP TO 15 VISITS

<i>No. of Visits Anticipated</i>	<i>No. of Patients</i>	<i>Radiological Benefit</i>	<i>Health Benefit</i>		
			<i>Normal</i>	<i>Pensioner</i>	<i>Child</i>
		\$	\$	\$	\$
1	286	4,076	277	97	151
2	770	10,973	1,494	522	812
3	1 691	24,097	4,921	1,720	2,673
4	2 334	33,260	9,056	3,165	4,920
5	2 636	37,563	12,785	4,468	6,946
6	4 097	58,382	23,845	8,333	12,955
7	1 953	27,830	13,261	4,634	7,205
8	3 700	52,725	28,712	10,034	15,599
9	1 421	20,249	12,405	4,335	6,740
10	4 248	60,534	41,206	14,401	22,387
11	659	9,391	7,032	2,457	3,820
12	3 160	45,030	36,782	12,855	19,984
13	310	4,418	3,909	1,366	2,124
14	310	4,418	4,210	1,471	2,287
15	1,239	17,656	18,027	6,300	9,794
	28 814	\$410,602	\$217,922	\$76,158	\$118,397

(79% of patients)

82. The table therefore shows that the following totals might be expected in the case of the 79 per cent of patients attending up to 15 times if actual practice follows the trends apparent from the chiropractors' survey of new patients:

Radiological benefit	...	...		\$
Health benefit:				\$
Normal consultation	...	...	217,922	
Pensioner	...	...	76,158	
Child or young person	...	...	118,397	
			<u>412,477</u>	
Total	...	...		<u><u>\$823,079</u></u>

83. To this total must, however, be added the 21 percent of patients who (according to the survey) can be expected to attend on more than 15 occasions. For the purposes of illustration we will regard them as reaching either limit for payment of the benefit by the sixteenth visit.

84. We will therefore add the remaining patients (7779 of them). The figures in respect of them are as follows:

Table 44.3

AMOUNTS PAYABLE IN RESPECT OF REMAINING
CHIROPRACTIC PATIENTS (MORE THAN 15 VISITS)

Visits	No. of Patients	Radiological Benefit	Health Benefit		
			Normal	Pensioner	Child
15 ...	7 779	\$110,851	\$113,184	\$39,556	\$61,493

85. The total payable for benefits would therefore be \$325,084 in respect of those 7779 patients. However, in some cases the benefit limits will be waived. We have no way of knowing in what proportion of cases this could happen, but we will assume 30 percent. It would be reasonable to allow at least a further \$100,000 to cover those cases (the radiological benefit will of course already have been paid near the outset of the treatment, and is therefore included in table 44.3).

86. We can now combine tables 44.2 and 44.3, including the allowance of \$100,000 (apportioned among the three classes of health benefit, 77.6 percent, 11.3 percent, 11.1 percent) in respect of benefits which might be paid after the waiver of the benefit limits.

Table 44.4

TOTAL AMOUNTS PAYABLE IN RESPECT OF TOTAL
NUMBER OF PATIENTS

	No. of Patients	Radiological Benefit	Health Benefit		
			Normal	Pensioner	Child
Up to 15 visits	28 814	\$ 410,602	\$ 217,922	\$ 76,158	\$ 118,397
Over 15 visits (assumed at limits)	7 779	110,851	113,184	39,556	61,493
Allowance for benefits payable if limits waived	...	...	77,600	11,300	11,100
Totals	36 593	<u>\$521,453</u>	<u>\$408,706</u>	<u>\$127,014</u>	<u>\$190,990</u>

87. Accordingly we have the prospect of a total annual sum of \$1,248,163, calculated on the above basis, being paid out in radiology and health benefits for 36 593 chiropractic patients. That is an average of \$34 per annum per patient overall.

88. We have found it interesting to take out the average per patient in respect of each form of benefit, showing the average radiology benefit separately.

Table 44.5
AVERAGE PAYABLE PER PATIENT
(Normal consultation; pensioner; child or young person)

	<i>No. of Patients (% of 36593)</i>	<i>Average Benefit Cost (Excluding Radiology Benefit)</i>	<i>Average Radiology Benefit</i>	<i>Total</i>
		\$	\$	\$
Normal consultation ...	28 396 (77.6%)	14.39	14.25	28.64
Pensioner ...	4135 (11.3%)	30.72	14.25	44.97
Child or young person ...	4 062 (11.1%)	47.02	14.25	61.27

89. It may be noted that, compared with the maximum rates we recommend, and allowing for waiver in appropriate cases, the above averages suggest a pattern similar to that which we found in Ontario and British Columbia.

Qualifications to Figures

90. We have thought it best to present the above figures on the assumption that all the patients notionally involved—

- (a) Presented symptoms which would entitle them to benefits in terms of the formula we recommend; and
- (b) Did not come under the accident compensation scheme.

We did so because, due to the lack of any really satisfactory basic data, we wished to provide plenty of room for error.

91. The above assumptions are of course not by any means justified, but they do allow us to provide a working estimate of a reasonable upper limit.

(a) Symptoms do not Attract Benefit

92. In the first place it is probable that in approximately 10 percent of the cases a benefit would not be payable because the symptoms would not come within the recommended formula. So the figures are inflated to that extent.

(b) Accident Compensation, not Health Benefit

93. They are further inflated by the fact that in approximately 41 percent of the cases a benefit would not be payable under the Social Security Act, but under the Accident Compensation Act. The percentage is suggested by the chiropractors' survey (Submission 19, Part II, p. 111), 1868 of the 4609 patients in the survey having reported being injured as the result of accident.

(c) Probable Real Cost

94. On the figures supplied in the chiropractors' survey, which we regard as a reasonable basis for extrapolation, the annual cost of chiropractic health and radiology benefits under the Social Security Act

could amount to considerably less than the \$1,246,325, the calculated figure we have adopted (para. 87). On that basis the cost of health benefits for chiropractic treatment could scarcely be considered a significant proportion of the total amount presently expended on health benefits generally.

95. At the same time those accustomed to producing cost estimates—a notoriously unreliable exercise, particularly in the health field—will appreciate that one of the items which has not formed part of the Commission's working equipment is a crystal ball; nor does any member of the Commission claim to have the qualities of Old Moore, Mother Shipton, or Nostradamus. We have simply had to do our best with the limited data available to us.

Accident Compensation

96. We are unable to provide any cost estimate in this area that would be even remotely reliable. That is because there are little or no relevant data.

97. There is no difficulty in understanding the extent of the problem of spinal troubles resulting from accidents or incidents at work or in the home. In a public address given in July 1978, Mr J. L. Fahy, one of the Accident Compensation Commissioners, is reported to have revealed that in 1 week alone more than 14 percent of accident cases treated by general practitioners were back injuries and complaints; in the 2 years to 30 May 1976 people suffering back injuries had made 20 940 claims on the Accident Compensation Commission, and in the same period \$7,100,000 had been paid in compensation for back injuries.

98. The Accident Compensation Commission was kind enough to provide us with more recent figures. In the 6 months between 1 April to 30 September 1978, out of a total of 9048 claims for back injuries, 7790 (or 86 percent) were recorded as "back strain" or "back sprain". In respect of those 7790 claims a total of \$2,561,295 (an average of \$329 per claim) was paid, or 77 percent of the total amount paid in respect of all back injury claims during that period.

99. The Accident Compensation Commission, understandably, was unable to provide us with any estimate of the cost to the Commission in terms of working days lost and compensated for. It is, however, fair to infer from the average compensation payment of \$329 per claim for back strain that compensation at the rate of 80 percent of normal average weekly earnings is likely to be a major component, though we cannot determine it precisely. It implies, however, that a number of claimants must have been away from work for more than 1 week, since income-related compensation is not paid unless a worker is incapacitated from work for 7 days or more.

100. For the reasons we have given, chiropractors play an almost non-existent role in the accident compensation scheme. The great bulk of the treatment for back complaints in terms of the scheme is done by medical practitioners, and physiotherapists on referral from medical practitioners. We do not understand it to be suggested that many people entitled to claim under the scheme for "back strain" or "back sprain" would willingly consult a chiropractor, whose fees cannot in practice be recovered under the scheme, when treatment by other health professionals is covered under the scheme.

101. At all events we consider it logical to conclude that if chiropractic treatment, without referral, were included under the accident

compensation scheme, chiropractors could not generate any greater number of claims. The number of claims is established by the number of accidents that give rise to the claims; claims cannot be generated. The fees of chiropractors who treated accident cases would therefore simply be in substitution for the fees of other practitioners who would otherwise have treated those cases.

102. On the evidence we have heard in the course of this whole inquiry and as the result of our inquiries overseas we see the possibility of such a development tending, if anything, to reduce the amount of claims for back injury. That is because, as we have said, chiropractors have the advantage of superior training and skill in dealing with a large proportion of back problems. Certainly they are better equipped to deal with such problems than the average medical practitioner or physiotherapist who does not have such training. There appear to us to be clear potential financial advantages, rather than additional cost, in giving chiropractors a full part to play in the accident compensation system.

103. We do not consider this will result in any financial loss for medical practitioners. The experience in Ontario and British Columbia, where chiropractors have participated in compensation schemes for many years, shows that chiropractors do not handle a great proportion of compensation cases. That is because the cases they are able to handle effectively fall within a narrow range.

Possible Difficulties

104. The Accident Compensation Commission, in its formal submission to us, expressed a reservation about bringing chiropractors into the scheme without medical referral. This reservation was based on the fear that, if this were done, the goodwill which the Accident Compensation Commission has established with the medical profession might come under threat (Submission 49, p. 2). We cannot be expected to take such a suggestion seriously, although it is true that there could be some minor administrative problems. The nature of these was indicated by the Accident Compensation Commission when it told us (*ibid.*, pp. 1-2):

If the recognition were to extend so far as to give chiropractors the power of registered medical practitioners to issue certificates for the purposes of the Accident Compensation Act then legislative changes would be required. The practical implications would be extensive and controversial, particularly if an accident victim received all his treatment from the chiropractor, and none from a medical practitioner. This would involve the chiropractor supplying the necessary certificates of injury and period of incapacity to the Commission; he would necessarily then become involved in questions of rehabilitation, referral to specialist and, frequently, lump sum assessments. The chiropractor would, in effect, be operating a treatment service parallel with, and indistinguishable from the medical profession. In the present state of non-collaboration between chiropractic and the medical profession, the results of such a parallel system would, at least, be confusing, possibly chaotic, and could only react to the detriment of the administration of the claims of accident victims.

105. In our view these difficulties are more apparent than real. In practice chiropractors are most unlikely to have sole charge of any case which is going to require specialist medical intervention. If any such case arises the chiropractor will almost certainly refer the patient (if such referral becomes possible) or at least ensure that the patient gets appropriate medical attention. The great bulk of cases which the chiropractor will see will be routine "back strain" and "back sprain" cases which will clearly be within his professional competence, and we are quite unable to see why he should not be able to issue the necessary

certificates of injury and period of incapacity. We **recommend** that the Act be amended accordingly.

106. We note that none of the difficulties envisaged by the Accident Compensation Commission have arisen in the Ontario or British Columbia workers' compensation systems, in which, as we have seen, chiropractic treatment has been a long-standing feature. This is because all forms of treatment are carefully and efficiently monitored. But in any event if any such difficulties did arise in New Zealand it is in the patient's interest that they be overcome in the same spirit of pragmatic compromise which we have noted in medical-chiropractic relations overseas. It should not be beyond the powers of the Accident Compensation Commission to promote such a spirit.

COLLECTION OF BENEFITS

107. Because of the limitations which we recommend should be placed on chiropractic benefits under both systems there is obvious administrative convenience in chiropractors claiming and receiving benefits direct. We do not favour a system where the patient himself pays the whole of the chiropractor's fee and then claims a refund.

CHIROPRACTORS AND OTHER BENEFITS

108. The Department of Social Welfare, in its submission to us (Submission 64), drew our attention to legislative provisions administered by the department which might require amendment as a consequence of any general recommendations which we might make. In the light of the recommendations which we are now making it is apparent that the provisions mentioned by the department could create anomalous situations if not amended.

(a) *Invalids' Benefits*

109. Section 44 of the Social Security Act provides that the Social Security Commission may require an applicant for an invalid's benefit, or an invalid's benefit holder, "to submit himself for examination by a medical practitioner . . . who shall certify whether or not in his opinion the applicant or beneficiary is permanently and severely restricted in his capacity for work . . . and shall state the grounds on which his opinion is founded." The term "medical practitioner" as defined in the Act does not include a chiropractor, and so chiropractors' certificates are not acceptable for invalids' benefit purposes.

110. We see no reason why a disabled person who is a chiropractic patient should be obliged to consult a medical practitioner to obtain such a certificate if, in the circumstances, the disability is of a kind which is within the chiropractor's normal scope of practice.

111. We **recommend** that section 44 be amended by adding after the words "medical practitioner" the words "or, in respect of any condition within the ambit of his profession, a registered chiropractor".

(b) *Sickness Benefits*

112. A similar situation exists in regard to sickness benefits. Section 56 of the Act provides that "Every application for a sickness benefit shall be supported by the certificate of a medical practitioner, or the certificate of a registered dentist in respect of any condition within the ambit of his profession, certifying that the applicant is incapacitated for work . . ."

113. Again we see no reason why a person under chiropractic treatment should be obliged to go elsewhere for a certificate which the chiropractor is qualified to give, and we therefore **recommend** that section 56 be amended by adding, after the words "registered dentist", the words "or a registered chiropractor".

(c) *War Pensions*

114. The War Pensions Regulations (S.R. 1956/7) provide that an ex-serviceman may apply for free medical or surgical treatment in respect of any disability which has been accepted by the War Pensions Board as related to service with the armed forces (regulation 34). Application for medical or surgical treatment may be made by "any medical practitioner to whom the service patient has applied for medical treatment or from whom he is receiving any such treatment . . ." (reg. 35). These provisions do not extend to chiropractic treatment, and ex-servicemen receiving such treatment for a service disability must meet the full cost of it.

115. More than mere inconvenience to the patient is involved here. We consider that the Regulations should cover chiropractic treatment.

116. We **recommend** that regulation 34 be amended so that an ex-serviceman may apply for free medical, surgical, or chiropractic treatment; and that regulation 35 be amended by deleting the words "any medical practitioner to whom the service patient has applied for medical treatment" and substituting "any medical practitioner or registered chiropractor to whom the service patient has applied for medical or chiropractic treatment as the case may be".

RECOMMENDATIONS

117. It will be convenient if we set out the recommendations contained in this chapter as follows:

A. *Chiropractic Benefits Under the Social Security Act*

(a) Subject to the limitations stated below, the chiropractic benefits should be equivalent to the general medical services benefits.

(b) (i) No benefit should be paid for any chiropractic treatment administered after 21 days from the date of the first consultation unless treatment for a period of more than 21 days is shown to be justified.

(ii) In no case should the total amount of chiropractic benefit paid in respect of any one patient in any one period of 12 months exceed the amounts stated in the table below, unless treatment involving payment in excess of any such amount is shown to be justified.

	<i>Maximum</i>
	\$
Ordinary patients	25
Special group patients (including children and young persons)	80

The above maxima are inclusive of the benefit payment of \$0.75 payable for each 15 minutes in excess of 30 minutes, but exclusive of the radiology benefit.

(c) Part II of the Social Security Act should be amended accordingly.

B. *Chiropractic Benefits Under the Accident Compensation Act*

(a) That accident compensation benefits be made available for the cost of treatment by a registered chiropractor (subject to the limitations stated below) without medical referral.

(b) That the Accident Compensation Act 1972 be amended accordingly, and that in particular section 111 be amended as follows:

- (i) In subsection (1), by inserting in line 5 after the word "medical" the words "or chiropractor's";
- (ii) In subsection (2), by inserting after sub-para (c) the following subparagraph:
 "(ca) Treatment of the person by a registered chiropractor";
- (iii) In subsection (5), by inserting in line 3, after the words "medical practitioner", the words "or a registered chiropractor";
- (iv) In subsection (8), by inserting in line 13, after the word "radiological", the word "chiropractic".

(c) That total payments in any one year in respect of a patient's chiropractic treatment (including X-ray costs) should be limited to \$200.

(d) That the total period of chiropractic treatment in respect of which benefits are payable should be limited to 21 days from the date of the first consultation.

(e) The limits stated in subclauses (c) and (d) should be waived in any case where chiropractic treatment beyond the financial or time limits is shown to be justified.

C. *Chiropractic Radiology Benefits Under the Social Security Act*

The radiological benefit should be confined strictly to the diagnostic process on initial consultation. It should be limited to three plates, at \$5 per plate, thus providing for a maximum radiology benefit of \$15.

D. *Rehabilitation*

(a) That chiropractors be expressly included as part of the Accident Compensation Commission's rehabilitation programme (Accident Compensation Act 1972, sections 48-53).

(b) That the Act be amended accordingly by—

- (i) Deleting, in section 49 (1) (a), the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic";
- (ii) Deleting, in section 52, the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic"

E. *Limitations on Chiropractic Treatment Under Both Acts*

(a) That the cost of treatment by a registered chiropractor or a chiropractic benefit, unless the treatment has been administered on referral from a registered medical practitioner, shall be payable only in respect of treatment aimed at the relief of specific musculo-skeletal symptoms, such as back pain, which are generally accepted as having their origin in biomechanical dysfunction of the vertebral column, pelvis, and the extremities, and their associated soft tissues. Without limiting the symptoms so described, such symptoms shall include migraine (both

common and classical), other forms of headache, and all cases of referred pain which can reasonably be attributed to biomechanical dysfunction, but shall not include symptoms indicating organic or visceral disorder. Payment of a benefit under the Acts should not be made unless the treatment in respect of which payment is claimed is justified by—

- (i) Specific identification of the symptoms at the relief of which the treatment is aimed; and
- (ii) Specific identification of the biomechanical dysfunction diagnosed as giving rise to the symptoms;

and unless the chiropractor has certified his assessment of how many treatments are likely to be required and over what period of time.

(b) Payment of a benefit under the Acts may be made in any case not coming within the terms of clause (a) of this recommendation where the treatment is given on medical referral.

F. *Conditions for Payment of Radiology Benefits (Medical and Chiropractic)*

(a) That radiology fees or the radiology benefit be paid direct to the medical practitioner or chiropractor concerned.

(b) That the patient is to be liable only for that part of the radiologist's or chiropractor's fee not recoverable under the Social Security or Accident Compensation Acts.

(c) That before being eligible to receive payment of a radiology fee or benefit under the Acts each medical practitioner should be required to undertake in writing to the Department of Health or the Accident Compensation Commission that he will, if called upon to do so, furnish a patient's radiographs to that patient's chiropractor for examination, and a chiropractor should be required to give a corresponding undertaking.

G. *Collection of Benefits*

Chiropractic benefits under either Act should be claimed and collected by the chiropractor direct from the Department of Health or the Accident Compensation Commission. The chiropractor should be entitled to recover from his patient only the amount of his fee not covered by those benefits.

H. *Miscellaneous Amendments to the Social Security Act*

(a) *Invalids' Benefits*

That section 44 be amended by adding after the words "medical practitioner" the words "or, in respect of any condition within the ambit of his profession, a registered chiropractor".

(b) *Sickness Benefits*

That section 56 be amended by adding after the words "registered dentist", the words "or a registered chiropractor".

I. *War Pensions Regulations*

That regulation 34 be amended so that an ex-serviceman may apply for free medical, surgical, or chiropractic treatment; and that regulation 35 be amended by deleting the words "any medical practitioner to whom the service patient has applied for medical treatment" and substituting "any medical practitioner or registered chiropractor to whom the service patient has applied for medical or chiropractic treatment as the case may be".

Chapter 45. CHIROPRACTORS AND THE HEALTH CARE TEAM OF THE FUTURE

INTRODUCTORY

1. One of the greatest barriers to integration of chiropractors into the general health care team has been ignorance. During this inquiry we have heard a great deal about chiropractic from non-chiropractors who might well have come within Isabella's category of those "Most ignorant of what he's most assur'd" (Measure for Measure, II, ii).

2. It would be easy to say that medical practitioners are on the whole biased and prejudiced against chiropractic, and that prejudice is what has kept chiropractors in isolation. It would be fairer at the present day, to say that ignorance and misinformation have been the main factors. If this inquiry has achieved nothing else, it has left little excuse for ignorance; it has, we hope, cleared up many aspects on which people have been misinformed and misled about chiropractic. We do not in the least overlook that some few "hard-sell" chiropractors are themselves to blame for people getting wrong impressions about chiropractic generally: the good work done as a matter of routine by the majority of chiropractors tends to be known only to their patients and to a few medical practitioners who have seen for themselves what can be achieved.

3. It is the work done by this responsible majority which deserves support and should, in the public interest, become part of the armamentarium of a general health service. The case for the inclusion of chiropractors in the general health care team is therefore overwhelming. Once New Zealand chiropractors accept that they must discipline their few maverick colleagues, and once the outdated and unnecessary medical ethical rule against referral to and collaboration with chiropractors has been done away with, we can foresee patients—particularly those with musculo-skeletal back problems—getting the kind of service to which they are entitled.

4. We must now try to gather the threads together in a constructive way. How will the future chiropractor compare with those in practice now? What is the likely future of spinal manual therapy? We will now answer these and other questions.

THE CHIROPRACTOR OF THE FUTURE

5. On several occasions during his presentation of the case for the New Zealand Medical Association, Mr Eichelbaum as counsel urged that the Commission should be careful not to assess New Zealand chiropractic exclusively by reference to the evidence of those chiropractors presently practising. He pointed out that our recommendations should take into account the practice of the chiropractor of the future; that, from the North American and Australian trends in chiropractic education and practice, it was likely that the future New Zealand chiropractor would tend to broaden rather than restrict his practice.

6. We take the point that we should assess chiropractic in New Zealand not only in relation to present practice, but also in relation to how those students at present progressing through the chiropractic colleges, and future chiropractic students, are going to see themselves as primary health

care practitioners. That is one of the reasons why we decided that we should extend our inquiry so that the Commission could gain a personal impression of overseas developments in chiropractic education.

General Assessment of Future Chiropractic Education

7. As we have said, some 70 percent of New Zealand practising chiropractors were educated in Palmer College in Davenport, Iowa. With the absorption of the International College of Chiropractic in Melbourne, Australia, into the Preston Institute of Technology, that pattern is hardly likely to be maintained. It is clear that in the future many prospective chiropractors will see the Preston Institute as their obvious first choice for chiropractic education, especially if our recommendations regarding chiropractic bursaries (chapter 38) are accepted. Some may still wish to attend Palmer College, perhaps as a matter of family sentiment, perhaps because of that college's tradition in chiropractic. Others may for similar reasons wish to attend the Canadian Memorial Chiropractic College in Toronto, partly also because of the financial difficulties faced by any foreign student in a United States college and the extreme present difficulties there in foreign students being able to obtain work to support themselves.

8. So the tendency will be for the Preston Institute to become the major source of chiropractic education for New Zealand purposes, with the possibility of some chiropractic students being able to surmount the financial hurdles to attend Palmer College or the Canadian Memorial Chiropractic College. We do not discount the possibility that some prospective students who are financially able to do so may wish to consider the National College of Chiropractic in Lombard, Illinois, which impressed us with its high standards and excellent facilities, or, for that matter, the other CCE accredited colleges, although those colleges seem to have attracted little support from New Zealand chiropractic students in the past. Palmer College has, of course, only very recently become fully accredited.

Chiropractors and Physiotherapy

9. In three of the chiropractic colleges we visited—National College in Illinois, Los Angeles College in California, and Canadian Memorial College in Ontario—it was taken for granted that chiropractic training should include techniques which we have come to associate with physiotherapy such as traction, heat, ultra-sound, and the like. Such equipment was much in evidence in those colleges' clinics.

10. While it seems to us that the use of physiotherapy aids by chiropractors properly trained in their use is a sensible and logical development, it does involve a duplication of effort. The New Zealand chiropractor of the future will in our prediction tend to rely on the physiotherapist to supply such treatment. That is because the use of typical physiotherapy aids is not taught at Preston Institute. There are local political reasons for this: again it is a case of local conditions setting the pattern of chiropractic education and practice. In a New Zealand context there is of course some inconvenience to the public in having to obtain two closely associated kinds of therapy from different sources, but that is in our view an argument in favour of chiropractors and physiotherapists working together on any case where both chiropractic and physiotherapy treatment is required. That is better than the education of one or the other being expanded.

11. At the same time we see no reason why a chiropractor should not use physiotherapy aids if he is properly trained in their use, as he will be if he has graduated from a chiropractic college such as National. However, ultra-sound is restricted by statute to medical practitioners and physiotherapists: Physiotherapy Amendment Act 1953, section 3; and there is clearly a case for amending this section to include chiropractors who are able to provide satisfactory evidence of training in the use of ultra-sound equipment. We so **recommend**.

Chiropractors and "Manipulative Therapists"

12. At earlier stages of this report we drew attention to part-time courses in manipulative therapy operated under the auspices of the New Zealand Manipulative Therapists' Association. We pointed to the lack of Government financial support for the courses, mentioned that they were maintained only by a small group of dedicated physiotherapists, and commented that their future seemed insecure.

13. We have reached the conclusion that these courses are an unnecessary duplication of training in manual therapy skills. This training is better done in the formal full-time courses offered by the chiropractic colleges. We cannot support any suggestion that the courses offered by the Manipulative Therapists' Association be subsidised from public funds. We have already indicated our view that, if there is to be any Government subsidy for education in spinal manual therapy, it would be best allocated towards bursary assistance to enable interested students to attend Preston Institute.

CHIROPRACTORS IN HOSPITALS

14. Chiropractors desire admission to hospitals for two reasons: first, to enable them to treat hospitalised patients who want and need chiropractic treatment; and secondly, as an aid in their diagnostic training. There is a third ground for admitting chiropractors to hospitals which they themselves did not advance: the enhancement of the work of hospital rheumatology and rehabilitation departments² by the work of highly-trained manual therapists.

(a) *Diagnostic Training*

15. We will deal with the second point first in order to dispose of it. During our public sittings the point was made by those who opposed chiropractic that chiropractors must be seriously limited in their diagnostic ability because they do not have access to hospitals. When confronted with the argument that the simple remedy for this alleged deficiency in training was to make hospital access available to them, the answer was (as we understood it) that this was impossible because of the philosophical differences between chiropractors and the medical profession.

16. We have already given our reasons for dismissing that argument. We do not accept the suggestion that chiropractors are deficient in the diagnostic abilities appropriate to their limited role; but we agree that their training in diagnosis would be improved by their having access to hospitals (see chapter 38, para. 34).

(b) *Access by Hospitalised Patients to a Chiropractor*

17. We return to the first point: that chiropractors wish, when the need arises, to be able to treat their patients who have been hospitalised. It is also pointed out that the immobility imposed in some cases by hospitalisation can create musculo-skeletal problems which can be relieved by chiropractic treatment.

18. This seems to the Commission to be a perfectly proper attitude and in the Commission's view it is unanswerable. The only limitation, in our view, must be that chiropractic treatment should not be given where there are medical contra-indications. By this we mean some solid and soundly-based medical reason. We do not mean that a hospitalised patient should be prevented from receiving chiropractic treatment simply because the doctor in charge of the case believes that chiropractic treatment would be ineffective, or because there is some imagined philosophical difference. In a case where there could be some risk attached to manual therapy we see no reason why doctor and chiropractor should not consult together on the problem so that the doctor is made to understand precisely what treatment and result the chiropractor has in mind, with due recognition given to the fact that the chiropractor can normally be expected to have a knowledge of biomechanics and training and skill in manual therapy beyond that of most medical practitioners.

19. We therefore see no good reason why chiropractors should not have access to hospitals in order to treat hospitalised patients in appropriate cases. It is worth noting that the New Zealand Nurses' Association Inc., in the oral presentation of its submission, saw no real difficulty in this as long as a nurse knew precisely where the responsibilities of nurse, doctor, and chiropractor lay. That in our view is a reasonable approach. The position, as we see it, is that a hospitalised patient should be entitled to chiropractic treatment if he wishes to have it, unless there are real medical contra-indications. Whether there are real medical contra-indications is a matter which the medical staff must decide in consultation with the chiropractor. If there are no such contra-indications, then the patient becomes the chiropractor's patient throughout the course of chiropractic diagnosis and treatment subject of course to any legitimate medical limitations that it may be necessary to impose.

20. We therefore **recommend**:

- (a) That hospital authorities allow chiropractors to have access to their hospitals to give chiropractic treatment to patients who request it unless the supervising physician or surgeon withholds his approval on the ground that there are precise and specific contra-indications.
- (b) That, if necessary, the Hospitals Act 1957 be amended to put the above recommendation into effect.

(c) *Assistance in Rheumatology and Rehabilitation Departments*

21. In his foreword to Fisk, *A Practical Guide to Management of The Painful Neck and Back* (Springfield, Illinois, 1977), p. vii, Dr B. S. Rose of the Department of Rheumatology and Rehabilitation at Waikato Hospital comments that:

Any practitioner attempting the treatment of common musculoskeletal complaints soon becomes acquainted with the problems of localized and referred segmental pains, which may be relieved by spinal manipulation. Without the necessary expertise, he is painfully aware that he is missing one cylinder, and that others with only this one cylinder firing are quick to exploit his patients. Some patients experience dramatic relief with no harm done.

Others are deprived of the opportunity for satisfactory investigation and treatment of nonmechanical aspects, and a few are positively harmed. A hospital department of rheumatology and rehabilitation medicine lacking the effective application of manipulative techniques in its physical medicine section fails to provide a comprehensive service. . . .

Dr Fisk's . . . specialist colleagues in our department and in the departments of neurology and orthopedic surgery are also greatly indebted to him for help with selected headache and backache patients. Those patients might otherwise have been regarded as neurotic after failing to respond to other measures.

22. It would be unfair to attribute to Dr Rose any intention to argue that chiropractors should participate in the work of such a department (in the same foreword he refers to "the cure-all attitude and theoretical mumbo jumbo which have hitherto bedevilled both discussion and practice in some quarters"); but the argument for the inclusion of chiropractors could scarcely be better put. It cannot seriously be doubted that chiropractors have the "necessary expertise" in spinal manipulation which other health professionals on the whole conspicuously lack. That is because the greater part of their training is devoted to acquiring that expertise.

23. The incorporation of chiropractors into this kind of hospital service is therefore an entirely logical and proper development. But it will not happen overnight. For one thing there are probably not enough chiropractors in New Zealand at present to enable such a development to be serviced. Secondly, it will be necessary as a first step to overcome the misunderstanding, mistrust, and ignorance which must be expected to hinder the formation of a proper working relationship between doctor and chiropractor in a hospital setting. Indeed, the same might be said of the factions, *pro* and *con* spinal manipulation, within medicine. As Dr Fisk himself aptly points out (*ibid.*, p. 4):

Those *against* mainly consist of orthopaedic surgeons, who see the failed manipulations; those *for* are a mixed group of enthusiasts who have found, by practical experience, that a considerable number of patients derive benefit from it. It is amazing how much heat with very little light may be generated by any discussion between the two groups. The degree of heat seems to be proportionate to the degree of ignorance on both sides.

24. At all events the Commission sees the participation by chiropractors in hospital physical medicine services as a development which should be positively encouraged in the public interest and so **recommends**. Quite apart from providing some patients with a benefit of which they are at present being deprived, such a development would enable chiropractors to demonstrate their expertise in an environment where it could hardly be ignored. The best way of persuading doctors that there is value in a chiropractor's expertise is to show that expertise in action.

DRUGLESS THERAPY v. ALLOPATHY

25. As we have seen, much is made by chiropractors of the drugless and non-surgical nature of their therapy. But modern chiropractors do not suggest that there is only one cause of disease; they admit that there are limits to their expertise; and they acknowledge the need for medical intervention and medical monitoring. They do, however, place emphasis on the body's natural functioning and its natural recuperative powers.

26. In these matters of emphasis we see some value in the contribution the chiropractic outlook can make to health care generally. There cannot be any fundamental objection to an attitude to health care which restricts drugs to cases where they are shown to be a matter of necessity rather than a matter of mere convenience. Nor can it seriously be suggested that

anyone is unreasonable to believe that it is better for the body's disorders to be relieved, if possible, by natural, rather than artificial or chemical means.

27. There is of course a danger in such ideas being taken to extremes. Given the choice, many people would prefer drugless or non-surgical treatment to drugs or surgery, and the risk is that such a choice might not be wisely made. But as long as the choice can be exercised on a properly informed basis, it is reasonable to suggest that it should be freely available. Anything that would help to reduce New Zealand's staggering pharmaceutical expenditure should at least be seriously considered.

28. The possibility we see in the future encouragement of chiropractors and medical practitioners as partners in the general health care team is that each, through a closer working association, may have a clearer view of the other's outlook. Thus the patient's area of choice may well be effectively widened. We would expect to see some medical practitioners questioning their use of drugs, just as we would expect to see some chiropractors forming a clearer view about the limitations of their form of treatment. It is a matter of the patient being offered the best of both worlds.

CHIROPRACTIC RESEARCH

29. It is clear that chiropractic research, noticeably inconspicuous in the past, is likely to develop under the influence of academics such as Haldeman, Kleynhans, Tran, and others, and Professor Suh's group working at the University of Colorado.

30. There are however four points that need to be clearly made:

- The kind of fundamental research that is needed is essentially long term. One needs to think of years, not months. Results will not necessarily come quickly.
- While the desire of chiropractic colleges to set up research programmes and conduct them within their own walls is understandable, it must be realised that only the universities have the resources to make extended research programmes feasible, and that only universities have the reputation of independence and scientific integrity which can give those programmes and their results the necessary universal credibility.
- A priority for research should be a properly designed trial of the effectiveness of spinal manual therapy for a selected condition. Such a trial could be conducted in New Zealand as a co-operative venture between chiropractors and a medical school, and should be publicly funded. We have already made a specific recommendation on this (see chapter 37, para. 139).
- There is an obvious need for continuing fundamental investigation of possible neurophysiological mechanisms to explain how specific spinal manual therapy can influence organic or visceral disorders. Medical and chiropractic researchers should pool their knowledge in conducting such research, not for the purpose of proving a point, but simply in a desire to get at the truth.

RELATIONS WITH THE MEDICAL PROFESSION

31. Provided the rule of medical ethics preventing referral to chiropractors is abolished, and provided chiropractors put their own disciplinary house in order, there is every prospect of a good working

relationship between chiropractors and other health professionals. No doubt it will develop first, as all inter-professional relationships do, on an individual basis. There may still be doctors who will remain fixed in their belief that all chiropractors are quacks, but we see them as a diminishing force in the future. It is, after all, only common sense to make use of another health professional's special skills if they are available, and on any view of the matter the chiropractor is highly trained in a field in which medical education has been very far from adventurous.

CHIROPRACTORS AS PARTNERS, NOT MEDICAL AUXILIARIES

32. It is clear that the chiropractor must come into the health care team as a partner, not as an auxiliary. He must not be required to give up his independent professional status. That is because he has training and expertise in an area where most medical practitioners have no special training or expertise. In that respect the doctor must defer to the chiropractor. So also must the chiropractor defer to the doctor in the much more extensive areas where specifically medical training is demanded.

33. The idea that in some matters a medical practitioner will have to defer to the chiropractor may seem at first sight outrageous. It is not outrageous at all. It is simply a question of the scope of professional training. You go to a dentist, not a doctor, for repairs to your teeth. There is nothing surprising in that. Doctors are not experts in dentistry; nor are they experts in spinal manual therapy. So it is right and proper that they should feel the need to defer to those who are experts.

34. The Commission has found it established beyond any reasonable degree of doubt that chiropractors have a more thorough training in spinal mechanics and spinal manual therapy than any other health professional. It would therefore be astonishing to contemplate that a chiropractor, in those areas of expertise, should be subject to the directions of a medical practitioner who is largely ignorant of those matters simply because he has had no training in them. That is one reason why physiotherapists are becoming irritated by their present position as paramedicals. They know more about physiotherapy than most doctors, and they tend to resent uninformed medical direction. That is why chiropractors have been so diffident about accepting the "referral ethic": in the field of spinal manipulation they are the experts; no doctor has the training or experience to tell them how to diagnose a vertebral malfunction or how to manipulate it.

35. The health team of the future will be one where all members of it take the trouble to understand, appreciate and, above all, respect each other's special area of expertise. Each member will understand and appreciate his own limitations. There is no room for professional jealousy or arrogance, although we would hope that there would be room for professional pride in the overall standards of the team. And each member will be prepared to pool his expertise with that of the others for the benefit of the patient who is, after all, the basic reason for the health team's existence.

SUMMARY

36. For the general reasons stated in this chapter and elsewhere in this report, the New Zealand chiropractor of the future is likely to have the following principal characteristics:

1. He will be better educated and trained than the most recently qualified chiropractor we have encountered;
2. He will belong to a much better disciplined profession if our recommendations are adopted;
3. He will have a closer working relationship with the medical profession and physiotherapists, involving the referral of patients and full co-operation and consultation on patients' problems;
4. He is likely to be more pragmatic about the results he can expect to achieve by spinal manual therapy and less doctrinaire in seeking to explain the results he achieves;
5. In the event of health and accident compensation benefits being made available for chiropractic treatment, he is unlikely to abuse the system.

RECOMMENDATIONS

INTRODUCTORY NOTE

The Commission's formal recommendations are set out below. They should be considered—

- *First*, in the context of the Commission's general conclusions, which are conveniently summarised in chapter 1, para. 14.
- *Secondly*, in the context of the section of the report to which each recommendation is related.

It is emphasised that the report should be read as a whole.

FORMAL RECOMMENDATIONS

CHIROPRACTORS AND THE GENERAL HEALTH CARE TEAM

Recommendation 1

That appropriate steps be taken to ensure that chiropractors are included as partners in the general health care team (see chapter 45, esp. paras. 3, 32-5), in particular—

- (a) By overhauling and strengthening the statutory provisions relating to discipline within the chiropractic profession (see recommendations 2-7, below);
- (b) By reconstituting the Chiropractic Board (see recommendations 8-9, below);
- (c) By transferring the administration of the Chiropractors Act 1960 from the Department of Justice to the Department of Health (see recommendation 10, below);
- (d) By abolishing by statute the rules of medical ethics prohibiting medical practitioners from referring patients to registered chiropractors or from collaborating with chiropractors concerning patients (see recommendation 11, below);
- (e) By enabling registered chiropractors to have access to hospitals to treat their own patients (subject to appropriate safeguards) (see recommendation 12 (1), below), and to take part in hospital programmes of physical medicine services (see recommendation 12 (2) below);
- (f) By providing health and accident compensation benefits for the patients of registered chiropractors (see recommendations 13, 14, below).

CHIROPRACTIC PROFESSIONAL DISCIPLINE

(See generally chapter 43)

Recommendation 2

That the present system of discipline within the chiropractic profession be overhauled, and that in particular:

- (a) All disciplinary powers and disciplinary action within the chiropractic profession be regulated by the Chiropractors Act 1960, amended in accordance with these recommendations;

- (b) The New Zealand Chiropractors' Association be reincorporated as a statutory body under the Chiropractors Act 1960, that its membership, objects, and powers be defined by the Act, that it should no longer act as a disciplinary body, and that membership of it be made compulsory for all chiropractors holding a practising certificate;
- (c) The range of disciplinary offences be enlarged by statute and the penalties revised (see further, recommendations 3-6, below).

RECOMMENDED NEW DISCIPLINARY STRUCTURE

(1) *New Complaints Committee*

Recommendation 3

(a) That the present Chiropractic Disciplinary Committee (Chiropractors Act 1960, section 7) be abolished and substituted by a statutory Complaints Committee.

(b) That the membership of the new Complaints Committee be the association's president and vice-president *ex officio*, two other persons being chiropractors holding current practising certificates, and one further member being a senior officer of the Department of Health to be nominated by the Director-General of Health.

(c) That the quorum of the new Complaints Committee be not less than three members, one of whom shall be the nominee of the Director-General of Health.

(d) That the secretary of the new Complaints Committee be the secretary for the time being of the Chiropractic Board.

(e) That the functions of the new Complaints Committee be—

(i) To make a preliminary investigation of any complaint against a chiropractor and to determine whether the chiropractor should be charged with a disciplinary offence before the Chiropractic Board; and

(ii) In relatively minor cases, to hear and determine the complaint itself.

(f) That the new Complaints Committee, if it hears and determines the case itself, have power to impose the following penalties or make the following orders:

(i) The imposition of a fine not exceeding a total of \$500 in respect of all charges;

(ii) Suspension for not longer than 3 months;

(iii) Censure;

(iv) An order that the chiropractor concerned pay the costs, or part of the costs, of the investigation and hearing.

Where the penalty is suspension, the chiropractor concerned should have the right to apply to the Chiropractic Board for rescission of the suspension. In all cases the chiropractor should have a right to appeal to the board.

(g) That in addition to the above powers, the new Complaints Committee be specifically empowered to require a chiropractor against whom a complaint has been made to furnish the committee, within a reasonable time of not less than 7 days, with a written explanation; and that failure to supply such an explanation within the time required should be declared to be professional misconduct and punishable as such.

*(2) Disciplinary Powers of Chiropractic Board***Recommendation 4**

That the Chiropractic Board, as reconstituted (see recommendation 8, below), should have enlarged disciplinary powers, the existing statutory grounds for disciplinary action being inadequate.

Recommendation 5

That the existing statutory grounds for disciplinary action be enlarged so that the full list would read as follows:

- (a) Gross negligence or malpractice in respect of his calling;
- (b) Conviction of an indictable offence punishable by two or more years' imprisonment;
- (c) Grave impropriety or misconduct, whether in respect of his calling or not;
- (d) Use of the title "doctor" on any notice or sign or in any publicity material other than in the form of the letters "D.C." following his name (see chapter 42);
- (e) Conduct unbecoming a member of the chiropractic profession.

As to the recommended new ground (e), it is recommended that it be spelled out by statute what "conduct unbecoming" can include. The following formula is recommended:

Without limiting the meaning of the expression "conduct unbecoming a member of the chiropractic profession", the following conduct shall be deemed to be included in that expression:

- (a) By words or conduct inducing any person to believe that a chiropractor should be consulted in the first instance in preference to a registered medical practitioner, in respect of any disease or disorder; or
- (b) By words or conduct inducing any person to believe that chiropractic treatment will necessarily cure or alleviate any organic or visceral disease or disorder; or
- (c) When consulted by a patient who he knows or ought to know is suffering from a disorder requiring medical care, failing to take reasonable steps to advise the patient to consult, or to continue consulting, a registered medical practitioner; or
- (d) Exhibits or publishes to the public any circular designed for general publication which has not been approved by the association.

Recommendation 6

That the penalties which may be imposed by the Chiropractic Board as reconstituted (see recommendation 8, below) be reframed as follows:

- (a) Removal from the register;
- (b) Suspension for such period as the board thinks fit;
- (c) A fine of not more than \$5,000 in respect of each charge;
- (d) Censure;
- (e) An order that the chiropractor concerned pay the whole or part of the costs of the investigation and hearing.

Recommendation 7

That the present right of appeal from the Chiropractic Board to the Magistrate's Court (with assessors) be abolished, and that a right of

appeal from the Chiropractic Board to the Supreme Court (without assessors) be substituted.

RESTRUCTURING THE CHIROPRACTIC BOARD

Recommendation 8

That the Chiropractic Board be reconstituted as follows:

- (a) The chairman should be a barrister of not less than 7 years' standing.
- (b) There should be six other members; four to be registered chiropractors of not less than 7 years' standing to be nominated by the association, one to be the Director-General of Health or his nominee, being a senior officer of his department, and one to be a registered medical practitioner nominated by the New Zealand Medical Council (or, failing nomination by the New Zealand Medical Council, the Director-General of Health) (see chapter 14).

Recommendation 9

That the quorum of the reconstituted Chiropractic Board be four members, not three as at present (Chiropractors Act 1960, section 4 (2)), at least one of whom, aside from the chairman, should be a non-chiropractic member (see generally chapter 43).

ADMINISTRATION OF CHIROPRACTORS ACT

Recommendation 10

That the Chiropractors Act 1960 be brought under the administration of the Minister of Health and the Department of Health (see chapter 14).

ABOLITION OF RULES OF MEDICAL ETHICS RELATING TO CHIROPRACTORS

(Chapter 41)

Recommendation 11

That the rules of medical ethics prohibiting medical practitioners in New Zealand from referring patients to registered chiropractors or from collaborating with chiropractors concerning patients be abolished, and accordingly that the Medical Practitioners Act 1968 be amended by inserting the following provision:

“Notwithstanding any rule to the contrary, it shall be lawful and ethical for any medical practitioner—(a) to refer a patient to a registered chiropractor for treatment provided the medical practitioner retains overall responsibility for the patient and first personally satisfies himself that the chiropractor concerned is capable of safely carrying out such treatment; and—(b) to collaborate and associate with a registered chiropractor concerning the diagnosis or management of a patient's disorder.”

ACCESS TO HOSPITALS BY CHIROPRACTORS

(Chapter 45)

Recommendation 12

(1) (a) That hospital authorities allow chiropractors to have access to their hospitals to give chiropractic treatment to patients who request it unless the supervising physician or surgeon withholds his approval on the ground that there are precise and specific contra-indications.

(b) That, if necessary, the Hospitals Act 1957 be amended to put the above recommendation into effect.

(2) That the participation by chiropractors in hospital physical medicine services should be positively encouraged in the public interest.

HEALTH AND ACCIDENT COMPENSATION BENEFITS FOR CHIROPRACTIC TREATMENT

(Chapter 44)

Recommendation 13

That, subject to the following limitations, *and subject to recommendation 14 below*, there be benefits payable under the Social Security Act 1964, and payments under the Accident Compensation Act, for chiropractic services:

(1) *Chiropractic Benefits under the Social Security Act*

(a) Subject to the limitations stated below, the chiropractic benefits should be equivalent to the general medical services benefits.

(b) (i) No benefit should be paid for any chiropractic treatment administered after 21 days from the date of the first consultation unless treatment for a period of more than 21 days is shown to be justified.

(ii) In no case should the total amount of chiropractic benefit (excluding a radiological benefit: see para. (c) below) paid in respect of any one patient in any one period of 12 months exceed the amounts stated in the table below, unless treatment involving payment in excess of any such amount is shown to be justified.

Maximum

\$

Ordinary patients 25

Special group patients (including children and young persons) 80

The above maxima are inclusive of the benefit payment of \$0.75 payable for each 15 minutes in excess of 30 minutes, but exclusive of the radiology benefit.

(c) Subject to recommendation 14 (3), below, a radiological benefit should be paid in respect of chiropractic X-rays in addition to the general chiropractic benefit. The radiological benefit should however be confined strictly to the diagnostic process on initial consultation and should be limited to three plates at \$5 per plate, thus providing for a maximum radiology benefit of \$15 per patient.

(d) Part II of the Social Security Act should be amended accordingly.

(2) *Payment for Chiropractic Treatment under the Accident Compensation Act*

(a) That accident compensation benefits be made available for the cost of treatment by a registered chiropractor (subject to the limitations stated below) without medical referral.

(b) That the Accident Compensation Act 1972 be amended accordingly, and that in particular section 111 be amended as follows:

- (i) In subsection (1), by inserting in line 5 after the word "medical" the words "or chiropractor's"
- (ii) In subsection (2), by inserting after subparagraph (c) the following subparagraph: "(ca) Treatment of the person by a registered chiropractor".
- (iii) In subsection (5), by inserting in line 3, after the words "medical practitioner", the words "or a registered chiropractor".
- (iv) In subsection (8), by inserting in line 13, after the word "radiological", the word "chiropractic".

(c) That total payments in any one year in respect of a patient's chiropractic treatment (including X-ray costs, but subject to recommendation 14 (3), below) should be limited to \$200.

(d) That the total period of chiropractic treatment in respect of which benefits are payable should be limited to 21 days from the date of the first consultation.

(e) The limits stated in subclauses (c) and (d) should be waived in any case where chiropractic treatment beyond the financial or time limits is shown to be justified.

(f) (i) That chiropractors be expressly included as part of the Accident Compensation Commission's rehabilitation programme (Accident Compensation Act 1972, sections 48-53).

(ii) That the Act be amended accordingly by—

- (i) Deleting in section 49 (1) (a), the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic"; and
- (ii) Deleting, in section 52, the words "professions of medicine and dentistry" and substituting "professions of medicine, dentistry, and chiropractic".

Recommendation 14

(1) Limitations on Chiropractic Treatment Under Both Acts

(a) That the cost of treatment by a registered chiropractor or a chiropractic benefit, unless the treatment has been administered on referral from a registered medical practitioner, shall be payable only in respect of treatment aimed at the relief of specific musculo-skeletal symptoms, such as back pain, which are generally accepted as having their origin in biomechanical dysfunction of the vertebral column, pelvis, and the extremities, and their associated soft tissues. Without limiting the symptoms so described, such symptoms shall include migraine (both common and classical), other forms of headache, and all cases of referred pain which can reasonably be attributed to biomechanical dysfunction, but shall not include symptoms indicating organic or visceral disorder. Payment under either Act should not be made unless the treatment in respect of which payment is claimed is justified by—

- (i) Specific identification of the symptoms at the relief of which the treatment is aimed; and

- (ii) Specific identification of the biomechanical dysfunction diagnosed as 'giving rise to the symptoms;

and unless the chiropractor has certified his assessment of how many treatments are likely to be required and over what period of time.

(b) Payment under either Act may be made in any case not coming within the terms of para. (1) (a) of this recommendation where the treatment is given on medical referral.

(2) *Collection of Benefits*

Chiropractic benefits under either Act should be claimed and collected by the chiropractor direct from the Department of Health or the Accident Compensation Commission. Where a benefit or payment is claimed, the chiropractor should be entitled to recover from his patient only the amount of his fee not covered by those benefits.

(3) *Conditions for Payment of Radiology Benefits (Medical and Chiropractic)* (see chapter 44, paras. 40-43)

(a) That radiology fees or the radiology benefit be paid direct to the medical practitioner or chiropractor concerned.

(b) That the patient is to be liable only for that part of the radiologist's or chiropractor's fee not recoverable under the Social Security or Accident Compensation Acts.

(c) That before being eligible to receive payment of a radiology fee or benefit under either Act each medical practitioner and chiropractor should be required to undertake in writing to the Department of Health or the Accident Compensation Commission that he will, if called upon to do so, furnish a patient's radiographs to that patient's chiropractor or medical practitioner (as the case may be) for examination.

CHIROPRACTIC AND PHYSIOTHERAPY

Recommendation 15

(1) *Use by Chiropractors of Physiotherapy Aids* (Chapter 45)

That chiropractors should not be encouraged to use physiotherapy aids such as heat, light, water, etc., but should instead be encouraged to refer patients requiring such aids to a registered physiotherapist; but a chiropractor properly trained in the use of physiotherapy aids should not be prevented from using them. In particular the Physiotherapy Amendment Act 1953, section 3 (relating to the use of ultra-sound equipment) should be amended so as to include chiropractors who are able to provide satisfactory evidence of training in the use of ultra-sound equipment.

(2) *Training of Physiotherapists in Spinal Manual Therapy* (Chapter 26, paras. 7-10, 21-22)

That the responsibility for spinal manual therapy training, because of its specialised nature, should in the future lie with the chiropractic profession; that part-time or vacation training for other health professionals in spinal manual therapy with a view to such other health professionals practising spinal manual therapy should not be encouraged; but that closer general co-operation between chiropractors and physiotherapists be encouraged.

(3) That any proposed Government funding for spinal manual therapy education and training be allocated, not to weekend or vacation courses for health professionals other than chiropractors, but to bursary assistance to enable prospective chiropractors and other health professionals to attend the Preston Institute in Melbourne (and see recommendation 16, below).

CHIROPRACTIC EDUCATION AND RESEARCH

EDUCATION

(Chapter 38)

Recommendation 16

(1) That the New Zealand Chiropractic Board encourage New Zealand students to obtain their chiropractic education at the International College of Chiropractic at the Preston Institute of Technology, Melbourne.

(2) In recognition of the fact that no Government subsidised training is available in New Zealand, that a system of bursaries should be established, to be administered by the Department of Health or the Department of Education, to provide support for New Zealand chiropractic students at the Preston Institute. (The analogy is with the former veterinary bursary scheme operated at a time when veterinary training was not offered in New Zealand.) Such chiropractic bursaries should be tenable only at the Preston Institute. (This recommendation is conditional upon full accreditation of the proposed B.App.Sc. (Chiropractic) degree by the Victorian Institute of Colleges and subsequently by the Australian Tertiary Education Commission.)

RESEARCH IN NEW ZEALAND

(Chapter 37)

Recommendation 17

(1) That the New Zealand Chiropractors' Association formulate a proposal for a clinical trial or trials on some aspect of chiropractic treatment to be conducted in co-operation with one of the clinical medical schools in New Zealand. This proposal should be submitted to the Medical Research Council. If the Council is not prepared to support such a trial, our recommendation is that a special grant of \$200,000 over a 4-year period be made by the Department of Health for this purpose.

(2) That the New Zealand Chiropractors' Association sponsor a post-doctoral research fellow to work in a New Zealand university on a topic related to fundamental chiropractic theory. The staff of the Otago University Medical School should be consulted in the formulation of such a topic. The funds required would be approximately \$15,000 per annum.

LIMITATION ON THE USE BY CHIROPRACTORS OF THE TITLE "DOCTOR"

(Chapter 42)

Recommendation 18

That chiropractors who are not registered medical practitioners be restricted in their use of the title "Doctor", and that some usages of the title by them be made illegal as well as providing grounds for disciplinary action (as to disciplinary action, see above, recommendation 5); and that

the Chiropractors Act 1960 be amended accordingly by inserting the following provision:

“Any chiropractor who displays or causes to be displayed, or produces or causes to be produced for display or circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material which contains, in relation to any chiropractor who is not a registered medical practitioner any of the terms “Dr”, “Doctor”, or “Doctor of Chiropractic”, commits an offence: Provided however that nothing in this section shall be read as prohibiting a chiropractor from displaying in his professional rooms any diploma or certificate relating to himself or to any other chiropractor with whose practice he is associated, or from using after his name letters denoting an academic or professional qualification.”

Alternative Recommendation

(The Commission makes the following alternative recommendation on the ground that it might be thought unjust to single chiropractors out when others in the health field, not being registered medical practitioners, use the title “Doctor”: see chapter 42, para. 21.)

That the Medical Practitioners Act 1969 be amended so as to make it an offence for any person who is not a registered medical practitioner to display or cause to be displayed, or produce or cause to be produced for display or circulation, to the public any sign, notice, letterhead, professional card, advertisement, or other written or printed material, in which the terms “Dr” or “Doctor” are used in such a way as to lead members of the public to believe that such person is a registered medical practitioner.

MISCELLANEOUS

AMENDMENT TO CHIROPRACTORS ACT: SCOPE OF PRACTICE

(Chapter 14, para. 10)

Recommendation 19

That the Chiropractors Act 1960, section 2, be amended by deleting the definition of “chiropractic” and substituting the following definition—

“‘Chiropractic’ means the examination and treatment by hand of the joints of the human spinal column, pelvis, and extremities, including associated soft tissues”.

AMENDMENTS TO THE SOCIAL SECURITY ACT 1964

(Chapter 44, paras. 109–113)

Recommendation 20

(1) *Invalids’ Benefits*

That section 44 be amended by adding after the words “medical practitioner” the words “or, in respect of any condition within the ambit of his profession, a registered chiropractor”.

(2) *Sickness Benefits*

That section 56 be amended by adding after the words “registered dentist”, the words “or a registered chiropractor”.

AMENDMENTS TO WAR PENSIONS REGULATIONS (S.R. 1956/7)

(Chapter 44, paras. 114-6)

Recommendation 21

That regulation 34 be amended so that an ex-serviceman may apply for free medical, surgical, or chiropractic treatment; and that regulation 35 be amended by deleting the words "any medical practitioner to whom the service patient has applied for medical treatment" and substituting "any medical practitioner or registered chiropractor to whom the service patient has applied for medical or chiropractic treatment as the case may be".

Appendix 1

BIBLIOGRAPHY

The following list contains the literature used by the Commission of Inquiry. Most of it was made available to the Commission by the professional bodies and Government departments associated with the main submissions. A small amount of material was undated and some gave no indication of volume number.

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Appendix 2

YEAR BY YEAR COURSE OUTLINE—B. APP. SC. COURSE AT PRESTON
INSTITUTE OF TECHNOLOGY

COURSE OUTLINE

Outline by Year

OUTLINE OF THE B. APP. SC. (CHIROPRACTIC SCIENCE) DEGREE PROGRAMME

First Year

Subject	Contact Hours Per Year				Term
	Lecture	Practical	Sub-total	Total hours	
<i>Anatomy</i>				100	
PE111 Systemic Anatomy	80	20	100		9
<i>Chemistry</i>				220	
CH160 General Chemistry	60	20	80		7
CH161 Organic Chemistry	60	80	140		10
<i>Chiropractic Sciences</i>				190	
Principles and Theory I					
KC111 History and Etymology	30	0	30		3
KC112 Philosophy Principles	30	0	30		3
KC121 Psychomotor Skills I	0	50	50		3
KC131 Spinal Studies I	80	0	80		8
<i>Humanities</i>				200	
HF031 Problems of Philosophy	45	0	45		4
HX004 Psychology	90	0	90		9
HS001 Sociology	45	0	45		4
Communication Skills	20	0	20		2
<i>Natural Sciences</i>				165	
SP014 Applied Physics	40	20	60		5
SB100 General Biology	45	15	60		5
SB102 Genetics and Physical Anthropology	30	15	45		4
<i>Physiology</i>				20	
KP101 Research Methodology/Biostatistics	20	0	20		2
Totals	675	220	895	895	78

*Term credit points:

1 lecture or tutorial hour per week per term = 1 term credit point.

2 laboratory or practical hours per week per term = 1 term credit point.

Adjustments have been made to eliminate fractions.

Second Year

Subject	Contact Hours Per Year				Term Credit Points
	Lecture	Practical	Sub-total	Total Hours	
<i>Anatomy</i>				460	33
KA204 Gross Anatomy—Body Wall and Extremities	50	90	140		9
KA205 Gross Anatomy—Viscera	50	60	110		8
KE121 Kinesiology and Applied Anatomy	20	20	40		3
KA201 Embryology	45	15	60		5
KA202 Histology	50	40	90		7
KA206 Radiographic Anatomy	0	20	20		1
<i>Biochemistry</i>				100	8
BH261 Biochemistry	55	45	100		8
<i>Psychomotoric Sciences</i>				170	14
CC211 Principles and Theory II	30	0	30		3
CC221 Psychomotor Skills II	20	20	40		3
CC231 Spinal Studies II	40	0	40		4
CC321 Extremity Technique I	10	20	30		2
CC322 Soft tissue Technique I	10	20	30		2
<i>Diagnostics</i>				30	2
DD405 Emergency Care	10	20	30		2
<i>Microbiology, Community Health, and Pathology</i>				80	6
MM303 Fundamentals of Pathology	30	20	50		4
MM401 General Pathology	20	10	30		2
<i>Physiology</i>				80	7
PP201 Cells and Fluids	30	20	50		4
PP304 Basic Nutrition	30	0	30		3
<i>Radiology</i>				50	4
RP301 Radiographic Physics and Technology	30	20	50		4
Totals	530	440	970	970	74

Third Year

Subject	Contact Hours Per Year				Term Credits
	Lecture	Practical	Sub-total	Total hours	
<i>Anatomy</i>				100	
KA301 Neuroanatomy	80	20	100		9
<i>Chiropractic Science</i>				210	
KC311 Principles and Theory III	30	0	30		3
KC331 Spinal Studies III	20	20	40		3
Spinal Studies IV					
KC431 Upper Cervical Analysis	10	10	20		2
KC434 Thermodynamic Analysis	10	10	20		1
Psychomotor Skills IV					
KC421 Gonstead Technique	0	40	40		2
KC422 Occipital/Cervical/Thoracic Technique	10	50	60		4
<i>Diagnosis and Practice</i>				80	
KD401 Physical Diagnosis	50	30	80		7
<i>Microbiology, Community Health and Pathology</i>				310	
KM301 Fundamentals of Microbiology	45	60	105		7
KM302 Clinical Microbiology and Community Health	75	0	75		8
KM402 Pathology of Neoplasms	30	15	45		4
KM403 Systemic Pathology	85	0	85		8
<i>Physiology</i>				250	
KP301 Nervous System, Special Senses, and Muscles	40	30	70		6
KP302 Respiration and Circulation	40	30	70		5
KP303 Digestion, Metabolism, and Endocrines	40	30	70		5
KP305 Clinical	40	0	40		4
<i>Radiology</i>				60	
KR401 Principles of Interpretation	30	30	60		4
Totals	635	375	1 010	1 010	82

Year	Contact Hours Per Year				Term Credit Points	Total Credit Points
	Lecture	Practical	Sub-total	Total Hours		
<i>Proprietary Science</i>				300		21
C411 Principles and Theory IV Psychomotor Skills IV	30	0	30		3	
C423 Lumbar/Pelvic Techniques Spinal Studies IV	10	80	90		5	
C432 Applied Kinesiology	20	10	30		2	
C433 Spinographology Psychomotor Skills V	10	20	30		2	
C521 Soft tissue Technique II	10	20	30		2	
C522 Extremity Technique II Spinal Studies V	10	20	30		2	
C532 Orthostatic Rehabilitation Principles and Theory V	10	20	30		2	
C512 Practice Development	30	0	30		3	
<i>Diagnosis and Practice</i>				630		53
D402 Laboratory Diagnosis	45	45	90		7	
D403 Clinical Orthopaedics	50	50	100		7	
D404 Clinical Neurology	50	30	80		7	
D501 Gastrointestinal Disorders	30	10	40		3	
D502 Genitourinary Disorders	20	0	20		2	
D503 Eye, Ear, Nose, and Throat Disorders	50	20	70		6	
D504 Cardiovascular and Respiratory Disorders	40	30	70		5	
D505 Obstetrics and Gynaecology	40	0	40		4	
D508 Dermatology	5	5	10		1	
D509 Social and Preventive Aspects of Chiropractic	30	0	30		3	
D511 Clinical Nutrition	40	0	40		4	
D512 Clinical Psychology	40	0	40		4	
<i>Pathology</i>				20		1
M403 Systemic Pathology—Bone	0	20	20		1	
Totals	570	380	950	950	75	75

Year	Contact Hours Per Year				Term Credit Points	Total Credit Points
	Lecture	Practical	Sub-total	Total Hours		
<i>Proprietary Science</i>				150		12
C511 Principles and Theory V Philosophy/Principles	30	0	30		3	
C513 Ethics and Jurisprudence Psychomotor Skills V	30	0	30		3	
C523 Correlative Technique Spinal Studies V*	20	40	60		4	
C531 Correlative Biomechanical Analysis	10	20	30		2	
<i>Diagnosis and Practice</i>				170		14
D506 Paediatrics and Febrile Disorders	20	10	30		2	
D507 Geriatrics	20	10	30		2	
D510 Clinical Toxicology	30	0	30		3	
D513 Correlative and Differential Diagnosis	10	20	30		2	
D514 Clinicopathological Conference	50	0	50		5	
<i>Pathology</i>				30		2
Radiographic Positioning	10	20	30		2	

OUTLINE ACCORDING TO DIVISIONS AND SUBJECTS

A. Basic Sciences and Humanities

Subject	Contact Hours			Term	Credit Points
	Lecture Hours	Practical Hours	Total Hours		
<i>1. Anatomy</i>					
PE111 Systemic Gross Anatomy	80	20	100		9
KA204 Gross Anatomy—Body Wall and Extremities	50	90	140		9
KA205 Gross Anatomy—Viscera	50	60	110		8
PE121 Kinesiology and Applied Anatomy	20	20	40		3
KA201 Embryology	45	15	60		5
KA202 Histology	50	40	90		7
KA206 Radiographic Anatomy	0	20	20		1
KA301 Neuroanatomy	80	20	100		9
Totals	375	285	660		51*
<i>2. Chemistry</i>					
CH160 General Chemistry	60	20	80		7
CH161 Organic Chemistry	60	80	140		10
CH261 Biochemistry	55	45	100		8
Totals	175	145	320		25
<i>3. Humanities (Behavioural Sciences)</i>					
HF031 Problems of Philosophy	45	0	45		4
HX004 Psychology	90	0	90		9
HS001 Sociology	45	0	45		4
HU008 Communication Skills	20	0	20		2
Totals	200	0	200		19
<i>4. Natural Sciences</i>					
SP104 Applied Physics	40	20	60		5
SB100 General Biology	45	15	60		5
SB102 Genetics and Physical Anthropology*	30	15	45		4
Totals	115	50	165		14
<i>5. Physiology</i>					
KP101 Research Methodology/Biostatistics	20	0	20		2
KP201 Cells and Fluids	30	20	50		4
KP304 Basic Nutrition	30	0	30		3
KP301 Nervous System, Special Senses and Muscles	40	30	70		6
KP302 Respiration and Circulation	40	30	70		5
KP303 Digestion, Metabolism, and Endocrines	40	30	70		5
KP305 Clinical	40	0	40		4
Totals	240	110	350		29

*Genetics and physical anthropology (45 hours), taught by the Department of Natural Science, form an additional important part of anatomy.

Subject	Contact Hours			Term	Credit Points
	Lecture Hours	Practical Hours	Total Hours		
<i>B. Chiropractic Sciences</i>					
	Principles and Theory I	60	0	60	6
KC211	Principles and Theory II	30	0	30	3
KC311	Principles and Theory III	30	0	30	3
KC411	Principles and Theory IV	30	0	30	3
	Principles and Theory V	90	0	90	9
KC121	Psychomotor Skills I	0	50	50	3
KC221	Psychomotor Skills II	20	20	40	3
	Psychomotor Skills III	20	40	60	4
	Psychomotor Skills IV	20	170	190	11
	Psychomotor Skills V	40	80	120	8
KC131	Spinal Studies I	80	0	80	8
KC231	Spinal Studies II	40	0	40	4
KC331	Spinal Studies III	20	20	40	3
	Spinal Studies IV	50	50	100	5
	Spinal Studies V	20	40	60	4
	Totals	550	470	1 020	77

C. Clinical Sciences

Subject	Contact Hours			Term	Credit Points
	Lecture Hours	Practical Hours	Total Hours		
<i>1. Diagnosis and Practice</i>					
KD401	Physical Diagnosis	50	30	80	7
KD402	Laboratory Diagnosis	45	45	90	7
KD403	Clinical Orthopaedics	50	50	100	7
KD404	Clinical Neurology	50	30	80	7
KD405	Emergency Care	10	20	30	2
KD501	Gastrointestinal Disorders*	30	10	40	3
KD502	Genitourinary Disorders*	20	0	20	2
KD503	Eye, Ear, Nose, and Throat Disorders*	50	20	70	6
KD504	Cardiovascular and Respiratory Disorders*	40	30	70	5
KD505	Obstetrics/Gynaecology	40	0	40	4
KD506	Paediatric and Febrile Disorders	20	10	30	2
KD507	Geriatrics	20	10	30	2
KD508	Dermatology	5	5	10	1
KD509	Social and Preventive Aspects of Chiropractic	30	0	30	3
KD510	Clinical Toxicology	30	0	30	3
KD511	Clinical Nutrition	40	0	40	4
KD512	Clinical Psychology	40	0	40	4
KD513	Correlative and Differential Diagnosis	10	20	30	2
KD514	Clinicopathological Conference	50	0	50	5
	Sub-totals	780	390	1 180	97
	Clinical Clerkship (Junior)			200	
	Total			1 380	

*Includes hours assigned to radiological interpretation which are suitably integrated into the course work and taught by the radiology staff.

Please Note: The degree will not be awarded until a minimum of 500 additional hours of practical experience on the basis of senior clerkship in the institutional clinics has been satisfactorily completed.

Should registration boards in future require a preregistration year of clinical practice under supervision, the senior clerkship will form part of such a requirement.

Subject	Contact Hours			Term	Credit Points
	Lecture Hours	Practical Hours	Total Hours		
2. Microbiology/Community Health/Pathology					
KM301 Microbiology Fundamentals	45	60	105		7
KM302 Clinical Microbiology/Community Health	75	0	75		8
KM303 Fundamentals of Pathology	30	20	50		4
KM401 General Pathology	20	10	30		2
KM402 Pathology of Neoplasms	30	15	45		4
KM403 Systemic Pathology	70	35	105		9
Total	270	140	410		34
3. Radiology					
KA206 Radiographic Anatomy (Under Anatomy)	0	20	20		1*
KC331 Spinal Studies III (Gonstead Analysis)	10	10	20		2*
KR302 Radiographic Positioning	10	20	30		2
SP301 †Physics and Technology	30	20	50		4
KC431 Upper Cervical Analysis (Radiographic Analysis)	5	0	5		1*
KC433 Spinography (Radiographic Analysis)	10	20	30		2*
KD403 Clinical Orthopaedics (Orthopaedic Radiology)	10	20	30		2*
KM403 Systemic Pathology (Bone Pathology)	10	10	20		2*
KR401 Principles of Interpretation	30	30	60		4
KC531 Correlative Biomechanical Analysis (Radiographic Analysis)	5	10	15		1*
KD501 Gastro-Intestinal Disorders (Radiological Interpretation)	5	5	10		1*
KD502 Genito-Urinary Disorders (Radiological Interpretation)	10	10	20		1*
KD504 Cardiovascular and Respiratory Disorders (Radiological Interpretation)	10	10	20		1*
KD513 Correlative and Differential Diagnosis (Radiological Analysis)	5	5	10		1*
	145	180	325		25

*Hours of study assigned to radiological interpretation which are integrated into the hours given for the subject referred to.

*Taught by Department of Natural Sciences.

Appendix 3

CHIROPRACTIC UNDERGRADUATE PROGRAMMES

(The Australian Council of Chiropractic Education Ltd.)

1. PREFACE

This publication outlines the desirable standard for chiropractic programmes as seen by the Council. It should be read in conjunction with the Council's other publications regarding educational standards for chiropractic colleges. In this paper the objectives, duration and content of a chiropractic programme are given.

The Council is aware that the information presented represents the minimum requirement that chiropractic programmes should offer to produce a graduate competent to enter the health care delivery system as a primary contact practitioner of chiropractic.

2. REQUIRED PROGRAMME OBJECTIVES

2.1 Introduction

The profession of chiropractic occupies a position, both by tradition and by stature, as an important portal of entry for patients into the health care delivery system. Hence, the person studying chiropractic must have a comprehensive understanding of all aspects of the human organism, including health standards and their maintenance and the various diseases and afflictions which may beset it. He must be qualified to undertake a differential role and to render appropriate treatment or service. His education must, therefore, be broad and liberal so that as a practitioner of chiropractic he not only seeks to become a master of his healing art but be cognizant of his limitations. It is also recognised that proper health care delivery must be a team effort objectively utilizing the best of all methods without interprofessional bias.

In order to produce an adequately qualified chiropractor in terms of the above statements it is necessary that the following objectives be met.*

2.2 Objectives

The basic chiropractic education should develop a spirit of inquiry which will cultivate a lifetime desire for study. In addition, upon completion of an undergraduate programme a student should be able to demonstrate the following.

2.2.1 An understanding of normal and abnormal spinal mechanics and an ability, based on fundamental scientific information, to relate the patho-physiology of the spine and related anatomical structures to the rest of the body.

2.2.2 An ability to establish satisfactory relationships with patients by showing concern and consideration and by developing patient co-operation by relieving anxiety, tension and discomfort. There must be a willingness to accept responsibility for the patient's welfare by provision of chiropractic treatment, while recognizing his professional capabilities and limitations.

2.2.3 A competence in gathering, recording and evaluating clinical information using history, physical, laboratory, x-ray and clinical examination procedures, having cognizance of the multifactorial causes of disease and the value of differential diagnostic assessment.

2.2.4 Judgment in deciding the appropriate care by instituting chiropractic management and/or referral to other health disciplines with full recognition of the consequences of inadequate or delayed treatment.

2.2.5 An ability to provide effective treatment for the patient by achieving manual dexterity necessary for manipulative and adjustive techniques and also have competence in modalities of treatment, adapting such procedures to the individual patient.

2.2.6 The need to provide continuing care by assessing the patient's progress, appropriately modifying treatment, judging the extent or end point of treatment, planning effective follow-up care, counselling and where necessary instructing the patient or his family regarding cause, management and prognosis.

* (In this context, general objectives are statements which describe in non-specific terms the types of knowledge or skills students should acquire. They may not be readily measurable but do represent philosophical goals for minimal qualifications in the discipline.)

2.2.7 An acceptance of the responsibilities of a practitioner of chiropractic for the care of the patient, to the profession of chiropractic, to other health disciplines and related community services and also for continuing self education directed to research and clinical practice.

2.2.8 Communicative skills directed toward other health disciplines, the legal profession and the courts, the scientific and academic community, and other professions. To expand understanding of the practice of chiropractic so that the community at large may benefit by the professional expertise of a practitioner of chiropractic.

3. COURSE DURATION

3.1 Total Length

In order to meet the broad objectives outlined under 2 above it is required that an undergraduate programme be of a duration of at least five (5) academic years.

3.2 Sub-divisions

3.2.1 *The Preclinical Programme*—It is suggested that the preclinical programme should extend over at least three years and that it should include definite clinical components from the outset.

3.2.2 *Clinical Studies*—The clinical studies should extend over at least two (2) years and should be devoted to the clinical sciences, clinical clerkship and internship.

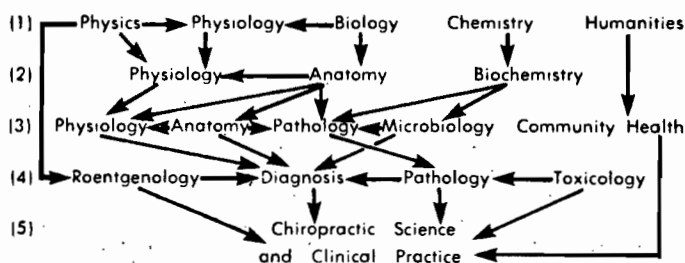
4. COURSE CONTENT

4.1 Introduction

The Council believes that it would be pre-empting the educational process if it were to outline in depth specific subject objectives and would also be limiting the individuality of an institution to proceed in any particular direction that its governing body may from time to time determine. However it does consider that institutions (a) should cover the following subjects and their respective sub-divisions; and (b) should teach these at a level on a par with that of other institutions preparing students for primary contact practice such as: chiropractic colleges having status with the Council on Chiropractic Education (U.S.A.), medical and dental institutions.

4.2 Prerequisites

The course must be presented in a proper sequence of subjects to ensure that a satisfactory substratum is present. Institutions should be able to provide evidence that students gain adequate passes in prerequisite subjects before proceeding to subjects at a more complex level. A suggested strata scheme is illustrated below.



4.3 Subjects

Every chiropractic programme should include the following subjects (for which the major sub-divisions are given):

Biology

Basic knowledge relating to the classification, structure and function of living organisms and the language of biological sciences.

Cell physiology and cytology

Evolution and genetics

A brief introduction to anatomy

Chemistry

Basic physical, inorganic, organic and analytical chemistry. The topics treated will form a basis for subsequent study in biochemistry and physiology.

Physical Chemistry: Introduction to thermodynamics, chemical equilibrium, phase equilibrium, ionic solutions and chemical kinetics.

Organic Chemistry: Bonding, structure and elementary stereo-chemistry of carbon compounds. An introduction to the chemistry of carbohydrates, lipids, proteins and other biologically important macromolecules.

Physics

A study of the basic principles of physics including: mechanics, thermal physics, electricity and magnetism, electronics, optics, wave motion and acoustics and atomic and nuclear physics with special reference to X-rays and X-ray diagnosis.

Physiology

An extensive study over two or three years of human and mammalian physiology including:

- (a) A study of normal body functions and compensatory mechanisms, in the light of the homeostatic process.
- (b) An understanding of psycho-physiological and socio-physiological principles.
- (c) Neurophysiology, with emphasis on synaptic and neuromuscular transmission, transmitter substances and receptors.
- (d) Equilibrium and postural control.
- (e) Cellular physiology and human and mammalian systemic physiology.
- (f) A basic understanding of ergonomics.
- (g) Basic health statistics and research design.

Biochemistry

A study of the chemistry of the constituents of living tissues including proteins, carbohydrates, lipids, nucleic acids and substances of smaller molecular weight. Enzyme catalysts and kinetics. Generation and dissipation of ATF, the principal metabolic pathways. Genetic code. Nucleic and protein synthesis. Cellular and endocrine control of metabolism. Blood and iron metabolism. Inborn errors of metabolism.

Anatomy

An extensive study over two years of the anatomy of the human body including:

Gross and systemic anatomy

Histology

Neuroanatomy

Embryology

Special attention is directed towards the following:

Ligamentous, cartilagenous, muscle, bone and nervous tissue.

The locomotor system as a whole.

Embryology relating to the axial skeleton.

Topographical and normal radiographic observations.

Microbiology

A study of the characteristics of pathogenic bacteria, viruses, fungi, protozoa and helminths; the properties that enable them to cause disease; the immunological response of the host; the principles of epidemiology, chemotherapy, sterilization and immunology; the techniques used in laboratory diagnosis of microbial disease.

Pathology

An outline of general pathology with reference to degenerative processes including necrosis and atrophy; circulatory disturbances; infarction thrombosis, embolism, hyperaemia, oedema; inflammation; disorders of growth; aplasia, hypoplasia, hyperplasia and hypertrophy, metaplasia; tissue regeneration and repair.

Community Health

Epidemiology of diseases, injuries and disabilities and their methodology. The social, economic, anthropological and psychological relations of the healing arts with disease in society.

Humanities

Students must study some of these subjects to assist their understanding of the fundamentals of logic and philosophical approaches to problem solving; also a knowledge of individual behavioural processes such as perception, learning, memory, cognition; in understanding of personality and abnormal psychology.

Physical Diagnosis

To include case history, inspection, vital signs and examination of:
thorax, abdomen, genitalia, anus and rectum, and the nervous system.

Clinical Diagnosis

The diagnosis of infectious diseases, and diseases of the following systems:
respiratory, cardiovascular, blood and lymphatic, gastrointestinal and genitourinary.
Diagnosis of nutritional diseases, diseases of the eye, ear, nose and throat.
Particular emphasis should be placed on diagnosis of diseases of the nervous system.

Laboratory Diagnosis

This should include urinalysis, haematology, faecal analysis, sputum analysis and basal metabolic rate.

Associated Clinical Sciences

These include studies in geriatrics, dermatology, syphology, clinical toxicology, psychology and psychiatry, gynaecology, obstetrics, paediatrics, jurisprudence, ethics and economics.

Chiropractic Science and Practice

- (a) Neuromusculoskeletal diagnosis to include: general survey of the patient, regional orthopaedic and neurological examination; osseous radiography, mechanical analysis, applied kinesiology and palpation.
- (b) Principles of Chiropractic Sciences to include: historical origins, philosophical principles and other relationships of chiropractic with emphasis on current hypotheses and theories of chiropractic, the scientific basis for chiropractic, vertebral subluxation concepts, and the relationship of chiropractic to other health professions.
- (c) Clinical Practice to include: an extensive and intensive knowledge of, and expertise in, occipital, spinal, pelvic and extremity adjustive and manipulative procedures of both hard and soft tissue. A sound knowledge of selective criteria in the application of such procedures together with an appreciation of positive, neutral and negative indicators. An understanding of the value of supplementary assistance and total case management. The foregoing being based upon an adequate period of exposure to patients and practical experience in an internship programme.

Roentgenology

Must include the following areas:

- (a) Technology to include dark room techniques, all aspects of positioning and image

production to include positioning for standard and specific views of the spine and all extremity articulations and skull, exposure factor manipulation, film quality, contrast and definition.

- (b) X-ray physics to include historical background; nature and fundamental properties of X-ray, functional components for basic operation of an x-ray machine; functional relationship of kVp, MAS, and focal film distance; accessories in production of x-ray images, techniques to reduce radiation dosage to the patient and practitioner.
- (c) X-ray interpretation to include: radiological terms and definitions; description of pathologies; integration of the radiographic pathology with other clinical data; consultation report; review of normal spinal anatomy and structures; traumatic bone lesions; diseases of bones; arthritis; tumors of bone; basic principles of interpretation for x-rays of the chest, circulatory system, gastrointestinal system; and postural roentgenology of the spinal column.

Appendix 4

NEW ZEALAND CHIROPRACTORS' ASSOCIATION

(A) EXTRACT FROM RULES

27. DISCIPLINARY POWERS

A. Council shall have authority to exercise disciplinary powers over all Association members in case of Professional Misconduct etc. and to impose penalties where applicable. Upon receipt of any written complaint, *the Secretary* shall notify *the Officers of the Association* who shall determine the nature and severity of such complaint, and, if the Officers are of the opinion that the complaint is one which requires to be answered, they shall refer the matter to the Investigation Committee appointed in accordance with these Rules with instructions to forthwith make all necessary investigations into the complaint and to report its findings. *IF*, however, the Officers are of the opinion that the case is one which involves moral behaviour or other serious offences, they shall instruct the Secretary to hand the complaint directly to the Chiropractic Board.

In cases where the Investigation Committee has reported its findings to the Council which includes a statement to the effect that the member is guilty of the complaint, Council shall do one or more of the following things:-

- 1) Censure him.
- 2) Order him to pay to the Association such sums as the Council may at any time think fit in respect of costs and expenses of and incidental to the enquiry including all or any part of the costs of and expenses of and incidental to any investigation of his conduct carried out by or for the Association.
- 3) Order him to pay to the Association such sum by way of penalty not exceeding five hundred dollars, (\$500), as Council thinks fit.
- 4) Order that he be suspended as a member for such period not exceeding three years as the Council thinks fit.
- 5) Order that his name be struck off the Roll Book of Members.

B. The actions of Council shall be governed by the following:

- 1) No order shall be made by Council under Para. A. hereof either striking the name of the member off the Roll Book of Members or suspending his membership except upon the following grounds:
 - a) That he has been convicted of any indictable offence punishable by imprisonment for a term of two years or more.
 - b) That he has been guilty of gross negligence or malpractice in respect of his calling.
 - c) That he has been guilty of grave impropriety or infamous conduct whether in respect of his calling or not.
 - d) That he has contravened any part of the Rule under the heading of "ANNUAL FEES AND LEVIES".

2) On the making of any order striking the name of a member off the Roll Book of Members under the powers conferred by paragraph A. hereof the Council may fix a time after which the person whose name is struck off as aforesaid may apply for re-election to membership. At the expiration of that time the person whose name has been so struck off may apply for re-election and all provisions of these rules as to eligibility for membership and election of members shall so far as applicable apply to such application for re-election under this rule.

3) If the Council does not fix any such time, the Appeal Board may refuse to consider any such application for such time as it thinks fit PROVIDED that any person aggrieved by the refusal of the Appeal Board to consider that application may apply to the next succeeding annual general meeting for a direction that the Appeal Board consider that application or that the applicant be enrolled as a member of the Association and at such annual general meeting a secret ballot shall be held and the application for such direction decided upon by a majority of those present and voting.

C. The Council shall not exercise with respect to any member any of the disciplinary functions conferred on it by these rules without giving him a reasonable opportunity of being heard in his defence.

D. An order striking the name of the member off the Roll Book of Members, suspending a member from membership, or censure, shall not take effect and no penalty or costs or

expenses shall be payable in any case until after the expiration of twenty-eight days after the notification by the Secretary to the person affected of the making of the order. If within the said period of twenty eight days the person gives due notice of appeal to the Secretary, the order shall not take effect and no penalty or costs or expenses shall be payable, unless and until it is confirmed by the Council, or an appeal is for any reason dismissed by the Council or an appeal is abandoned PROVIDED THAT, unless the Council otherwise orders, the striking of the name of a member off the Roll Book of Members shall take effect, the period of suspension specified in the order shall commence, and the penalty or costs and expenses specified in the order shall be payable on the day when the order commences to have effect.

28. APPEALS

(a) An appeal against any order of the Council shall lie to the Appeal Board at the instance of the member to whom the order relates, or in cases where the proceedings before the Council have been taken on the application of any person other than the member concerned, then at the instance of the applicant.

(b) Every such appeal shall be brought by notice of appeal delivered to the Secretary within twenty-eight days after the day on which the order was notified to the member concerned such notice to be signed by the appellant and to contain an address for service of notices on the appellant.

(c) Upon receipt of any such notice of appeal the Appeal Board shall fix such amount as it thinks fit as security for appeal, such amount to be paid to the Treasurer by the appellant within fourteen days after the day on which the amount fixed as security for appeal was notified to the appellant.

(d) If the amount required under the last preceding paragraph as security for appeal is not paid within fourteen days or within such further time as the Appeal Board may in special cases permit, the notice of appeal shall be deemed to be abandoned.

(e) As soon as the amount required as security for appeal has been paid to the Treasurer the Appeal Board shall appoint a time and place for hearing of the appeal and notify all parties concerned.

(f) In addition to other powers conferred upon it by these rules the Appeal Board may on the hearing of any appeal make such order as in its absolute discretion it thinks fit regarding the amount paid as security for appeal and in particular may order that the whole or any part of the amount paid be forfeited to the Association to be applied by it toward the costs of conducting the appeal.

(g) Every appeal to the Appeal Board made under these rules shall be by way of rehearing and, unless the Appeal Board otherwise directs, on any such rehearing it shall not be permissible to recall witnesses who gave evidence before the Council to call other witnesses. On any appeal the Appeal Board may make such order as it thinks proper and may exercise all or any of the powers conferred upon the Council by these rules.

(h) The evidence received by the Council bearing on the question shall, unless the Appeal Board otherwise directs, be brought before the Appeal Board as follows:

(i) As to any evidence given orally by the production of a copy of any written record or note made by or at the discretion of the Chairman of the Council or such other materials as the Appeal Board may deem expedient.

(ii) As to any evidence given by statutory declaration, and as to any exhibits, by the production of the declarations, and of such of the exhibits as may have been forwarded by the Council and by production by the parties to the appeal of such exhibits as are in their custody.

(iii) As to any written explanation given by the member concerned to the Council, by the production of such written explanation.

(i) At any hearing or inquiry before the Council or the Appeal Board the member concerned or any other party may be represented by counsel.

(j) Any sum ordered by the Council or by the Appeal Board to be paid by way of penalty or costs or expenses under these rules shall be deemed to be a debt due by the person ordered to pay it to the Association, and shall be recoverable accordingly in any Court of competent jurisdiction.

(k) It shall be the duty of the Secretary to advise all members as to the terms of any order made by the Council in exercise of its disciplinary powers and which has not been disturbed by the Appeal Board on appeal, or as to the terms of any order of the Appeal Board made on the hearing of any appeal against any such order of the Council.

(B) STATEMENT ON STANDARDS OF PRACTICE

(Minimum procedure for members of the New Zealand Chiropractors' Association (Inc.))

Introduction

The need for an established routine of practice, suitable to New Zealand, becomes necessary when it is considered that the Chiropractic profession has among its members, graduates from different schools and of varying years of experience in the field. In setting out minimum routine procedure, due consideration has been given to technical advancement taking place in the profession. It has also been taken into consideration, that in the event of legal proceedings against a Chiropractor, office records become of prime importance as evidence, and some of the suggestions have been made with this view.

Office Procedure

There is no suggestion that there should be uniformity of record cards or record systems, but all members should conform to a minimum standard in recording the case history of new patients and progress while under Chiropractic care.

Case History

A case history must include the following information:

- (a) Name, occupation, address, sex, marital state and date.
- (b) Comprehensive history of past and present health.
- (c) Previous treatment.
- (d) Past illnesses, operations and/or accidents.
- (e) X-Ray history—particularly if recent.

Initial Examination

In addition to any other examination, a physical examination of the spinal column must be made and the findings noted. If physical examination of other regions of the body be made, the findings should also be noted.

X-Ray examination

- (a) An X-Ray examination should be made before any adjustment is performed.
- (b) Film size should be of an appropriate size to the area under examination. No X-Ray should be regarded as an up-to-date record of a spinal area if it is over five years old.
- (c) No record of X-Ray film should be regarded as up-to-date if there is reasonable evidence of changed circumstances, or if an accident has intervened.
- (d) Exposure technique must be consistent with minimum radiation dosage to patient and maximum radiographic detail. Poor films should be retaken.
- (e) In addition to X-Rays taken consistent with the Chiropractic technique employed, X-Ray examinations should include views from two directions, (e.g. A-P and Lateral) in the areas of the spine relative to the patient's symptoms unless impractical.
- (f) Care must be taken to protect the patient from excessive radiation with particular attention to the following:
 1. *Collimation*—field size must be minimum size appropriate to the area under examination.
 2. *Gonad Shielding*—(i) the male gonads shall not be exposed to direct radiation. When collimation does not give protection, a gonad shield must be used.
(ii) the female gonads shall not be exposed to direct radiation unnecessarily. When exposure to direct radiation cannot be avoided, maximum filtration and minimum radiation techniques must be used.
 3. *Filtration*—shall be used to reduce radiation and improve radiographic quality in areas of variable density.
 4. *Compression Stabilisation*—of patients shall be employed where practical to reduce exposure techniques. Stabilisation aids should be used on all exposures.
- (g) X-Ray identification must clearly show the following information:
 1. Patient's surname and initials and whether Mr, Mrs or Miss.
 2. Date of exposure.
 3. Identification—right and left.

4. Identification of Chiropractors office where X-Rays made.

5. Position of patient at time of exposure, e.g., sitting, standing, A-P P-A etc.

(h) Record of all X-Rays made of patient and the technique used are to be maintained with patient's file.

(i) X-Ray examination (exposure) shall be performed only by a registered Chiropractor, interning Chiropractor, conditionally registered Chiropractor, qualified radiological service person or registered Radiographer.

Treatment Procedure

Patients to be suitably attired whenever practical.

Daily Records

In addition to complete case history records, progress records of patients shall include:

(a) Date of each visit and adjustment made.

(b) Any advice given to patient or relatives.

(c) Relevant matters which in the opinion of the Chiropractor are significant, must be recorded.

General

1. Sufficient time must be allowed at each visit to adequately maintain minimum Standards of Practice.

2. All records, including X-Ray films are to be regarded as part of the Chiropractors case records, and as such may be transferred only to a registered Chiropractor. Professional courtesy demands that prompt attention be given to transferring records of a patient.

3. All records shall be filed for a period of not less than seven years from the last visit.

4. *Transferring of Patients.* When a patient transfers to another Chiropractor the following procedure shall apply:

(a) Relevant information of the case.

(b) Receipt of records shall be promptly acknowledged by recipient Chiropractor.

(c) When X-Rays are transferred the recipient Chiropractor shall not dispose of them without reference to the original Chiropractor unless seven (7) years have elapsed since last visit.

(d) X-Rays, case history and other progress records to remain the property of the Chiropractor for whom they were taken initially.

5. *Office Personnel.* Consultation, physical examination, X-Ray examination may only be made by personnel registered under the Chiropractic Act unless supervised personally by one so registered.

(C) STATEMENT ON LAW AND ETHICS

THE LAW

The title—Chiropractors—is protected by the provisions of the Chiropractors Act, 1960, and may be used only by persons who have been registered under the Act. The scope and practice of the profession of Chiropractic are limited by the same Act to "the examination and adjustment by hand of the segments of the human spinal column and pelvis."

PROFESSIONAL ETHICS

As is the case in respect of all other professions the special law regarding that of chiropractic has been designed to protect the interests of the public in general as well as those of the individual practitioner. It seeks to establish and to regulate standards of professional competence within the field concerned and to guard the qualified practitioner by registering his exclusive right to the use of the title "Chiropractor". It also provides penalties for those found, after proper enquiry, to be guilty of gross negligence or malpractice in respect of their calling or of serious breaches of the general law, or of grave impropriety or misconduct in either their professional activities or their personal lives.

To maintain and enhance the status of the profession in the eyes of the community and to ensure that its practitioners do nothing to damage its image or to inhibit its development, chiropractors must determine and accept a measure of personal and professional discipline going beyond the bare requirements of the law. To this purpose, and so that all concerned

may be guided by similar standards, the following *Code of Ethics* has been prepared and is recommended to all practitioners as a supplement to their Chiropractic Oath and to the Golden Rule (Matt. 7. v 12), which all men should honour.

The code has been subdivided as to a chiropractor's relationships—

- (a) with his patients,
- (b) with his colleagues,
- (c) with practitioners in other professions,
- (d) with the public.

(A) *Relationship With Patients*

(1) A chiropractor shall never betray the confidence of a patient, or divulge diagnostic findings acquired during consultation or in the course of professional treatment to anyone without the consent of the patient except when required to do so by law, or where failure to take action would constitute a menace or danger to the patient or to another member of the community.

(2) If a patient's condition, or lack of progress, gives cause for anxiety, a chiropractor shall not hesitate to call a second opinion, either from another chiropractor or from another appropriate practitioner or specialist. A chiropractor so called as consultant shall communicate only through the chiropractor in charge of the case, and not directly to the patient or relatives.

(3) A chiropractor shall never suggest that a patient is worse than he really is, or that he has a condition not evidently present, thereby exploiting him.

(4) A chiropractor shall not solicit a testimonial or commendatory letter, but if one is spontaneously forthcoming it shall not be exhibited or passed on, or published, without the patient's consent.

(5) A chiropractor shall not at any time intentionally misinform a patient as to his professional qualifications.

(6) A chiropractor must never divulge that any particular person is his patient.

(B) *Relationship Between Colleagues*

(1) All registered chiropractors, whether members of the New Zealand Chiropractors' Association or not, must consider one another as colleagues and, therefore, no sense of competition should exist between them.

(2) A chiropractor shall not criticise, condemn or belittle a colleague in the presence of a patient or other lay person.

(3) A chiropractor shall not attempt to persuade a person to become his patient if he knows that person is already attending a colleague; this also applies to an assistant who leaves the employ of a principal.

(4) A chiropractor who undertakes the treatment of a patient because the patient's own chiropractor is not available, shall render all the assistance he can. At the earliest opportunity he shall return the patient to his own chiropractor and supply all relevant details of the case whilst under his care.

(5) X-Ray Plates, case histories and like data received from another practitioner shall be acknowledged by return mail or at first available opportunity.

(6) A chiropractor should respond graciously to a request from a colleague requiring his professional assistance. It is an accepted practice that chiropractic care is freely given to a colleague.

(7) Before commencing practice in a new location a chiropractor should make a courtesy call on all colleagues already operating in that area.

(8) Individual chiropractors shall not arrange or conduct professional seminars without first obtaining permission from the Chiropractic Board and Council of the N.Z. Chiropractors' Association.

(9) No overseas chiropractor or chiropractors shall conduct professional seminars in New Zealand without approval obtained on their behalf from the Chiropractic Board.

(C) *Relationship With Practitioners in Other Professions*

(1) So that his patients may be assured of the best and most enlightened attention available from whatever source, a chiropractor is expected to encourage and maintain respect for practitioners in other branches of the healing arts. The causes of human suffering

are so varied and the knowledge of any individual is so limited that an attitude of intolerance or disparagement of the honest efforts of kindred practitioners ill-becomes anyone engaged in this field.

(D) Relationship With the Public

(1) A chiropractor shall not use his name or his qualification for the commercialising of any product nor shall he advertise or permit any advertisement, indicating that he has any business connection with any manufacturing or marketing establishment.

(2) A chiropractor shall not publicly claim he has discovered, or make unconfirmed claims for, any diagnostic or therapeutic technique remedy or apparatus not yet accepted as part of standard chiropractic theory and practice.

(3) No chiropractor shall distribute or mail or have distributed or mailed to members of the general public, material bearing information as to the locality or description of his Chiropractic practice but a chiropractor who has acquired a practice from a colleague may inform established patients accordingly by mail.

(4) A chiropractor shall clearly identify himself as a registered chiropractor on his office sign and shall ensure that all out-dated signs, listings, cards or other means of identification are removed or discontinued.

(5) A chiropractor shall refrain from self advertisement or the seeking after patients in an unprofessional or improper manner. Any advertisement or published notification beyond the following limits shall be regarded as unethical and any such existing must be discontinued forthwith:

(a) *Announcements*—Announcements of office openings, change of location or association with another chiropractor shall not exceed a maximum of two columns wide and three inches high and shall not contain any reference to the practice of chiropractic other than that material permitted on a professional card. Such announcements shall not exceed six separate publications or extend over a total period exceeding thirty days from the date of first publication. Newspapers, professional journals and directories only may carry a professional card which should conform both in space and print with other professional card insertions in those publications and not exceed one inch single column.

(b) *Letterheads and Cards*—Professional cards and letterheads on stationery and accounts shall not contain any material other than the name, or names, address, office hours, telephone number, name of clinic if applicable, professional identification and professional qualifications.

(c) *Office Identification*—The display of notices as to the location of offices shall be limited to the building in which the offices are situated, such notice shall be of modest size and shall include only sufficient information to enable the public to know the location of the rooms, the office hours and the name and qualifications of the chiropractor.

(d) *Telephone Directory Listings*—Telephone directory listings shall not include more than the name, address, telephone number and identification as a chiropractor and shall not exceed the size permitted within the normal charge for a business telephone service.

(6) No chiropractor or chiropractic body shall offer free services of any kind to the general public without approval from the Chiropractic Board.

(D) CODE OF ETHICS

Foreword

THE GOLDEN RULE represents the vital principle of all ethical codes, and the purpose of this Code of Chiropractic Ethics is to indicate and interpret the application of this rule to the practice of our profession. As such, it is commended as a compass for guidance to all members of the New Zealand Chiropractors' Association.

Duty to the Profession

Every chiropractor should regard it as his or her duty:

1. (a) To advance the profession of Chiropractic.

(b) To support the New Zealand Chiropractors' Association (Inc) in its activities for the maintenance and betterment of the profession.

(c) To assist any Chiropractic Board established by statute in its administration of a Chiropractic Act.

2. To keep himself in touch with every modern development of his profession, to increase his knowledge and efficiency by the adoption of modern methods of proved worth and to contribute his share to the general knowledge and advancement of the profession.
3. To maintain the highest personal character in both public and professional life.
4. To be conscientious in enlightening the public regarding the maintenance of health, remembering that the quality of his service shall be a measure of the standing of the profession.

Duty to Patients

1. The confidence shown by the patient placing his case in the care of a chiropractor should, under all circumstances, be respected.

2. No exaggeration of the patient's disabilities should be made.

3. It should be the aim of every chiropractor to establish and maintain high ideals of professional honour and responsibility, and to endeavour in every way to render satisfaction to his patients.

4. No specific guarantee regarding results to be obtained by chiropractic adjustments should be given, but an assurance of benefit, where same can be confidently expected, is permissible.

5. The charges made for services rendered should be reasonable and should approximate the charges of fellow chiropractors.

6. Every chiropractor should adhere strictly to his scale of fees and charges; special consideration may be given to proved necessitous cases.

7. The duty of every chiropractor is to see that both he and his staff act in a courteous manner to persons seeking their attention.

Appendix 5

DRAFT HEALTH DISCIPLINES AMENDMENT ACT [ONTARIO]

Part VII, (ss. 169-193), enacted

2. The said Act is amended by adding thereto the following Part:

PART VII.
CHIROPRACTIC

Interpretation

169.—(1) In this Part,

- (a) "by-laws" means the by-laws made under this Part;
- (b) "College" means the College of Chiropractors of Ontario;
- (c) "Council" means the Council of the College;
- (d) "licence" means a licence for the practice of chiropractic issued under this Part;
- (e) "member" means a member of the College;
- (f) "practice of chiropractic" means the services usually performed by a chiropractor in the diagnosing, preventing, relieving or correcting of:
 - (i) abnormal mobility, fixation or anatomical malposition of the spine, pelvis or joints for the purpose of relieving interference with the normal functioning of the nervous system of the body, and
 - (ii) abnormal mobility or abnormal stability of skeletal muscles;
- (g) "Registrar" means the Registrar of the College;
- (h) "regulations" means the regulations made under this Part.

Health discipline

(2) The practice of chiropractic is a health discipline to which this Part applies.

College of Chiropractors of Ontario established

170.—(1) The College of Chiropractors of Ontario is established as a body corporate without share capital with power to acquire, hold and dispose of real and personal property for the purposes of this Part.

Objects

- (2) The objects of the College are,
- (a) to regulate the practice of chiropractic and to govern its members in accordance with this Act, the regulations and the by-laws;
 - (b) to establish, maintain and develop standards of knowledge and skill among its members;
 - (c) to establish, maintain and develop standards of qualification and practice for the practice of chiropractic;
 - (d) to establish, maintain and develop standards of professional ethics among its members;
 - (e) to administer this Part and perform such other duties and exercise such other powers as are imposed or conferred on the College by or under any Act;
 - (f) such other objects relating to chiropractic as the Council considers desirable.

in order that the public interest may be served and protected.

Membership in the College

171.—(1) Every person licensed by the College is a member of the College subject to any term, condition or limitation to which the licence is subject.

Resignation of membership

(2) A member may resign his membership by filing with the Registrar his resignation in writing and his licence is thereupon cancelled, subject to the continuing jurisdiction of the

College in respect of any disciplinary action arising out of his professional conduct while a member.

Cancellation for default of fees

(3) The Registrar may cancel a licence for non-payment of any fee prescribed by the regulations after giving the member at least two months notice of the default and intention to cancel, subject to the continuing jurisdiction of the College in respect of any disciplinary action arising out of his professional conduct while a member.

Council of College

172.—(1) There shall be a Council of the College which shall be the governing body and board of directors of the College and shall manage its affairs.

Composition of Council

(2) The Council shall be composed of,

- (a) one person who is a member and the holder of a licence not limited to practising for educational purposes only and who is appointed by the Canadian Memorial Chiropractic College from among its faculty;
- (b) three persons who are not members of a Council under this Act or registered or licensed under this Act or any other Act governing a health practice and are appointed by the Lieutenant Governor in Council; and
- (c) six persons who are members elected in the manner determined by the regulations.

Remuneration

(3) The persons appointed under clause b of subsection 2 shall be paid, out of moneys appropriated therefor by the Legislature, such expenses and remuneration as is determined by the Lieutenant Governor in Council.

Expiration of appointment

(4) The appointment of every person appointed under subsection 2 shall be for a term not exceeding three years, and a person whose appointment expires is eligible for re-appointment.

Qualifications to vote

(5) Every member who is,

- (a) resident in Ontario;
- (b) not in default of payment of the annual fees prescribed by the regulations; and
- (c) the holder of a licence not limited to practising for educational purposes only,

is qualified to vote at an election of members of the Council.

President and Vice President

(6) The Council shall elect annually a President and a Vice-President from among its members.

Registrar and staff

(7) The Council shall appoint during pleasure a Registrar and such other officers and servants as may from time to time be necessary in the opinion of the Council to perform the work of the College.

Quorum

(8) A majority of the members of the Council constitutes a quorum.

Interim appointments

(9) Upon the coming into force of this Part, the Lieutenant Governor in Council shall appoint to the Council six persons who are members and shall be deemed to be the persons referred to in clause c of subsection 2 and,

- (a) three of such persons shall be appointed to remain in office until the members elected

- to the Council at the first election under the regulations take office; and
- (b) three of such persons shall be appointed to remain in office until the members elected to the Council at the second election under the regulations take office.

Powers of Minister

173. In addition to his powers and duties under Part I, the Minister may,
- (a) review the activities of the Council;
- (b) request the Council to undertake activities that, in the opinion of the Minister, are necessary and advisable to carry out the intent of this Act;
- (c) advise the Council with respect to the implementation of this Part and the regulations and with respect to the methods used or proposed to be used by the Council to implement policies and to enforce its regulations and procedures.

Regulations

174. Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,
- (a) respecting and governing the qualifications, nomination, election and term of office of the members to be elected to the Council, and controverted elections;
- (b) prescribing the conditions disqualifying elected members from sitting on the Council and governing the filling of vacancies on the Council;
- (c) respecting any matter ancillary to the provisions of this Part with regard to the issuing, suspension and revocation of licences;
- (d) prescribing classes of licences and governing the requirements and qualifications for the issuing of licences or any class thereof and prescribing the terms and conditions thereof;
- (e) providing for the maintenance and inspection of registers of persons permitted to practise and for the issuance of certificates of standing by the Registrar;
- (f) governing standards of practice for the profession;
- (g) authorizing persons other than members to perform specified acts in the practice of chiropractic under the supervision or direction of a member;
- (h) prohibiting the practice of chiropractic where there is a conflict of interest and defining the activities that constitute a conflict of interest for the purpose;
- (i) defining professional misconduct for the purposes of this Part;
- (j) prescribing the minimum number of members who may constitute a clinic and the minimum range of chiropractic services that shall be provided in a clinic;
- (k) providing for a program of continuing education of members to maintain their standard of competence and requiring members to participate in such continuing education;
- (l) regulating, controlling and prohibiting the use of terms, titles or designations by members or groups or associations of members in respect of their practices;
- (m) respecting the reporting and publication of decisions in disciplinary matters;
- (n) providing for the compilation of statistical information on the supply, distribution and professional activities of members and requiring members to provide the information necessary to compile such statistics;
- (o) respecting the duties and authority of the Registrar;
- (p) requiring and providing for the inspection and examination of the office, chiropractic records, books, accounts, reports and equipment of members in connection with their practice;
- (q) prescribing the records that shall be kept respecting patients;
- (r) requiring the payment of annual fees by members and fees for licensing, examinations and continuing education, including penalties for late payment, and fees for anything the Registrar is required or authorized to do, and prescribing the amounts thereof;
- (s) prescribing the qualifications for and conditions of registration of students and governing in-service training for students;
- (t) prescribing limitations, restrictions or conditions that shall apply in respect of x-ray for the purpose of diagnosis or in respect of diagnostic procedures in the practice of chiropractic by a person licensed under this Part;

- (u) authorizing other acts and procedures that may be used in the practice of chiropractic by persons licensed under this Part and prescribing limitations, restrictions or conditions to which such acts and procedures or any of them shall be subject;
- (v) providing for the establishment and operation of an appraisal committee for the purposes of examining and assessing the standard of practice in the profession and reporting thereon to the Council and examining and assessing the standards of practice, qualifications and continuing education of members and making recommendations to the Registration Committee thereon;
- (w) prescribing forms and providing for their use;
- (x) providing for the exemption of any member from any provision of the regulations under such special circumstances in the public interest as the Council considers advisable and prescribing conditions that shall attach to such exemptions or to any such exemption;
- (y) defining classes of specialists in various branches of the practice of chiropractic, prescribing the qualifications required, providing for the suspension or revocation of any such designation and for the regulation and prohibition of the use of terms, titles or designations by members indicating specialization in any branch of the practice of chiropractic.

By-laws

175.—(1) The Council may pass by-laws relating to the administrative and domestic affairs of the College not inconsistent with this Act and the regulations and without limiting the generality of the foregoing.

- (a) prescribing the seal of the College;
- (b) providing for the execution of documents by the College;
- (c) respecting banking and finance;
- (d) fixing the financial year of the College and providing for the audit of the accounts and transactions of the College;
- (e) providing procedures for the election of President and Vice-President of the College, the filling of a vacancy in those offices, and prescribing the duties of the President and Vice-President;
- (f) respecting the calling, holding and conducting of meetings of the Council and the duties of members of Council;
- (g) respecting the calling, holding and conducting of meetings of the membership of the College;
- (h) delegating to the Executive Committee such powers and duties of the Council as are set out in the by-law, other than the power to make, amend or revoke regulations and by-laws;
- (i) prescribing the remuneration of the members of the Council and committees other than persons appointed by the Lieutenant Governor in Council and providing for the payment of necessary expenses of the Council and committees in the conduct of their business;
- (j) providing for the appointment, composition, powers and duties of such additional or special committees as may be required;
- (k) providing for a code of ethics;
- (l) prescribing forms and providing for their use;
- (m) providing procedures for the making, amending and revoking of the by-laws;
- (n) respecting management of the property of the College;
- (o) providing for the establishment, maintenance and administration of a benevolent fund for needy members in Ontario and the dependants of deceased members;
- (p) respecting the application of the funds of the College and the investment and reinvestment of any of its funds not immediately required, and for the safe-keeping of securities;
- (q) providing for the entering into arrangements by the College for its members respecting indemnity for professional liability and respecting the payment and remittance of premiums in connection therewith and prescribing levies to be paid by members and exempting members or any class thereof from all or part of any such levy;
- (r) respecting membership of the College in a national organization with similar functions, the payment of an annual assessment and provision for representatives at meetings;
- (s) providing for the appointment of inspectors for the purposes of this Part;

- (t) respecting all of the things that are considered necessary for the attainment of the objects of the College and the efficient conduct of its affairs.

Distribution of by-laws

- (2) A copy of the by-laws made under subsection 1 and amendments thereto,
 (a) shall be forwarded to the Minister;
 (b) shall be forwarded to each member; and
 (c) shall be available for public inspection in the office of the College.

Signing by-law and resolution

(3) Any by-law or resolution signed by all members of the Council is as valid and effective as if passed at a meeting of the Council duly called, constituted and held for the purpose.

Licence to practise

176.—(1) No person shall engage in or hold himself out as engaging in the practice of chiropractic unless he is licensed under this Part.

Method of practice

(2) A person who is licensed under this Part may engage in the practice of chiropractic by means only of,

- (a) diagnosis subject to such limitations, restrictions or conditions as are set out in the regulations in respect of x-ray for the purpose of diagnosis or in respect of diagnostic procedures;
 (b) manual adjustment, manipulation or mobilization or any combination of them;
 (c) the use of exercise, non-rigid supports, light therapy, thermal therapy, electro therapy, mechano therapy and hydro therapy; and
 (d) such other acts and procedures as are authorized by the regulations and subject to such limitations, restrictions or conditions as are set out in the regulations.

Exceptions

(3) Subsection 1 does not apply to a student engaging in a curriculum of studies at a school of chiropractic in Ontario who practises chiropractic as required by the curriculum under the supervision of a member of the chiropractic staff of the school.

Proof of practice

(4) For the purpose of subsection 1, proof of the performance of one act in the practice of chiropractic on one occasion is sufficient to establish engaging in the practice of chiropractic.

Conflict with other health discipline

(5) A member or person authorized by the regulations may engage in the practice of chiropractic notwithstanding that any part of such practice is included in the practice of any other health discipline.

Use of drugs prohibited

177. No member shall use drugs in the practice of chiropractic.

Establishment of Committees

178.—(1) The Council shall establish and appoint as hereinafter provided the following committees,

- (a) Executive Committee;
 (b) Registration Committee;
 (c) Complaints Committee;
 (d) Discipline Committee,

and may establish such other committees as the Council from time to time considers necessary.

Vacancies

(2) Where one or more vacancies occur in the membership of the Council or any committee, the members remaining in office constitute the Council or committee so long as their number is not fewer than the prescribed quorum.

Chiropractic Review Committee

(3) The Council may give the Chiropractic Review Committee established under *The Health Insurance Act, 1972 (1972, c. 91)* such other duties as the Council considers appropriate and that are not inconsistent with its duties under that Act.

Executive Committee

179.—(1) The Executive Committee shall be composed of the President, who shall be chairman of the Committee, the Vice-President and one member who shall be a person appointed to the Council under clause b of subsection 2 of section 172.

Quorum

(2) Two members of the Executive Committee constitute a quorum.

Duties

(3) The Executive Committee shall perform such functions of the Council as are delegated to it by the Council, the by-laws or this Part and, subject to ratification by the Council at its next ensuing meeting, may take action upon any other matter that requires immediate attention between meetings of the Council, other than to make, amend or revoke a regulation or by-law.

Registration Committee

180.—(1) The Registration Committee shall be composed of,

- (a) one member of the Council who is a member of the College;
- (b) the person appointed to the Council under clause a of subsection 2 of section 172;
- (c) two members of the College who are not members of the Council; and
- (d) one person appointed to the Council under clause b of subsection 2 of section 172.

Chairman

(2) The Council shall name one member of the Registration Committee to be chairman.

Quorum

(3) A majority of the members of the Registration Committee constitutes a quorum.

Issuance of licences

181.—(1) The Registrar shall issue a licence to any applicant therefor who is qualified under this Part and the regulations and has passed such examinations as the Council may set or approve, and the Registrar shall refer to the Registration Committee every application for a licence that he proposes to refuse or to which he considers terms, conditions or limitations should be attached.

Powers and duties of Registration Committee

(2) The Registration Committee,

- (a) shall determine the eligibility of applicants for licences and may require an applicant to take and pass such additional examinations as the Council may set or approve and pay such fees therefor as the Registration Committee fixes or to take such additional training as the Registration Committee specifies; and
- (b) may exempt an applicant from any licensing requirement.

Idem

(3) The Registration Committee may direct the Registrar to issue or refuse to issue licences or to issue licences subject to such terms, conditions and limitations as the Committee specifies.

Review of qualifications

(4) The Registration Committee may review the qualifications of any member and may impose a term, condition or limitation on his licence pending the demonstration of such standard of competence through the completion of such experience, courses of study or continuing education as the Committee specifies.

Registers of licensees

(5) The Registrar shall maintain one or more registers in which is entered every person who is licenced to practise chiropractic identifying the terms, conditions and limitations attached to the licence, and shall note on the register every revocation, suspension and cancellation of a licence and such other information as the Registration Committee or Discipline Committee directs.

Continuance of registration

(6) Every person who was registered as a chiropractor under *The Drugless Practitioners Act (R.S.O. 1970, c. 137)* immediately before this Part comes into force shall be deemed to be the holder of a licence under this Part subject to any limitation to which the registration was subject.

Complaints Committee

182.—(1) The Complaints Committee shall be composed of,

- (a) three persons who are members of the College;
- (b) one person who is a member of the College and Council; and
- (c) one person appointed to the Council under clause b of subsection 2 of section 172.

Idem

(2) No person who is a member of the Discipline Committee shall be a member of the Complaints Committee.

Chairman

(3) The Council shall name one member of the Complaints Committee to be its chairman.

Quorum

(4) Three members of the Complaints Committee constitute a quorum.

Duties

183.—(1) The Complaints Committee shall consider and investigate complaints made by members of the public or members of the College regarding the conduct or actions of any member of the College, but no action shall be taken by the Committee under subsection 2 unless,

- (a) a written complaint has been filed with the Registrar and the member whose conduct or actions are being investigated has been notified of the complaint and given at least two weeks in which to submit in writing to the Committee any explanations or representations he may wish to make concerning the matter; and
- (b) the Committee has examined or has made every reasonable effort to examine all records and other documents relating to the complaint.

Idem

(2) The Committee in accordance with the information it receives may,

- (a) direct that the matter be referred, in whole or in part, to the Discipline Committee or to the Executive Committee for the purposes of section 186;
- (b) direct that the matter not be referred under clause a; or
- (c) take such action as it considers appropriate in the circumstances and that is not inconsistent with this Part or the regulations or by-laws.

Decision and reasons

(3) The Committee shall give its decision in writing to the Registrar for the purposes of section 8 and, where the decision is made under clause b of subsection 2, its reasons therefor.

Discipline Committee

- 184.—(1) The Discipline Committee shall be composed of,
- (a) three persons who are members of the College;
 - (b) one person who is a member of the College and Council; and
 - (c) two persons appointed under clause b of subsection 2 of section 172.

Quorum and votes

(2) Three or more members of the Discipline Committee, of whom one shall be a person appointed to the Council by the Lieutenant Governor in Council, under clause b of subsection 2 of section 172, constitute a quorum, and all disciplinary decisions require the vote of a majority of the members of the Discipline Committee present at the meeting.

Disability of lay member

(3) Where a quorum of the Discipline Committee commences a hearing and the member thereof who is appointed under clause b of subsection 2 of section 172 becomes unable to continue to act, the remaining members may complete the hearing notwithstanding his absence.

Chairman

- (4) The Council shall name one member of the Discipline Committee to be chairman.

Reference by Council or Executive Committee

(5) Notwithstanding section 183, the Council or the Executive Committee may direct the Discipline Committee to hold a hearing and determine any specified allegation of professional misconduct or incompetence on the part of a member.

Duties of Discipline Committee

- 185.—(1) The Discipline Committee shall,
- (a) when so directed by the Council, Executive Committee or Complaints Committee, hear and determine allegations of professional misconduct or incompetence against any member;
 - (b) hear and determine matters referred to it under section 183, 184 or 187; and
 - (c) perform such other duties as are assigned to it by the Council.

Idem

(2) In the case of hearings into allegations of professional misconduct or incompetence, the Discipline Committee shall,

- (a) consider the allegations, hear the evidence and ascertain the facts of the case;
- (b) determine whether upon the evidence and the facts so ascertained the allegations have been proved;
- (c) determine whether in respect of the allegations so proved the member is guilty of professional misconduct or incompetence;
- (d) determine the penalty to be imposed as hereinafter provided in cases in which it finds the member guilty of professional misconduct or of incompetence.

Professional misconduct

- (3) A member may be found guilty of professional misconduct by the Committee if,
- (a) he has been found guilty of an offence relevant to his suitability to practise, upon proof of such conviction;
 - (b) he is in contravention of section 177; or
 - (c) he has been guilty in the opinion of the Discipline Committee of professional misconduct as defined in the regulations.

Incompetence

(4) The Discipline Committee may find a member to be incompetent if in its opinion he has displayed in his professional care of a patient a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice.

Powers of Discipline Committee

(5) Where the Discipline Committee finds a member guilty of professional misconduct or incompetence it may by order,

- (a) revoke the licence of the member;
 - (b) suspend the licence of the member for a stated period;
 - (c) impose such restrictions on the licence of the member for such a period and subject to such conditions as the Committee designates;
 - (d) reprimand the member and, if deemed warranted, direct that the fact of such reprimand be recorded on the register;
 - (e) impose such fine as the Committee considers appropriate to a maximum of \$5,000 to be paid by the member to the Treasurer of Ontario for payment into the Consolidated Revenue Fund;
 - (f) direct that the imposition of a penalty be suspended or postponed for such period and upon such terms as the Committee designates,
- or any combination thereof.

Costs

(6) Where the Discipline Committee is of the opinion that the commencement of the proceedings was unwarranted, the Committee may order that the College reimburse the member for his costs or such portion thereof as the Discipline Committee fixes.

Stay on appeal for incompetence

(7) Where the Discipline Committee revokes, suspends or restricts a licence on the grounds of incompetence, the decision takes effect immediately notwithstanding that an appeal is taken from the decision.

Stay on appeal for professional misconduct

(8) Where the Discipline Committee revokes, suspends or restricts the licence of a member on grounds other than for incompetence, the order shall not take effect until the time for appeal from the order has expired without an appeal being taken or, if taken, the appeal has been disposed of or abandoned.

Service of decision of Discipline Committee

(9) Where the Discipline Committee finds a member guilty of professional misconduct or incompetence, a copy of the decision shall be served upon the person complaining in respect of the conduct or action of the member.

Continuation on expiry of Committee membership

(10) Where a proceeding is commenced before the Discipline Committee and the term of office on the Council or on the Committee of a member sitting for the hearing expires or is terminated before the proceeding is disposed of but after evidence has been heard, the member shall be deemed to remain a member of the Discipline Committee for the purpose of completing the disposition of the proceeding in the same manner as if his term of office had not expired or been terminated.

Continuation of proceedings

(11) Where The Board of Directors of Chiropractic, immediately before this section comes into force, proposed to hold a hearing with respect to the professional competence or conduct of any person registered as a chiropractor under *The Drugless Practitioners Act (R.S.O. 1970. c. 137)*, the hearing may be proceeded with by the Discipline Committee as a hearing under this Act.

Idem

(12) Where The Board of Directors of Chiropractic, immediately before this section comes into force, commenced but did not complete a hearing and the making of a decision with respect to the professional competence or conduct of any person registered as a chiropractor under *The Drugless Practitioners Act*, the hearing shall be transferred to the Discipline Committee as a hearing under this Act and the Discipline Committee may continue the

hearing upon receipt of a transcript of the hearing, and may require the preparation and delivery of such a transcript certified by the secretary-treasurer of the Board of Directors of Chiropractic, or may require the hearing or any part thereof to be commenced *de novo*.

Interpretation

186.—(1) In this section,

- (a) "Board of inquiry" means a board of inquiry appointed by the Executive Committee under subsection 2;
- (b) "incapacitated member" means a member suffering from a physical or mental condition or disorder of a nature and extent making it desirable in the interests of the public or the member that he no longer be permitted to practise or that his practice be restricted.

Reference to board of inquiry

(2) Where the Registrar receives information leading him to believe that a member may be an incapacitated member, he shall make such inquiry as he considers appropriate and report to the Executive Committee who may, upon notice to the member, appoint a board of inquiry composed of at least two members of the College and one member of the Council appointed under clause b of subsection 2 of section 172 who shall inquire into the matter.

Examination

(3) The board of inquiry shall make such inquiries as it considers appropriate and may require the member to submit to physical or mental examinations by such qualified person or persons as the board designates and if the member refuses or fails to submit to such examinations, the board may order that his licence be suspended until he complies.

Hearing by Registration Committee

(4) The board of inquiry shall report its findings to the Executive Committee and deliver a copy thereof and a copy of any medical or other report obtained under subsection 3 to the member about whom the report is made and if, in the opinion of the Executive Committee, the evidence so warrants, the Executive Committee shall refer the matter to the Registration Committee to hold a hearing and may suspend the member's licence until the determination of the question of his capacity becomes final.

Parties

(5) The College, the person whose capacity is being investigated and any other person specified by the Registration Committee are parties to the hearing.

Medical evidence

(6) A legally qualified medical practitioner or a person who is licensed under this Part to engage in the practice of chiropractic is not compellable to produce at the hearing his case histories, notes or any other records constituting medical or chiropractic evidence but, when required to give evidence, shall prepare a report containing the medical or chiropractic facts, findings, conclusions and treatment and such report shall be signed by him and served upon the other parties to the proceedings,

- (a) where the evidence is required by the College, at least five days before the hearing commences; and
- (b) where the evidence is required by the person about whom the report is made, at least five days before its introduction as evidence,

and the report is receivable in evidence without proof of its making or of the signature of the legally qualified medical practitioner or of the person licensed under this Part to engage in the practice of chiropractic, as the case may be, making the report but a party who is not tendering the report as evidence has the right to summon and cross-examine the medical practitioner or the person licensed under this Part to engage in the practice of chiropractic on the contents of the report.

Powers of Registration Committee

(7) The Registration Committee, shall after the hearing,

- (a) make a finding as to whether or not the member is an incapacitated member; and
 (b) where the member is found to be an incapacitated member, by order,

- (i) revoke his licence,
 (ii) suspend his licence for such period as the Committee considers appropriate,
 or
 (iii) attach such terms and conditions to the licence as the Committee considers appropriate.

Procedures

(8) The provisions of Part I and this Part applying to proceedings of the Health Disciplines Board on hearings and review in respect of applications for registration and appeals therefrom apply, *mutatis mutandis*, to proceedings of the Registration Committee under this section, except that the decision takes effect immediately notwithstanding that an appeal is taken from the order.

Restoration of licence

187.—(1) A person whose licence has been revoked or suspended for cause under this Part, or whose registration has been suspended or cancelled for cause under a predecessor of this Part, may apply in writing to the Registrar for the issuance of a licence or removal of the suspension, but such application shall not be made sooner than one year after the revocation or cancellation or, where the suspension is for more than one year, one year after the suspension.

Reference to Discipline Committee

(2) The Registrar shall refer the application to the Discipline Committee or, where the revocation or suspension was on the grounds of incapacity, to the Registration Committee, which shall hold a hearing respecting and decide upon the application, and shall report its decision and reasons to the Council and to the former member.

Procedures

(3) The provisions of Part I and this Part applying to proceedings of the Health Disciplines Board on hearings and review in respect of applications for registration, except subsection 9 of section 11, apply, *mutatis mutandis*, to proceedings of the Registration Committee and Discipline Committee under this section.

Investigation of members

188.—(1) Where the Registrar believes on reasonable and probable grounds that a member has committed an act of professional misconduct or incompetence, the Registrar may, with the approval of the Executive Committee, by order appoint one or more persons to make an investigation to ascertain whether such act has occurred, and the person appointed shall report the result of his investigation to the Registrar.

Powers of investigator

(2) For purposes relevant to the subject-matter of an investigation under this section, the person appointed to make the investigation may inquire into and examine the practice of the member in respect of whom the investigation is being made and may, upon production of his appointment, enter at any reasonable time the business premises of such person and examine books, records, documents and things relevant to the subject-matter of the investigation, and, for the purposes of the inquiry, the person making the investigation has the powers of a commission under Part II of *The Public Inquiries Act, 1971 (1971, c.49)*, which Part applies to such inquiry as if it were an inquiry under that Act.

Obstruction of investigator

(3) No person shall obstruct a person appointed to make an investigation under this section or withhold from him or conceal or destroy any books, records, documents or things relevant to the subject-matter of the investigation.

Search warrant

(4) Where a provincial judge is satisfied, upon an *ex parte* application by the person making an investigation under this section, that the investigation has been ordered and that such person has been appointed to make it and that there is reasonable ground for believing there are in any building, dwelling, receptacle or place any books, records, documents or things relating to the person whose affairs are being investigated and to the subject-matter of the investigation, the provincial judge may, whether or not an inspection has been made or attempted under subsection 2, issue an order authorizing the person making the investigation, together with such police officer or officers as he calls upon to assist him, to enter and search, if necessary by force, such building, dwelling, receptacle or place for such books, records, documents or things and to examine them, but every such entry and search shall be made between sunrise and sunset unless the provincial judge, by the order, authorizes the person making the investigation to make the search at night.

Removal of books, etc.

(5) Any person making an investigation under this section may, upon giving a receipt therefor, remove any books, records, documents or things examined under subsection 2 or 4 relating to the member whose practice is being investigated and to the subject-matter of the investigation for the purpose of making copies of such books, records or documents, but such copying shall be carried out with reasonable dispatch and the books, records or documents in question shall be promptly thereafter returned to the member whose practice is being investigated.

Admissibility of copies

(6) Any copy made as provided in subsection 5 and certified to be a true copy by the person making the investigation is admissible in evidence in any action, proceeding or prosecution as *prima facie* proof of the original book, record or document and its contents.

Report of Registrar

(7) The Registrar shall report the results of the investigation to the Council or the Executive Committee or to such other committee as he considers appropriate.

Matters confidential

189.—(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 188, and any member of the Council or a Committee, shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry or investigation under section 188 and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations;
- (b) as may be required for the enforcement of *The Health Insurance Act, 1972 (1972, c.91)*;
- (c) to his counsel; or
- (d) with the consent of the person to whom the information relates.

Testimony in civil suit

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

Restraining orders

190.—(1) Where it appears to the College that any person does not comply with any provision of this Part or the regulations, notwithstanding the imposition of any penalty in respect of such non-compliance and in addition to any other rights it may have, the College may apply to a judge of the High Court for an order directing such person to comply with such provision, and upon the application the judge may make such order or such other order as the judge thinks fit.

Appeal

(2) An appeal lies to the Supreme Court from an order made under subsection 1.

Penalties

191.—(1) Every person who is in contravention of subsection 1 of section 176 is guilty of an offence and on summary conviction is liable for the first offence to a fine of not more than \$2,000 and for each subsequent offence to a fine of not more than \$2,000 or to imprisonment for a term of not more than six months, or to both.

Idem

(2) Subject to the provisions of Parts II, III and V, any person not licensed under this Part who takes or uses any name, title, addition or description implying or calculated to lead people to infer that he is licensed or registered under this Part or that he is recognized by law or otherwise as a chiropractor, or who assumes, uses, or employs the title or description "doctor" or "chiropractor", or any affix or prefix indicative of such titles or qualifications, as an occupational designation relating to the treatment of human ailments or physical defects, or advertises or holds himself out as such is guilty of an offence and on summary conviction is liable for the first offence to a fine of not more than \$1,000 and for each subsequent offence to a fine of not more than \$2,000.

Idem

(3) Any person who obstructs a person appointed to make an investigation under section 188 in the course of his duties is guilty of an offence and on summary conviction is liable to a fine not exceeding \$2,000.

Transfer of assets and liabilities

192.—(1) The College is the successor to The Board of Directors of Chiropractic appointed under *The Drugless Practitioners Act (R.S.O. 1970, c.137)*, being chapter 137 of the Revised Statutes of Ontario, 1970 and all assets and liabilities of and all rights, actions and interests given to or received or held by The Board of Directors of Chiropractic or to which The Board of Directors of Chiropractic is subject immediately before this section comes into force,

- (a) vest in and enure to the benefit of and are binding upon the College; and
- (b) may be enforced as if given to or received or held by or for the benefit of or entered into with the College.

Amendment of references

(2) A reference in any Act, regulation, agreement or document to The Board of Directors of Chiropractic shall be deemed to be a reference to the College or to the Council, as the case requires.

Commencement

(3) This Act comes into force on a day to be named by proclamation of the Lieutenant Governor.

Short title

(4) The short title of this Act is *The Health Disciplines Amendment Act, 1978*.

Appendix 6

DRAFT REGULATION MADE UNDER THE HEALTH
DISCIPLINES ACT, 1974 [ONTARIO]

CHIROPRACTORS

1.—(1) A member is eligible for election to the council who,

- (a) holds a General licence under the Act and is a resident of Ontario;
 - (b) has been nominated as a candidate for election in accordance with section 5; and
 - (c) is in good standing in the College.
- (2) A member is in good standing in the College for the purpose of subsection 1 where,
- (a) he is not in default of payment of any fees prescribed by the regulations;
 - (b) his professional conduct is not the subject of disciplinary proceedings;
 - (c) his licence is not under suspension; and
 - (d) his licence is not subject to a term, condition or limitation other than one prescribed by the regulations.

2.—(1) The first election of members to the Council shall be held in the year 1981, at which time three members shall be elected to replace the three members of the Council appointed under subsection 9 of section 172 of the Act whose terms of office are to expire following the first election of members.

(2) The second election of members to the Council shall be held in the year 1983 at which time three members shall be elected to the Council to replace the three members of the Council appointed under subsection 9 of section 172 of the Act whose terms of office are to expire following the second election of members.

(3) Elections shall be held every two years beginning with the year 1985 and on the occasion of each election three members shall be elected to the Council to replace the three members of the Council whose terms of office are to expire with the election.

(4) The term of office of an elected member of the Council is four years commencing with the first regular meeting of the Council immediately following his election.

(5) When an election of members to the Council is not held within the prescribed period, the members of the Council then in office shall continue in office until their successors are elected or appointed.

3.—(1) The Registrar shall, in the month of January of each year in which an election is held, make out and sign an alphabetical list of the members of the College who are entitled to vote at the election to be held in that year.

(2) During the period beginning with the 1st day of February and ending with the 14th day of February in each year in which an election is held, the list mentioned in subsection 1 may be examined by any member of the College during normal business hours at the office of the Registrar, and if, within that period, a member of the College complains in writing to the Registrar of the improper omission or insertion of any name in the list, the Registrar shall forthwith inquire into the complaint and rectify any error he may find and shall notify the member forthwith of his decision.

(3) If any member of the College is dissatisfied with the decision of the Registrar, he may in writing require the Registrar to refer his decision to the Council which shall forthwith review the matter and give its decision to the Registrar before the 5th day of March in which the complaint is made.

(4) The decision of the Council is final, and the list shall remain as is or shall be altered by the Registrar in accordance with the decision of the Council.

(5) The list as it stands on the 5th day of March in the year in which an election is held shall be signed by the Registrar and constitutes the list of those entitled to vote at the election to be held in that year.

4.—(1) The election of members to the Council shall be held on or before the 1st day of May in each election year.

(2) The date of each election shall be set by the Council and the election shall be carried out under the supervision of the Registrar.

(3) Where there is an interruption of mail service during any period material to an election, the Registrar shall extend the time for receiving nominations and holding the

election for such period as the Registrar considers necessary to compensate for the interruption.

(4) At least fifty-five days before the date of the election the Registrar shall mail the following material to all members entitled to vote:

1. A list of members eligible for election.
2. Nomination forms in the form provided by the Registrar.
3. A written notice stating,
 - i. the date of the election,
 - ii. the last date for receiving nominations for the election,
 - iii. that to be eligible for an election a candidate must be nominated by at least five members entitled to vote, and
 - iv. that nominations shall be submitted in writing to the Registrar and received by him not later than 4 p.m. on the last date for receiving nominations.

5.—(1) The nomination of candidates for election as members of the Council shall be,

- (a) in writing;
- (b) in the nomination form provided by the Registrar; and
- (c) signed by at least five members who hold a general licence under the Act.

(2) The nomination form shall have the candidate's consent signed thereon and shall be filed with the Registrar at least forty days before the date of the election.

(3) The Registrar shall notify without undue delay, after nominations have been closed, all nominated candidates of the names of the members nominated and a candidate may withdraw his candidacy by notice of withdrawal delivered to the Registrar not later than thirty days before the date of the election.

6. Voting for elections of members to the Council shall be by mail ballot.

7. Where only three candidates have been nominated, no vote shall be taken and the candidates shall be deemed to be elected and the Registrar shall notify the candidates of their election.

8.—(1) The Registrar shall prepare suitable ballots.

(2) Voting material with instructions shall be mailed by the Registrar to all members qualified to vote at least ten days before the date of the election.

9.—(1) Members qualified to vote may vote for three candidates.

(2) A ballot shall be marked in the appropriate space with an "x" for the candidate or candidates of the voting member's choice, shall be sealed in the blank envelope supplied and the validation slips attached to the blank envelopes shall bear the voting member's name and address in legible print.

(3) A ballot that does not comply with subsection 2 is null and void.

10. Only ballots received by the Registrar on or before 4 p.m. of the date of the election shall be counted by the Registrar or his designated agent.

11.—(1) In the event that a scrutineer is unable or unwilling to act, the Registrar shall appoint another scrutineer to replace the scrutineer unable or unwilling to act.

12. The Registrar shall, at the counting of the ballots, decide upon the eligibility of any member to vote and shall also decide any dispute that may arise between the scrutineers.

13. The persons entitled to be present at the counting of the ballots are the President, the Vice-President, the Registrar, such clerical staff as the Registrar authorises, the scrutineers and each candidate or his representative appointed in writing.

14. Each outer return envelope shall be opened by the Registrar in the presence of the scrutineers and the Registrar and the scrutineers shall check the names on all validation slips with the list of qualified members furnished by the Registrar under section 3 and, if correct, the Registrar shall remove the validation slips from the sealed envelopes containing the ballots and place the sealed envelopes in the ballot box.

15. Where a tie vote occurs in an election the scrutineers shall determine by lot the member who shall be declared elected to the Council.

16. Upon completion of the count, the scrutineers shall complete a return in duplicate setting out the number of votes cast for each candidate and the number of spoiled ballots and file the returns with the Registrar together with the ballots.

17.—(1) All ballots, the validation slips, the list of voters and one copy of the scrutineers' return shall be placed in one parcel that shall be retained by the Registrar who shall, in the presence of the scrutineers, seal the parcel with the seal of the College and mark on it a statement of the contents.

(2) The Registrar shall retain the parcel referred to in subsection 1 for a period of thirty days from the date of the counting of the ballots and thereafter shall destroy the parcel unless a candidate challenges the election or its result.

18.—(1) Upon the completion of the count and receipt of the returns of the scrutineers, the Registrar shall declare the three members who have received the largest number of votes to be elected as members of the Council and shall notify each candidate of the election results.

(2) The Registrar shall give notice in writing to successful candidates of the date of the next meeting of the Council.

19.—(1) Within thirty days after the counting of the ballots, a candidate may require a recount of the ballots on depositing with the Registrar the sum of \$150.00 and a written request for the recount.

(2) Where a recount has been requested, the Registrar shall appoint the time and place and arrange for the recount which shall take place within fifteen days from the date of the request and, subject to subsection 3, shall be conducted in the same manner as the original counting of the ballots and the candidate or a representative appointed by the candidate may be present at the recount.

(3) The recount shall be conducted by two persons appointed by the President of the College who have not acted as scrutineers in the election.

(4) The portion of the deposit of \$150.00 remaining after payment of the actual cost to the College of conducting the recount shall be returned to the person who paid the deposit but if the recount changes the result of the election the full amount of the deposit shall be returned to the person who paid the deposit.

20.—(1) Where an elected member of the Council,

(a) is found to be an incapacitated member;

(b) is found guilty of professional misconduct or incompetence;

(c) fails to attend without cause three consecutive meetings of a committee of the Council;

or

(d) ceases to hold a General licence under the Act,

the member is disqualified from sitting on the Council and the seat of the member on the Council shall be deemed to be vacant.

(2) Where an elected member of the Council dies or resigns or his seat otherwise becomes vacant before the expiry of his term of office, the Council shall,

(a) where the unexpired term of the member whose seat became vacant does not exceed one year, appoint a successor from among the members of the College; or

(b) where the unexpired term of office of the member whose seat became vacant exceeds one year direct the Registrar to hold a by-election in accordance with the provisions of this Regulation,

and the appointed or re-elected successor shall serve until the expiry of the term of office of the member whose seat became vacant.

(3) A by-election to fill a vacancy on Council shall be held on a date to be named by the Council.

21.—(1) The following classes of licences are prescribed:

1. General.

2. Academic.

(2) A General licence shall be in Form 1.

(3) An Academic licence shall be in Form 2.

22.—(1) The requirements and qualifications for the issuing of a General licence to an applicant are,

(a) completion of an application for a General licence in a form that shall be supplied by the Registrar;

(b) one of,

(i) a diploma or degree in chiropractic from a school of chiropractic approved by the Council, or

(ii) a diploma or degree in chiropractic from a school accredited by The Accreditation Commission of the Council on Chiropractic Education;

(c) a certificate of registration issued by The Canadian Chiropractic Examining Board and the successful completion of such additional examinations as may be prescribed by the Council;

- (d) Canadian Citizenship or an immigrant visa or employment visa under the *Immigration Act* (Canada);
- (e) reasonable fluency in the English or French language;
- (f) evidence that the applicant is not subject to an outstanding penalty respecting a finding of professional misconduct and that there are no current proceedings against the applicant for professional misconduct, incapacity or incompetence; and
- (g) payment of the examination, licence and registration fees prescribed by this Regulation.

23.—(1) The requirements and qualifications for the issuing of an Academic licence to an applicant are,

- (a) completion of an application for an Academic licence in a form that shall be supplied by the Registrar;
- (b) a current unrestricted licence to engage in the practice of chiropractic in a jurisdiction outside of Ontario;
- (c) evidence that the applicant is not subject to an outstanding penalty respecting a finding of professional misconduct and that there are no current proceedings against the applicant for professional misconduct, incapacity or incompetence;
- (d) an appointment as a lecturer to a school of chiropractic in Ontario approved by the Council;
- (e) Canadian citizenship or an immigrant visa or employment visa under the *Immigration Act* (Canada);
- (f) reasonable fluency in the English or French language; and
- (g) payment of the fee prescribed by this Regulation for initial registration in the Academic register.

(2) An academic licence is valid only during the period during which the holder of the licence holds an appointment at a school of chiropractic in Ontario approved by the Council.

24. It is a condition of every General licence that where the holder of a General licence has not engaged in the practice of chiropractic for a continuous period of three years, the holder shall not engage in the practice of chiropractic until the qualifications of the holder have been reviewed by the Registration Committee.

25. The Registrar is the chief administrative officer of the College and is subject to the direction of the Council.

26.—(1) The following registers shall be maintained by the Registrar:

1. General.
2. Academic.

(2) Every member who is a holder of a General licence shall be entered by the Registrar in the General Register.

(3) Every member who is a holder of an Academic licence shall be entered by the Registrar in the Academic Register.

(4) The registers shall be open to inspection by any person during normal business hours.

(5) The Registrar shall, upon request by a member and payment of the prescribed fee, issue a certificate which shall state,

- (a) the class of licence held by the member and any terms or conditions attached thereto; and
- (b) whether the member is a member in good standing of the College.

27.—(1) The Registrar shall mail to each member a notice, together with an application for renewal of the licence, at least thirty days before the due date for payment of the annual licence fee.

(2) The notice referred to in subsection 1 shall state the amount of the annual fee, the date on which the fee is due and the penalty for non-payment of the fee.

(3) The Registrar shall issue a receipt to a member upon receipt of the annual fee and completed application for renewal of the licence.

28. A person whose licence has been cancelled by the Registrar under subsection 3 of section 171 of the Act may make application for a licence upon payment of all outstanding fees, together with a penalty of \$100.00.

29. Where two or more consecutive years have elapsed since the date of cancellation of a former member's General licence under subsection 3 of section 171 of the Act, the Registrar may issue a licence to the former member if the member,

- (a) pays the relevant fees and penalties prescribed in section 30; and
- (b) completes such studies and passes such examinations as the Council may prescribe.

30. The following fees and penalties are payable to the College in the circumstances, at the time and in the amounts specified:

1. An examination fee in the amount of \$100.00 is payable upon writing Council examinations.
2. An annual licence fee is payable on or before the 1st day of January in each year in the amount of \$200.00 by every member holding a General licence.
3. An annual licence fee is payable on or before the 1st day of January in each year in the amount of \$100.00 by every member holding an Academic licence.
4. A penalty of \$50.00 is due and payable by a member for late payment of an annual licence fee.
5. A penalty of \$100.00 is due and payable by a person to whom a licence is issued under section 28.
6. A fee of \$50.00 is payable for initial registration in the General Register.
7. A fee of \$50.00 is payable for initial registration in the Academic Register.
8. A person whose licence has been revoked by the Discipline Committee or the Registration Committee and who makes application for a licence shall, upon filing his application, pay a fee of \$200.00.

31.—(1) The Council shall determine the information required for the compilation of statistics with respect to the supply, distribution, qualifications and professional activities of members and may direct the Registrar to obtain the required information.

(2) Upon the written request of the Registrar, members shall provide to the Registrar the information requested for the compilation of statistics.

32. Every member shall provide the Registrar with the complete address of his principal residence and the address of the place at which the member engages in the practice of chiropractic and shall inform the Registrar of any change of address within ten days thereof.

33. A member, in the practice of chiropractic, shall only use the title "chiropractor" or "doctor of chiropractic" or the prefix "doctor" or an accepted abbreviation thereof, followed by the professional designation "chiropractor" or the accepted affix "D.C." or the proper designation for any university degree held by a member or such other designation approved by the Council.

34. The decisions of the Discipline Committee shall be published by the College in its annual report and may be published by the College in any other publication of the College and where a member has been found guilty of professional misconduct or incompetence, the full name and address of the member may be stated and a summary of the charge, the decision and the penalty imposed may be stated and the text or substance of any restriction on the licence of the member or of any reprimand may be added, but where a member has been found not guilty of professional misconduct or incompetence, the identity of the member shall not be published but the substance of the proceedings may be published without identification of the parties for the purpose of publishing advice to the member or to the profession.

35. For the purpose of Part VII of the Act, "professional misconduct" means,

- (1) failure by a member to abide by the terms, conditions and limitations of his licence;
- (2) contravention of any provision of Part VII of the Act or the regulations thereunder or *The Health Insurance Act, 1972*, or the regulations thereunder;
- (3) failure to maintain the records that are required to be kept respecting a member's patients;
- (4) exceeding the lawful scope of practice;
- (5) having a conflict of interest;
- (6) using a term, title or designation other than one authorised by this Regulation;
- (7) permitting, counselling or assisting any person who is not licensed under Part VII of the Act to engage in the practice of chiropractic in Ontario except as provided for in the Act or this Regulation;
- (8) charging a fee in excess of payments prescribed by the regulations under *The Health Insurance Act, 1972* without prior notification to the patient;
- (9) failing to provide an itemised account where a request therefor is made by a patient or a representative of the patient;
- (10) charging a fee for services not performed;

- (11) falsifying a record in respect of an examination or a treatment of a patient;
- (12) knowingly submitting a false or misleading account or false or misleading charges for services rendered to a patient;
- (13) falsely announcing or holding out to the public that a member is a specialist;
- (14) engaging in the practice of chiropractic while the member's ability to perform a professional service is impaired by alcohol or a drug;
- (15) sexual impropriety with a patient;
- (16) failing to provide within a reasonable time and without cause any report or certificate requested by a patient or his authorised agent in respect of an examination or treatment performed by a member;
- (17) failure to maintain the standards of practice for the practice of chiropractic;
- (18) giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient, without the consent of the patient, unless required to do so by law;
- (19) making a misrepresentation respecting a treatment or device;
- (20) sharing fees with any person who has referred a patient or receiving fees from any person to whom a member has referred a patient or requesting or accepting a rebate or commission for the referral of a patient;
- (21) abusing a patient verbally or physically without cause;
- (22) using the designation "clinic" or "centre" or any other designation indicative of the practice of chiropractic by a group where only one member is engaged in the practice of chiropractic under the said designation, or when two or more members are engaged in the practice of chiropractic under the said designation but only one member is engaged in the full-time practice of chiropractic at the location where the practice is carried on;
- (23) publishing, displaying, distributing or causing or permitting directly or indirectly, the publishing, displaying, distribution or use of any notice, advertisement or material of any kind whatsoever relating to the practice of chiropractic containing anything other than a member's name and address, telephone number, office hours and professional title without first submitting the proposed notice, advertisement or material to the Council, which may grant or refuse permission to publish, distribute or use such notice, advertisement or material;
- (24) publishing, displaying or distributing or causing or permitting directly or indirectly, the publishing, displaying, distribution or use of any advertisement, notice or material of any kind whatsoever that contains falsehoods, misrepresentations or misleading or distorted statements as to bodily functions or malfunctions of any kind or as to cures by any method of treatment used by a member or as to a member's training, qualifications or attainments;
- (25) listing in the white pages of a telephone directory anything other than a member's name, address, professional designation and telephone number;
- (26) listing in the yellow pages of a telephone directory anything other than a member's name, address and telephone number in light face lower case type;
- (27) charging a fee that is excessive in relation to the services performed;
- (28) using in any way with respect to a member's practice, after the expiration of a period of three years from the date of its acquisition, the name of another member whose practice a member has acquired;
- (29) permitting a professional card containing a member's name, address, telephone number, office hours and professional title to appear more than once in any one issue of a newspaper, periodical or other publication;
- (30) permitting an announcement, upon opening practice, to appear in any newspaper, periodical or other publication for a period longer than one month preceding and one month following the date of such opening;
- (31) in the case of the holder of an academic licence, engaging in the practice of chiropractic except for the purpose of supervising students who are enrolled at a school of chiropractic in Ontario approved by the Council and are practising chiropractic as required by the course curriculum;
- (32) conduct or an act relevant to the practice of chiropractic that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

36.—(1) In this section,

- (a) "benefit" means any benefit, gift, advantage or emolument of any kind whatsoever, whether direct or indirect, and includes,
- (i) the receipt of any benefit from the services of any person or reimbursement of the cost thereof,
 - (ii) the benefit or receipt of the payment or reduction of any amount of any debt or financial obligation,
 - (iii) the receipt of any consultation fee or other fee for services rendered, except under a written contract for each such service where,
 - a. a copy of the contract is available and produced to the College on demand,
 - b. each contracted service is within the normal scope of the member's specialty, and
 - c. each service is supported by records adequate to satisfy the College that it was in fact performed,
 - (iv) the acceptance of any loan except where there is written evidence of indebtedness.
 - a. that is executed at the time of transfer of funds,
 - b. that is witnessed at the time of actual execution by an individual whose name is legibly recorded on the document,
 - c. that is available and produced to the College on demand, and
 - d. that provides for a fixed term of loan and fixes a set interest rate, both of which are reasonable having a view to prevailing market rates at the time of the loan.
 - (v) the acceptance of a loan that is interest free or related in any way to any referral made by the member,
 - (vi) the acceptance of credit unless the credit is unrelated in any way to any referral of patients to the creditor and the credit is extended under an agreement in writing,
 - a. that is executed at the time of the transaction,
 - b. that is witnessed at the time of actual execution by an individual whose name is legibly recorded on the agreement,
 - c. that is available and produced to the College on demand, and
 - d. that provides for a fixed term of credit and fixes a set interest rate, both of which are reasonable having a view to prevailing market rates at the time of the transaction;
- (b) "chiropractic goods or services" includes chiropractic goods, appliances, materials, services and equipment and laboratory services;
- (c) "member of his family" means any person connected with a member by blood relationship, marriage or adoption, and
- (i) persons are connected by blood relationship if one is the child or other descendent of the other or one is the brother or sister of the other.
 - (ii) persons are connected by marriage if one is married to the other or to a person who is connected by blood relationship to the other, and
 - (iii) persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child of a person who is so connected by blood relationship (otherwise than as a brother or sister) to the other;
- (d) "supplier" means a person who,
- (i) sells or otherwise supplies chiropractic goods or services, or
 - (ii) is registered or licensed under any Act regulating a health profession.
- (2) It is a conflict of interest for a member where the member, or a member of his family, or a corporation wholly, substantially or actually owned or controlled by the member or a member of his family,
- (a) receives any benefit, directly or indirectly from,
 - (i) a supplier to whom the member refers his patients or their specimens, or
 - (ii) a supplier who sells or otherwise supplies any chiropractic goods or services to the patients of the member;
 - (b) rents premises to
 - (i) a supplier to whom the member refers his patients or their specimens, or

(ii) a supplier who sells or otherwise supplies any chiropractic goods or services to the patients of the member,

except where,

(iii) the rent is normal for the area in which the premises are located, and

(iv) the amount of the rent is not related to the volume of business carried out in the premises by the tenant;

(c) rents premises from,

(i) a supplier to whom the member refers his patients or their specimens, or

(ii) a supplier who sells or otherwise supplies any chiropractic goods or services to the patients of the member,

except where,

(iii) the rent is normal for the area in which the premises are located, and

(iv) the amount of the rent is not related to the referral of patients to the landlord.

(3) It is a conflict of interest for a member to charge under *The Health Insurance Act, 1972* or *The Workmen's Compensation Act*, or to charge any other public or governmental agency for the examination or treatment of or other services performed for the spouse, children or parents of the member.

37. In the course of his diagnosis of a patient no member shall undertake any diagnostic procedures, including x-rays, unless such procedures are required to practise chiropractic as authorized under the Act and this Regulation.

38.—(1) A member holding a General licence shall participate at least once in each three years in the program of continuing education approved by the Council related to the maintenance of a member's standard of competence and shall report upon such participation on an annual basis upon the request of the Registrar.

(2) A member who fails to participate in the program of continuing education referred to in subsection 1 shall be referred by the Registrar to the Registration Committee for review of the qualifications of the member.

39.—(1) A member shall,

(a) keep a legibly written or typewritten record in respect of each patient of the member, setting out,

(i) the name and address of the patient

(ii) each date the member sees the patient,

(iii) a history of the patient,

(iv) particulars of each examination of the patient by the member,

(v) each diagnosis made by the member respecting the patient,

(vi) each treatment prescribed by the member for the patient,

and

(vii) each x-ray taken of the patient, the reason therefor and the results thereof;

and

(b) keep a day book, daily diary book or appointment record setting out the name of each patient seen or treated or in respect of whom a professional service is rendered by the member.

(2) A member shall keep the records required under subsection 1 in a systematic manner and shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of chiropractic, whichever first occurs.

(3) A member shall make records kept pursuant to subsection 1 and books, records, documents and things relevant thereto, available at reasonable hours for inspection by a person appointed by the Registrar under section 188 of the Act or a person appointed as an inspector under subsection 1 of section 43 of *The Health Insurance Act, 1972*.

40.—(1) The Council shall appoint annually an appraisal committee composed of,

(a) two members of the Council; and

(b) three members of the College, of whom two shall be members of the Faculty of the Canadian Memorial Chiropractic College and one shall be a practising chiropractor who is not a member of the Council.

(2) The Council shall name one member of the Appraisal Committee as the chairman.

- (3) Three members of the Appraisal Committee constitute a quorum.
- (4) The Appraisal Committee shall report not less than once a year to the Council and make recommendations concerning the standard of practice in the practice of chiropractic.
- (5) The Appraisal Committee, for the purpose of examining and assessing the standard of practice in the practice of chiropractic and the standards of practice of members,
 - (a) may cause general inspections to be made by appointment and at reasonable hours of the records of members and the equipment used by them in the practice of chiropractic; and
 - (b) may make such recommendation to a member as the Committee considers necessary respecting the member's standards of practice, equipment and record keeping.
- (6) Where a member fails within a reasonable time to comply with a recommendation of the Appraisal Committee, the Committee shall report its findings and may make recommendations to the Registration Committee in respect thereof.

[Forms omitted]

*Appendix 7*THE WORKMEN'S COMPENSATION BOARD POLICY AND
PROCEDURE MANUAL

TREATMENT CONTROL IN CHIROPRACTIC CLAIMS

OBJECTIVES:

1. To improve methods of treatment control in cases where chiropractic treatment is rendered.
2. To ensure that referrals regarding treatment control, are done on a timely basis.
3. To ensure ongoing control of treatment by the Medical Branch so that proper benefit is realized.

ACUTE CASES

Claims Adjudicator

1. Flags file as soon as it is known that chiropractic treatment is being rendered.
2. Refers file, including a brief memo, explaining the claim status, to the Section Medical Adviser if treatment by a chiropractor exceeds six weeks or earlier if non-spinal column injuries involved.

Medical Aid Services

3. Refers all transcripts showing chiropractic treatment extending beyond six weeks (flag 87), to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

4. Records the incoming claim number and passes the file to the Section Medical Adviser, if it was referred by a Claims Adjudicator, or requests the file if a medical aid transcript was received.

Section Medical Adviser

5. Reviews the file and:
 - a) If the employee is improving and has returned to work and chiropractic treatments are only being given once a week or so, arranges for the file to be recalled in six weeks.
 - b) If the employee is still on full treatment and especially if the employee has not returned to work, contacts the chiropractor by telephone or letter and requests that an orthopaedic consultation be arranged and that a copy of the report be forwarded to the Board.

Section Medical Adviser's Secretary

6. Makes out a control card to recall the file in two weeks and telephones the chiropractor to determine if the appointment was arranged, the date of the appointment and the specialist's name, and to remind the chiropractor of the need for an early report.
7. Returns the file to the Section Medical Adviser after two weeks, if the action suggested in number 6, has not been carried out.

Section Medical Adviser

8. Reviews the file and if the chiropractor has not referred the employee to a specialist, arranges a consultation or Board examination.

Section Medical Adviser's Secretary

9. Places a further recall date (4 weeks after appointment date) on the control card and sends the claim back to file.
10. Recalls the file after four weeks and if the report is not on file, telephones the specialist, requests a report and places a further two weeks recall date on the control card.
11. Returns the file to the Section Medical Adviser after two weeks whether a report is on file or not.

Section Medical Adviser

12. Reviews the file and:

- a) If the orthopaedic specialist is supervising treatment, writes the chiropractor informing him of this and that further treatment cannot be authorized beyond one week from the date of the letter.
- b) If we arrange a consultation, the chiropractor is advised of this and informed regarding further treatment after the date of consultation.
- c) If the employee is examined at the Board, the chiropractor is informed of our decision and how much longer chiropractic treatment will be authorized.
- d) Returns the file to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

13. Records the A83 or B83 status on the control card, along with the date of the memo and refers the file to the Claims Adjudicator to process an A83 or B83 crum.

Claims Adjudicator

14. Informs the injured employee of the status in writing and processes an A83 and B83 MAPAS crum.

Section Medical Adviser's Secretary

15. Refers all control cards on which an 83 status has been recorded, to desk 999, Section Medical Adviser's Secretary Primary Adjudication Compensation Section, at the end of each month.

Section Medical Adviser's Secretary Primary Adjudication Compensation Section

16. Lists all the claim numbers on form 799, medical aid transcript request.
17. Files all control cards alphabetically.
18. Walks forms 799 to Data Processing monthly.

Data Processing

19. Feeds forms 799 data into computer and medical aid transcripts, form 734, are prepared for the Section Medical Adviser Controlling Chiropractic Claims, desk 998.

Section Medical Adviser Controlling Chiropractic Claims

20. Reviews transcripts to determine if A83 or B83 crums have been processed.
21. Destroys transcripts if appropriate crums have been processed.
22. If appropriate crums have not been processed, passes transcripts to the Section Supervisor, Primary Adjudication Compensation Section.

Section Supervisor, Primary Adjudication Compensation Section

23. Arranges transcripts for delivery to Section Supervisors.

Section Secretary

24. Delivers transcripts to appropriate Section Supervisors to arrange for appropriate 83 MAPAS crum.

PROLONGED CASES

This category applies to reopened claims and pension claims.

*Reopened Claims**Claims Adjudicator*

1. Flags the claims jacket as soon as it is known that the injured employee is having further problems and that chiropractic treatment is being rendered.
2. Determines if the chiropractor has been informed previously that further chiropractic treatment cannot be rendered without prior authorization.
3. Proceeds with necessary inquiries (REO forms, special letter, telephone calls, etc.) or renders a decision if this is possible.
4. Once entitlement is determined:

- a) Refers claim to the Section Medical Adviser, PROVIDING the chiropractor had been involved in the claim previously and had been informed of the need to have prior authorization for further treatment.
- b) Refers the claim to the Section Medical Adviser if treatment extends beyond six weeks (same as in acute cases) if the chiropractor had not been informed of the need for prior authorization for further treatment.

Medical Aid Services

5. Refers all transcripts showing chiropractic treatment extending beyond six weeks (flag 87) or showing a gap in treatment (flag 91) to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

6. Records the incoming claim number and passes the file to the Section Medical Adviser if it was referred by a Claims Adjudicator or requests the file if a medical aid transcript was received.

Section Medical Adviser

7. Reviews the claim and regardless of whether the referral was as per 4(a) or 4(b), decides how many, if any, treatments should be accepted (anything beyond a second six weeks' period requires a surgical consultant's opinion).
8. Notifies the chiropractor in writing of the decision, and gives direction to the Claims Adjudicator regarding appropriate 83 crum or extension of treatment and passes the file to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

9. Makes out a control card indicating the 83 status or recalling the file at the end of the extension granted (up to six weeks).
10. Refers the file to the Claims Adjudicator to note the extension of treatment or to process the appropriate 83 crum and notify the injured employee in writing.
11. Refers the file to the Section Medical Adviser when extension has expired.

Claims Adjudicator

12. Informs the injured employee of the status in writing and processes an A83 MAPAS or B83 MAPAS crum.

Section Medical Adviser

13. Review the file keeping in mind that any further authorization of treatment requires the surgical consultant's concurrence, and:
 - a) If extension is felt to be warranted, refers the claim to the appropriate surgical consultant.
 - b) If further treatment is not warranted, notifies the chiropractor in writing of the decision, gives direction to the Claims Adjudicator in a memo regarding A83 or B83 crum and then passes the file to the Section Medical Adviser's Secretary.

Surgical Consultant

14. Reviews the file, gives appropriate direction to the Section Medical Adviser (i.e. grant extension or refuse further treatment, and arrange consultation or Board examination) and returns file to the Section Medical Adviser.

Section Medical Adviser

15. Reviews the surgical consultant's recommendation and:
 - a) If extension of treatment is warranted, notifies the chiropractor accordingly and passes the file to the Section Medical Adviser's Secretary to recall the file when the extension has expired.

N.B. Each and every additional extension considered must be seen by the surgical consultant again.
 - b) If an extension of treatment is refused, notifies the chiropractor in writing, gives direction to the Claims Adjudicator regarding A83 or B83 crum and passes the file to the Section Medical Adviser's Secretary to record the status.

Section Medical Adviser's Secretary

16. Makes out a control card:

- a) To recall the file when the extension has expired, or
- b) Records the 83 status, the date of the memo and refers the file to the Claims Adjudicator to crum A83 or B83.

Claims Adjudicator

17. Informs the injured employee of the status in writing and processes the appropriate 83 MAPAS crum.

Section Medical Adviser's Secretary

18. Refers all control cards on which an 83 status has been recorded to desk 999, Section Medical Adviser's Secretary, Primary Adjudication Compensation Section, at the end of each month.

Section Medical Adviser's Secretary Primary Adjudication Compensation Section

19. Lists all the claim numbers on form 799, medical aid transcript request.
20. Files all control cards alphabetically.
21. Walks forms 799 to Data Processing monthly.

Data Processing

22. Feeds forms 799 data into computer and medical aid transcripts, form 734, are prepared for the Section Medical Adviser Controlling Chiropractic Claims, desk 998.

Section Medical Adviser Controlling Chiropractic Claims

23. Reviews transcripts to determine if A83 or B83 crums have been processed.
24. Destroys transcripts if appropriate crums have been processed.
25. If appropriate crums have not been processed, passes transcripts to the Section Supervisor, Primary Adjudication Compensation Section.

Section Supervisor Primary Adjudication Compensation Section

26. Arranges transcripts for delivery to Section Supervisors.

Section Secretary

27. Delivers transcripts to appropriate Section Supervisors to arrange for appropriate 83 MAPAS crum.

Pension Claims

Generally speaking, a chiropractor must have prior authorization before treatment may be rendered in pension claim not involving lost time.

Claims Adjudicator

1. Immediately refers to the Section Medical Adviser, any pension files in which chiropractic treatment is being rendered, providing no prior authorization was given. A brief memo should be placed on file giving some background and the current claim status.

Medical Aid Services

2. Refers all transcripts showing chiropractic treatment extending beyond six weeks (flag 87) or showing a gap in treatment (flag 91) to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

3. Records the incoming claim number and passes the file to the Section Medical Adviser if it was referred by a Claims Adjudicator or requests the file if a medical aid transcript was received.

Section Medical Adviser

4. Reviews the file and:

- a) If treatment is in order, may authorize the chiropractor to treat the injured employee for up to six weeks (with a maximum of two treatments per week) and to then submit a further 26C.
- b) If treatment is not in order, notifies the chiropractor in writing, requests the Claims Adjudicator to crum A83 or B83 and passes the file to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

5. Makes out a control card indicating the 83 status or recalling the file at the end of the extension granted (up to six weeks).

6. Refers the file to the Claims Adjudicator to note the extension or to process the appropriate 83 crum and notify the injured employee in writing.

7. Refers the file to the Section Medical Adviser when the extension has expired.

Claims Adjudicator

8. Notifies the injured employee of the status in writing and processes an A83 MAPAS or B83 MAPAS crum.

Section Medical Adviser

9. Reviews the file keeping in mind that any further authorization of treatment requires the surgical consultant's concurrence.

- a) If extension is felt to be warranted, refers the claim to the appropriate surgical consultant;
- b) If further treatment is not warranted, notifies the chiropractor in writing of the decision, gives direction to the Claims Adjudicator in a memo regarding A83 or B83 crum and then passes the file to the Section Medical Adviser's Secretary.

Surgical Consultant

10. Reviews the file, gives appropriate direction to the Section Medical Adviser (i.e. grant extension, or refuse further treatment, and arrange consultation or Board examination) and returns file to the Section Medical Adviser.

Section Medical Adviser

11. Reviews the surgical consultant's recommendation and:

- a) If extension of treatment is warranted, notifies the chiropractor accordingly and passes the file to the Section Medical Adviser's Secretary to recall the file when the extension has expired.

N.B. Each and every additional extension considered must be seen by the surgical consultant again.

- b) If an extension of treatment is refused, notifies the chiropractor in writing, gives direction to the Claims Adjudicator regarding A83 or B83 crum and passes the file to the Section Medical Adviser's Secretary to record the status.

Section Medical Adviser's Secretary

12. Makes out a control card:

- a) To recall the file when the extension has expired, or
- b) Records the 83 status, the date of the memo and refers the file to the Claims Adjudicator to crum A83 or B83.

Claims Adjudicator

13. Informs the injured employee of the status in writing and processes the appropriate 83 MAPAS crum.

Section Medical Adviser's Secretary

14. Refers all control cards on which an 83 status has been recorded to desk 999, Section

Medical Adviser's Secretary, Primary Adjudication Compensation Section, at the end of each month.

Section Medical Adviser's Secretary Primary Adjudication Compensation Section

15. Lists all the claim numbers on form 799, medical aid transcript request.
16. Files all control cards alphabetically.
17. Walks forms 799 to Data Processing monthly.

Data Processing

18. Feeds forms 799 data into computer and medical aid transcript form 734, are prepared for the Section Medical Adviser Controlling Chiropractic Claims desk 998.

Section Medical Adviser Controlling Chiropractic Claims

19. Reviews transcripts to determine if A83 or B83 crums have been processed.
20. Destroys transcripts if appropriate crums have been processed.
21. If appropriate crums have not been processed, passes transcripts to the Section Supervisor, Primary Adjudication Compensation Section.

Section Supervisor, Primary Adjudication Compensation Section

22. Arranges transcripts for delivery to Section Supervisors.

Section Secretary

23. Delivers transcripts to appropriate Section Supervisors to arrange for appropriate 83 MAPAS crum.

APPEALS PROCEDURES

Section Medical Adviser

1. If, while reviewing medical mail, the Section Medical Adviser sees an appeal from a chiropractor regarding termination or restriction of treatment, the mail is marked "Return" and passed to the Section Medical Adviser's Secretary along with the other medical mail.

Section Medical Adviser's Secretary

2. Handles with all the other medical mail in the usual manner.

Claims Adjudicator

3. Walks the appeal letter, along with the file, to the Section Medical Adviser. No acknowledgement to the chiropractor, or covering memo, is necessary.

Section Medical Adviser

4. Reviews the claim and:
 - a) If reversal of the decision is not warranted, sends an acknowledgement letter to the chiropractor and refers the file to the Section Medical Adviser Controlling Chiropractic Claims with an appropriate memo.
 - b) If reversal of the decision is warranted, notifies the chiropractor in writing of the duration of the extension and passes the file to the Section Medical Adviser's Secretary.

Section Medical Adviser's Secretary

5. Makes out a control card recalling the claim when the extension has expired.
6. Refers the file to the Section Medical Adviser Controlling Chiropractic Claims (desk 998) for record and control purposes.

Section Medical Adviser Controlling Chiropractic Claims

7. Makes up a control card arranging for transcript to be requested in one week.
8. Requests the Claims Adjudicator to process an A-MAPAS or B-MAPAS crum.

Claims Adjudicator

9. Processes an A-MAPAS or B-MAPAS crum.

Section Medical Adviser Controlling Chiropractic Claims

10. Requests a medical aid transcript via form 799, one week after the A-MAPAS or B-MAPAS crum was requested, to ensure that the status has been changed.

11. Alters the recall date on the control card to the date that the extension of treatment expires.

12. When the extension has expired, requests the Claims Adjudicator to process an A83 or B83 crum and alters the recall date on the control card to one week later to ensure that the 83 status has taken in the MAPAS record.

Subsequent appeals should be dealt with as follows:

-through — to the Senior Surgical Consultant.

-through — to the Director, Medical Branch.

-through — to the Board with appropriate input from the Executive Director, Medical Services Division.

BY AUTHORITY:

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