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President's message

Moving the profession forward

ONE OF the things I enjoy most as president of the ECU is that I get to meet and talk to chiropractic students - chiropractors in training as I think of them. This January I spoke at the University of South Wales and at the McTimoney College; I addressed more than 150 students. In February I spoke to students in Odense, Istanbul, Paris and Toulouse. One of the things that greatly impresses me is the sense of vocation in our new recruits and their desire to join a profession they can be proud of.

What does this mean for us, established chiropractors? Do we have a special responsibility to these young people at the outset of their careers? You bet we have. The students want to join a profession which is dedicated to improving the well-being of people across the

globe, a profession that will make them proud to call themselves chiropractors. They fret when they sense a profession divided. It is our responsibility, as established chiropractors, to make those wishes and desires come true and the ECU accepts the challenge.

It is no accident that we are called the European Chiropractors' Union. We exist to represent chiropractors past, present and future. Our work is based on education, legislation and research.

Let me give you some examples to illustrate how we move the profession forward. The General Council took a decision a few years ago to focus on expansion of the profession - especially in countries where there are few practitioners. Turkey is a case in point - a country with 75 million people but only seven chiropractors. Needless to say not too many people in that country know what chiropractic is all about.

Sometimes, however, a few dedicated colleagues can make a big difference. Last August, on the shore of the Bosphorus, the medical faculty of the Bachecehir University opened the first chiropractic programme in this part of the world. The university advertised the programme on its intranet, on a page almost impossible to find, and for only 12 days. After the 12 days there had been nearly 90 applicants. Forty of these were accepted; even better, the university has already received more than 450 applicants for the next semester. Amazing! The ECU is determined to continue to support this programme. I would like to offer a big thank-you to our dedicated colleagues in Turkey.

Legislation for chiropractic in Europe is widely different. We have countries like Switzerland, Norway, Liechtenstein, the United

Kingdom and Denmark which have legislation of the highest level. And we have countries in Europe - for example Spain and Greece - with no legislation at all. Collectively the national associations of the ECU have made securing legislation in more countries a major focus.

It is with great pleasure that I can tell you about the efforts that are being made in Belgium and the Netherlands. Their leadership teams are working tirelessly to get legislation through the national parliaments. Last autumn the Belgian Chiropractic Association organised a colloquium for politicians, lawmakers, journalists and colleagues. With the support of the ECU, experts in different fields were brought in to give evidence about the scientific basis for chiropractic, undergraduate education, the CEN standard for chiropractic services, pursuing legislation, the differences in medical and chiropractic education and the study of the global burden of disease. The colloquium attracted a lot of media attention and was a big success. This is good example of how national associations can promote chiropractic in a sound and professional way to get attention from decision makers. It is something other national associations could also do and the ECU would be happy to support such initiatives.

Healthcare is one of the most rapidly developing scientific environments in the world. Its professions are valued according to the amount and the quality of the research they produce. What is best practice today will not be good enough tomorrow as new research produces new insights. The ECU already invests heavily in research and that is about to be further enhanced. We have

decided to create a European Centre for Chiropractic Research Excellence which this year will manage around €200.000 of research money. It will operate from the campus of the University of Southern Denmark, which has established a very strong focus on research into musculoskeletal disorders. Also, as from 1 January, the Danish Chiropractic Association has come back to the ECU after a 12-year absence.

The importance of attracting a strong intake of able recruits to the profession is something that all chiropractors can agree on. Each of us has a personal obligation to show that, just as we have benefited from the wisdom of those who went before us, so we are prepared to contribute personally to the continuing growth and success of chiropractic. Together we will prosper, divided we will fall.

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ECU General Council Meeting

A report of the meeting on 20-21 November 2015

Financial support

- A grant of up to €170.000 over three years in support of membership initiatives by the British Chiropractic Association.
- A grant of €5.000 to support a colloquium organised by the Belgian Chiropractic Association to foster understanding of the profession by decision makers and those who influence opinion about healthcare matters.
- Agreement to subsidise access to the Research Review Service weekly reports for members of affiliated national associations. As a result, individuals will be able to take out an annual subscription at 50% of the normal cost. Member associations will draw the offer to the notice of their members.

Membership

- Agreement to re-admit the Danish Chiropractors' Union (DKF) as a member association of the ECU.
- Agreement to proceed with setting up a European Centre for Chiropractic Research Excellence in association with the Nordisk Institut for Kiropraktik og Klinisk

Biomekanik (NIKKB) located at the University of Southern Denmark (see page 10).

- Nomination of Dr Mariá José Hernández as a candidate for the ECCE Council. (Dr Hernández was subsequently elected to the Council.)

Strategy

- GC members shared insights deriving from experience with implementation of Vision 2020 for chiropractic (see page 6 for further details).
- Adopted a recast strategy for relations with the institutions and working parties of the European Union.

Awards

- Agreed to offer the courtesy professional title of Doctor of Chiropractic to suitably qualified and experienced chiropractors (see page 5).
- Agreed to seek nominations for a possible ECU award for outstanding humanitarian work by a chiropractor in the field. Member associations were invited to put forward nominees by the end of February (see below).

Forthcoming meeting

The General Council will meet again on 4 May 2016.

General Council adopts targets for EU relations

THE GENERAL Council (GC) has adopted as its prime target an aim for chiropractic to be recognised in all countries of Europe as the mainstream spinal healthcare profession with its patients protected by effective regulation of the profession.

The top priority should be for all member states to recognise the professional qualification of chiropractors under the EU Recognition of Professional Qualifications Directive (Directive 2005/36/EC as amended by Directive 2013/55/EC). To qualify requires that one-third of EU member states has done so. There are currently 28 member states¹ which means securing recognition in 10 of them. The prospects for doing so are examined in a separate article on page 7.

Other priorities adopted in the November GC meeting were:

- a. To promote the CEN chiropractic quality standard in all European countries

where chiropractic is not recognised, in order that it might form the basis for draft legislation.

- b. To promote aspects of healthcare across EU bodies (e.g. the importance of musculoskeletal disorders as a priority for healthcare in an ageing population building on the work of chiropractors in the Bone and Joint Decade project).
- c. To select not more than two EU areas in which the ECU will participate in any one year.
- d. To encourage chiropractors and researchers to engage with EU medical and scientific committees as experts in spinal health.
- e. To leverage work in member states to inform discussion at the European level and vice versa.
- f. To demonstrate through assembled evidence that chiropractic has a distinctive identity, is safe, non-addictive and cost effective.

¹ Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK

ECU award for humanitarian work

THE GENERAL Council of the ECU has made the decision to look into the possibility of making an award for outstanding humanitarian work by a chiropractor in the field. Nominations would be sought annually, though an award would

not necessarily be made each year.

Ian Beesley, the Secretary-General, comments: "We know that when there are natural disasters such as earthquakes or other calamities that involve first response rescuers, chiropractors

have provided important free treatment for rescuers, whose musculoskeletal systems are often put under severe strain and risk of damage during their efforts to save lives. Others have given pro bono chiropractic treatment to refugees and to the dispossessed."

The intention is that the award should be prestigious and attract professional recognition; it will be presented by the ECU president at the annual scientific convention and it is hoped to make the first award in May in Oslo.

Doctor of Chiropractic: hallmark of the profession

THE CYPRUS national association has successfully moved that, following the report of a working party comprising representatives of EAC, Cyprus and the Netherlands, the ECU should offer the courtesy title of Doctor of Chiropractic to suitably experienced chiropractors. The decision at the November 2015 ECU General Council meeting means that successful applicants will receive a certificate with the wording:

'Having demonstrated the required knowledge and professional competences through a chiropractic qualification accredited by the European Council for Chiropractic Education, having completed a National Graduate Education Programme in accordance with the criteria of the European Academy of Chiropractic, and having agreed to abide by the code of ethics as a member of a national chiropractic association participant in the European Chiropractors' Union, or as an individual member, the European Academy of Chiropractic recognises the courtesy title of Doctor of Chiropractic.'

European chiropractic educational institutions grant qualifications as follows:

- Masters' degrees are offered by AECC, WIOC, McTimoney and the Danish School which offers a Masters in Biomechanics.
- Doctor of Chiropractic titles are awarded by the Zürich programme which offers a Doctor of Chiropractic Medicine (DCM) after



"The courtesy professional title of Doctor of Chiropractic (DC) positions chiropractic alongside other health professions"

completing a two-year postgraduate research project (i.e. eight years of study).

- Italy will soon open a full five-year Doctor of Chiropractic programme in Rome.
- The French and the Turkish institutions also prefer to give a courtesy Doctor of Chiropractic title after graduation.

The courtesy professional title of Doctor of Chiropractic (DC) positions chiropractic alongside other health professions that also use courtesy professional titles, e.g., medical doctors (MD), doctors of osteopathy (DO), doctors of veterinary medicine (DVM), doctors of dental surgery (DDS) etc. It is also noteworthy that physiotherapists are making strong efforts to acquire a Doctor of Physiotherapy title (DPT).

The General Council agreed that chiropractic needs both academic qualifications (Masters/PhD) and a recognition of professional qualification to ensure the survival and distinct identity of the profession. The Doctor of Chiropractic (DC) title has been the hallmark of our profession since 1897 and has different legal implications under some jurisdictions. Depending on the legislation in place, practitioners in some countries do not need the DC title in order to practise but in other countries they do.

Those that meet the criteria of the European Academy of Chiropractic (EAC) can now apply for their courtesy title of Doctor of Chiropractic. For further information please contact your national association or the registrar of the European Academy of Chiropractic.

Speaking after the decision, Stathis Papadopoulos, president of the Cyprus association said: "I am delighted by the wise decision of the General Council and freely acknowledge the help in turning the decision of principle into a practical reality."



BACKspace available electronically

SECRETARY-GENERAL IAN Beesley has announced that **BACKspace** is now available electronically: "As Øystein Ogre and I have travelled to the chiropractic colleges I have been much struck by the extent to which students



carry all that they require by way of textbooks, articles and essays digitally on laptops and iPads. I should not have been surprised since I now find it most convenient to read large books, novels and magazines electronically. So, if, like me you are squeezed for archive space or just want to be up with the trend and would like to receive your copies of **BACKspace** electronically, drop an e-mail to Claire Wilmot (info@chiropractic-ecu.org). You'll get your copy sooner and be saving the ECU money as well."

NB: The ECU will never pass your details to a third party without your permission.



Pursuing the vision

During the General Council meeting in November 2015 a breakout session focused on the lessons from national associations' pursuit of the goals in the Vision 2020 project. Here Vivian Kil provides some insights.

Legislation

Positives

Preparation: It really pays off to be thoroughly prepared before speaking to government bodies - having documentation and supporting information readily available, especially the code of ethics and bylaws of the national association, details of the Graduate Education Programme, the commitment to research and the arrangements in place to show that patients are safe.

Connections: Link with a bigger profession so that if the law changes for that profession chiropractic is in with a chance of getting the changes by default. Focus on public health and what chiropractic contributes to healthcare in general; do not focus on what is in it for chiropractic.

Communications: Hosting a colloquium for all stakeholders has proved to be successful in obtaining support from decision-makers and influencers.

Negatives

Criticism of others: Criticising others tends to rebound on the critic. It is better to talk about the strength of chiropractic and to avoid negatives.

Public Awareness/PR

Positives

Everyday topics: Be up-front and personal; use everyday illustrations such as car seat safety, breathing and stress, problems following extensive use of mobile phones, bad posture, too much sitting down.

One message: It is important to have a clear and simple message which is repeated. Journalists often change wording and information so always ask to see a copy before print.

Clean up websites: Journalists will often look at websites for background. Make sure that your website reinforces the simple messages and avoids unsubstantiated claims. Check that information is up to date; if the latest message is more than a month old or inaccurate it can damage your reputation.

Negatives

Chiropractic per se: Using chiropractic as a topic for news items did not work; the general public does not find it interesting and can be put off by the title.

Debate: Do not engage in debate with other professions, just focus on the strength of chiropractic.

Education

Positives

Connections: Having links with local universities can help stimulate academic interest in chiropractic. Having a connection with a partner in chiropractic education (such as an established college) also helps.

Politics: Connections within the education authorities and national healthcare research community are an asset.

Varied sources of finance: Money is often a stumbling block to progress and there is a need to look at a variety of ways of obtaining the necessary backing – through professional bodies, a university, a government body, a benefactor etc.

Negatives

Ministry opposition: It is very difficult to achieve a chiropractic educational programme in the face of Ministry of Education opposition. They do not have to be an active proponent of chiropractic education but as a minimum you need to achieve their willingness to let it happen (neutrality).

Lack of legal recognition: Lack of legal recognition is a major obstacle to establishing a chiropractic education; active work in support of recognition can be an important step on the way to an educational programme.

Attracting recruits

Positives

Be active: Reach out to existing students in other healthcare professions; around five per cent would consider switching to a chiropractic course.

Access: consider how difficulties of access can be overcome, such as by setting up a system of scholarships for chiropractic studies and other means.

Buddying up: During the recruitment process put a prospective student in touch with someone who is already in a chiropractic educational programme – people often consult contemporaries when considering their educational and career options.

Negatives

Student fairs: Representing chiropractic education at large student fairs does not work. It is not possible to compete with bigger university courses that can afford bigger stands and more enticing freebies.

Lack of information: If there is no existing chiropractic education in a country it is often difficult for a national association to answer all the questions which a prospective student may have.

Lack of a career path: It is difficult to encourage students to take up the profession if they must travel abroad for the courses and may face an uncertain career at home. They may have a vocation but they also need an income.



ECU news

Interdisciplinary working

Positives

Flagship projects: projects such as the very successful Bone and Joint Decade (BJD) project in Norway encourage continuing co-operation with other healthcare professions.

Association with national projects: if there is a national project related to healthcare or wellness it is important to be at the table as a team player with other professions.

Reach out to others: when organising a conference, seminar or workshop invite people from different professions to join in.

Be imaginative: Teaming up with an insurance company which receives 4,000 calls a day has helped one association create a situation where the company refers patients to chiropractors and has been very beneficial to the profession.

Negatives

Being inward looking: in the UK it turned out to be too difficult to join in BJD projects due to the lack of unity within the chiropractic profession.

Expense: Inviting other healthcare professions to seminars, conferences and workshops and covering their expenses can be expensive.

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Recognition of professional qualifications

*As he steps down from the chairmanship of the ECU EU Affairs Committee, **Philippe Druart** reports a promising step forward towards the recognition of professional qualifications across all member states. This recognition is key to the provision of good healthcare across Europe and at the heart of the European single market.*



© O Haagenen

RECOGNITION ENABLES professionals to work across national boundaries. It is enshrined in two European Union Directives, the latest of which came into force on 18 January 2016.¹

According to a briefing from the European Universities Association (EUA) the updated Directive opens up a route to wider automatic recognition of professional qualifications by the introduction of common training frameworks (CTFs).² These will allow groups representing at least one-third of member states (i.e. currently 10 member states) to agree curricula based on 'common sets of knowledge, skills and competences'. Other member states and those in the European Economic Area may then opt in. The reference to 'knowledge, skills and competences' is significant and marks a shift towards competence-based curricula in the amended Directive. It is also noteworthy that the curricula may be proposed by representative professional bodies operating at EU or national level, or by Competent Authorities (normally ministries or statutory regulatory bodies). That means the ECU can propose a curriculum provided that it has the agreement of national associations that have obtained legislation/regulation.

What is the relevance to chiropractic? When the EEA (and Portugal, which is not included in the EU data) are included in the set of countries that recognise and regulate chiropractic, the total is 13 (i.e. 40%). If chiropractic were regarded as a medical speciality

that would probably mean that recognition of qualifications was automatic – the threshold is set at two-fifths of member states with training programmes pitched at the level beyond basic medical and dental training. (Currently automatic recognition operates in only seven large specific professions: medical doctor, general nurse care, dentist, midwife, veterinary surgeon, pharmacist and architect.)³ Chiropractic is included in a 'General Sector' category where recognition works by comparing the level of a mobile professional's attainment against the level required by the host country and by imposing appropriate compensation measures such as adaptation periods and aptitude tests.

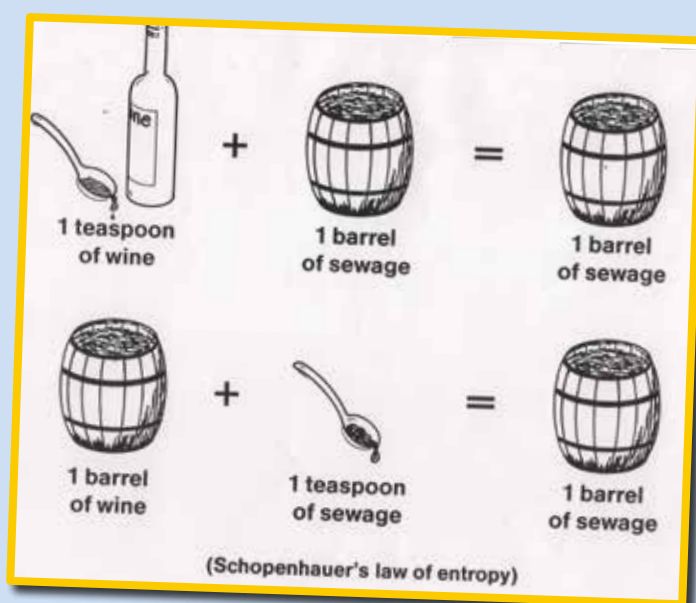
Here a door might open if chiropractic can demonstrate its inclusion as a health profession in

the European Union taxonomy of occupations (ESCO – on whose expert panel chiropractic is represented). The CEN standard for quality in chiropractic services might also play a role in collecting the evidence of European agreement on education, competences, professional responsibility and ethics. Other healthcare professions will, of course, be thinking on similar lines. The question is whether there is sufficient common ground between chiropractors and other healthcare professions to justify a reclassification to the area where recognition is automatic.

1 Directive 2005/36/EC updated by Directive 2013/55/EU

2 www.eua.be/Libraries/higher-education/EUA_briefing_note_on_amended_Directive_January_2014.pdf?sfvrsn=0

3 Ibid



Convention

A ticket to Oslo

Gitte Tønner, ECU Convention Academic Organiser, promises an exciting 2016 ECU Convention

WHY SIGN up? Well, wherever you are in your career - a freshly-baked graduate, in mid-career or closer to retirement - there's something to interest you. What the convention offers includes insight into what is going on elsewhere in the profession and skills that you might want to add to your tool box (we have lots of hands-on stuff for you). If you're thirsty for what's new in research, you will hear it hear straight from the proverbial

horse's mouth; if you – like most of us – have an opinion and you like to participate in the exchange of ideas, and maybe be inspired or inspire others, come along!

We will be excited to have you join us to celebrate chiropractic in Europe. Local Norwegian talent will demonstrate ultrasound diagnostics and will be present in numbers. In addition, we will welcome people from beyond the chiropractic profession, this year with world expert on Vitamin D,

Johan Moan, and renowned French orthopaedic surgeon Olivier Gagey, as well as a very thought-provoking debate on Friday morning that will include a Danish philosopher. And we will be joined by leading personalities from the World Federation.

Thanks to generous sponsorship, there is also an opportunity to attend reasonably-priced pre-convention seminars on 4 May: Researchers' Day will include discussion on how to get

the message across and a session from the Special Interest Group on Neurology will be about recognising concussion.

Nor is the social side of things neglected – the City of Oslo will welcome delegates in the iconic Oslo City Hall and there will be two further exciting evening opportunities to party whilst celebrating being part of something special, and all in Oslo's beautiful capital.

See you soon!

THE PROGRAMME (possibly subject to alteration)					
THURSDAY 5 MAY		FRIDAY 6 MAY		SATURDAY 7 MAY	
08.30-10.30	SESSION 1 Welcome and Opening Ceremony 'Building Bridges' Greg Stewart, Søren O'Neill, Kim Humphreys	08.30-10.30	SESSION 5 A Clinical Uncertainty and Practitioner Behaviour – a multidisciplinary and interactive debate part I SESSION 5 B Ulrik Sandstrøm: part I Functional Muscle Testing	09.00-11.00	SESSION 8 'Bridging Gaps' Heidi Haavik and Greg Kawchuk Richard Brown
10.30-11.00 Break – Posters – Exhibition					
11.00-13.00	SESSION 2 Clinical implications of current research Abstract Presentations	11.00-13.00	SESSION 6 A Clinical Uncertainty and Practitioner Behaviour – a multidisciplinary and interactive debate part II SESSION 6 B Ulrik Sandstrøm: part II Functional Muscle Testing	11.30-13.00	SESSION 9 'Building Trust': Kent Greenawalt Research Awards Closing Address Preview ECU Convention 2017
13.00-14.30 Lunch – Posters – Exhibition					
14.30-16.00	SESSION 3 a. Johan Moan: Sun and Vitamin D: muscles, bones, brain and beyond b. SIG Paediatrics w/ Miller and Weber c. SIG Clinical Chiropractic: Managing Risk through Incident Reporting d. Activator Methods Workshop: The acute low back and osteoporotic patients	14.30-16.30	SESSION 7 a. Olivier Gagey: A new look at the shoulder b. Douglas Johnson: MultiRadiance c. Heidi Haavik: Student workshop d. Ultrasound diagnostics (max 50)	14.30-16.00	SESSION 10 a. Ellen Aartun: Function and Disability b. Thomas Lauvsnes: Foot and ankle analysis and adjusting c. Matthew Antonucci: Concussion from a functional neurology perspective
16.00-16.30 Break – Posters – Exhibition				(exhibit break-down after break)	
16.30-18.00	SESSION 4 a. Alison Dantas: Lead, Govern, Innovate: 'Let's Start with the Patient' b. SIG Neurology/Nicole Oliver: The Pons c. Rubinstein: Abstract Presentations d. SIG Sports: Assessment/Performance enhancement of the Young Athlete		Get yourselves ready for Frock'n'Rock	16.30-18.00	SESSION 11 a. TBA b. Thomas Lauvsnes: Foot and ankle (repeat) c. Matthew Antonucci: Functional Neurology Grand Rounds
	Informal dinner		Frock'n'Rock Drinks 19:00 and seating 20:00		

2016 Convention Building Bridges



Oslo 5-7 May 2016 • Radisson Blu Scandinavia

Registration is OPEN www.chiropractic-ecu.org

With a mix of interesting seminars including Vitamin D, Neurology and Paediatrics this convention is one not to be missed. This year we have invited international speakers who will enlighten, challenge and inform you. Come to the convention to update your skills, meet others and build bridges within our profession.

Social events

Thursday Night – The organising committee have been able to arrange a night at one of Oslo's most exciting on-trend restaurants which is walking distance from the convention hotel. This venue will offer all, the chance to network, dance and eat in a sumptuous venue.

Friday Night – The Frock & Rock night will be an exciting evening with a Norwegian twist.

For up to date information look at our Facebook page (ECU Conventions) or the website.



Focus on an enlarged research budget

THE ESTABLISHMENT of a new European Centre for Chiropractic Research Excellence, involving the Nordic Institute of Chiropractic and Clinical Biomechanics (NIKKB), was agreed at the ECU General Council Meeting in November 2015.

The Institute celebrated its 25th anniversary in 2015. During that time it has become one of the most respected research institutes for chiropractic and clinical biomechanics in the world. It is affiliated to the University of Southern Denmark and has its home on the university campus, where it enjoys close collaboration with related institutes at the university. Its researchers have many research projects underway at any given time. Some of the current studies are:

Can chiropractic care help children with headaches?

According to a Danish study from 2008, headache was the second most frequent cause for children aged 2-17 years missing school and seeing a chiropractor. It is common

knowledge that early diagnosis and treatment is important to prevent children from continuing to suffer from headaches into adulthood.

Knowledge of what effect chiropractic care has on children suffering from headaches is based on several years of clinical experience, some limited paediatric research and studies of adult patients. More precise and concrete knowledge is needed. To increase this knowledge, a randomised, controlled study of chiropractic practice in Denmark has been launched. The project will examine how chiropractic care works in children aged 7-14 years who have suffered from headaches for a long time. The results of the study will help to determine who benefits most from chiropractic treatment and provide knowledge that can be used in future research of paediatric headache and chiropractic. Data collection began in October/November 2015 and the study will take place over a period of two years.

Chiropractic treatment of colic

Chiropractors see the effect of

their treatment of colic every day, and many parents seek help from chiropractors. But how does chiropractic treatment of infant colic work? Currently there is no secure scientific study of the effect of the treatment. On the Danish island of Fyn, NIKKB and the Department of General Practice have initiated a study of chiropractic treatment on infant colic.

Children participating in the study will be divided into two groups: half the children will receive chiropractic treatment while the other half will receive a placebo treatment. After the treatment, the parents are being asked to keep a log registering their child's crying pattern for two weeks. These data will then be used to deduce the possible effect of chiropractic treatment. The study, which is funded by the Danish foundations Kiropraktorfonden and Fonden for Almen Praksis, was launched in October 2015.

Daycare Study

A study of children in daycare will



investigate the correlation between back pain and motor skills. The effects of other factors such as physical activity and obesity, MS, well-being, cognition, language and other possible diagnoses will be considered. A randomised study will be conducted to clarify whether motor intervention can improve children's lives through its effect on balance, strength, coordination and agility. Children leaving school will be measured in a number of areas over time to follow their development. 30 kindergartens (1,500 children) from Svendborg Municipality in Denmark are invited to participate in the study. Test rounds begin this spring, followed by intervention later this year.

You can follow NIKKB at www.nikkb.com

European Academy of Chiropractic in partnership with RRS Education

50% Discount on RRS Education's Research Reviews for EAC Members

THE EUROPEAN Academy of Chiropractic is pleased to announce a new affiliation with RRS Education (formerly Research Review Service), a trusted source of continuing-education solutions for chiropractors, physiotherapists, osteopaths and other manual medicine providers around the world. Staying on top of emerging research and integrating this information into practice is a daunting task for busy practising clinicians, who require understandable, convenient, unbiased analysis of contemporary research. RRS Education is a continuing education company dedicated to enhancing and promoting patient-centred, profitable, sustainable, evidence-informed care. It delivers clinically-relevant information in multiple formats to suit the needs of busy clinicians. The weekly Research Reviews are written by clinicians, for clinicians, extracting important clinical pearls to enhance your practice and patient care. Now, thanks to a subsidy from the European Chiropractors' Union, EAC members can enjoy a 50% discount.

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- **WEEKLY EMAIL ALERTS** with information about new reviews and links to other helpful research content*

Research

Research Corner:

Are psychosocial factors relevant for chiropractors? Part II

THE ROLE of psychosocial factors in back pain was introduced more than 25 years ago when it became clear that the traditional pathological model of disease did not adequately explain the course of low back pain and response to treatment. The new model proposed that each person's unique biological, psychological, and social circumstances be given equal weight in the aetiology and treatment.

In the last edition of *BACKspace*, I described the study carried out in Belgium and the Netherlands which examined the role of psychosocial factors in chiropractic practice. Here we present its conclusions and discuss their implications for clinical practice.

Do chiropractors believe that the psychosocial factors are relevant and important? According to a study conducted in 2005, 80-90% of those surveyed

indicated that they believe the psychosocial factors influence pain syndromes.¹ In a recent symposium in the Netherlands, two of the chiropractic speakers emphasised the role of the biopsychosocial model in chiropractic practice. Interestingly, many studies suggest that **few patients in a chiropractic practice have high (or complex) psychological risk profiles.**²

In this latest study conducted with our colleague, Luc Aillet of Belgium, we addressed two questions: firstly, we wanted to identify if there is a relationship between the psychosocial profile of our patients and outcomes with chiropractic care. Interestingly, we found that **only patients with somatisation* are found to consistently have worse outcomes.** All other psychosocial factors** which were evaluated were either inconsistently associated with worse outcomes or not at all.³

Secondly, we wanted to determine what the added value is of the psychosocial status beyond the clinical factors. The results demonstrated that **screening psychosocial status on the first visit with a standardised, validated questionnaire (4DSQ) helps only marginally** to predict which patients will likely benefit from care. We found instead that it is **sufficient to have knowledge on the nature and the severity of the presenting complaint** (e.g. duration, location, severity of pain).

These results would seem to be consistent with findings from colleagues in the UK and Scandinavia. There is, however, a small percentage of our patients who have complex psychosocial profiles, or in other words, are depressed, have abnormal levels of distress and internalise their stress resulting in physical symptoms (i.e. somatisation). However, this small sub-group requires further study, and does not represent the majority of our patients.

In general, these results would suggest that screening for psychosocial status at the first visit has little additional benefit. Does this mean we shouldn't screen for these at all? From previous studies we know that psychosocial factors help predict who is likely to progress from an acute to a chronic stage of back pain-related disorders. Identifying this group is important in order to prevent patients from becoming disabled. If kinesiophobia is readily detected, for example, then the treatment plan should be adjusted accordingly by providing the patient with education and information. In addition, depressed patients with back pain may



respond to treatment as for any similar non-depressed patient, but the depression can affect his/her ability to return to work, which in turn, may cause chronicity. So, in this way it is easier to understand the relevance of the psychosocial factors. They are simply not the black and white determinants of results as the last 25 years' paradigm would lead us to believe.

So, if screening for the psychosocial factors is less relevant than was supposed, is the old pathoanatomical model the alternative? As with so many models, it is likely that some combination of factors will provide the answer. It is incumbent upon the practitioner to identify those patients who are 1) unlikely to respond to care and not treat them indefinitely, hoping for that magical moment when they might suddenly recover, and 2) identify those at risk of developing chronic complaints. Identifying whether chiropractors (or any other practitioners) are any good at identifying these factors and generating valid prognoses is fodder for another (PhD) study.

Sidney Rubinstein, DC, PhD
Chair, ECU Research Council
with Tammy de Koekkoek, DC,
DABCO

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* Somatisation refers to the physical expression of symptoms as a result of psychological distress

** e.g. distress, depression, anxiety and somatisation.

1 Walker S et al. *J Chiro Med* 2005;1:11-18.

2 Kongsted A et al. *Chiropractic & Manual Therapies* 2011;34:204-210.

3 Ailliet L et al. *Man Ther.* 2015 Jul 20.

4 Ailliet L et al. Accepted. *Physical Therapy J.* 2016 Feb 4.

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60-second interview

BACKspace interviews three figures from the world of chiropractic

Name	 Lone Kousgaard Joergensen <i>Danish Association President</i>	 Jakob Bjerre <i>Danish Association CEO</i>	 Maria Jose Hernandez Ortiz <i>New member of the ECCE Council</i>
Education and practice	Master's degree in Clinical Biomechanics from University of Southern Denmark. Chiropractor since 2002. Co-owner of clinic with four chiropractors, two PTs, two massage therapists and four receptionists since 2011. Several years as president of the Southern regional division of the DCA as well as the committee responsible for the agreements with this regional health administration. Since 2008 member of the DCA board, vice president from 2010 and president since 2013.	Master's degree in public administration and economics. Leadership experience from different healthcare institutions. Several management and coaching courses.	Bachelor of Medicine and Surgery from the Autonomous University of Madrid; Pathology Specialty, Ramón y Cajal Hospital, Madrid; Diploma in underwater and hyperbaric medicine; Doctor of Medicine; Doctor of Chiropractic, Life Chiropractic College West USA. Chiropractor since 2005. International Vice-President of the Spanish Chiropractic Association (AEQ) in 2015.
First job	Intern (GEP) at chiropractic clinic	Administrative officer in the finance department of one of the biggest hospitals in Denmark.	I spent two years in a pharmaceutical research centre working as a toxicologist.
Memorable professional moment	I still remember my fifth day as a chiropractor, where I had a patient carried in; he had not been able to rise from the floor at home all day. He walked out of my clinic 50 minutes later. Hallelujah! Another memorable moment was when I realised that establishing the ECCRE (see page 10) could be the key for the DCA to re-enter the ECU, followed by my colleagues supporting it at our annual meeting in November.	When I helped the board first design 'the prolapse package', a new structured procedure for patients with acute lumbar disc herniation, and then in 2013 succeeded in negotiating a settlement for it with the public health administration. It's a very innovative framing of chiropractic treatment in primary care.	When I quit my job and gave up my salary at the Son Dureta Hospital to embark on an adventure to study chiropractic in the USA. It was very difficult, especially because I had to teach in addition to studying, but I also consider this the best gift that life has given me.
Professional practice	Kiropraktorerne Kongevej in Sonderborg, Southern Denmark	n/a	QuiroVida Chiropractic Centre in Palma de Mallorca
Special interests	I care for my patients at any stage of their level of pain and disease and have a special interest in complex problems and in sports medicine. I like to treat my chiropractic patients after having done a thorough examination as a body detective.	I take a special interest in how to consolidate professionalism by always finding the right strategy for the right task. Sometimes it's diplomacy behind the lines. Other times it's direct confrontation.	Women's health, writing and reading about health. I'm interested in healthcare research and I very much enjoy teaching.
Ambitions for the chiropractic profession	I would like to get to a point where everybody knows what a chiropractor is and does. At the same time I strive to maintain and fortify the chiropractic unity in the evidence-based direction and strengthen our political impact through dialogue, cooperation and alliances. I am fighting for chiropractors to be considered as a natural first choice in any healthcare system for patients with musculoskeletal pain, as a result, among other, of our academic education level.	Development, influence and growth - nationally as well as globally.	My vision for the chiropractic profession is dedicated to true health promotion, especially through the optimal maintenance of the musculoskeletal system health. But very importantly, also through advice, guidance and support of the patient's decisions to make the changes needed to maintain and increase the body's own ability to get and stay healthy. I would make the spine check-up and spinal adjustment an integral and basic part of preventative healthcare.
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General news

BCU calls on Belgian universities to provide chiropractic education

The Belgian Chiropractors' Union (BCU) held a colloquium¹ at the Federal Parliament in Brussels on 25 September 2015. **Bart Vandendries**, BCU president, reports.

THE SESSION was supported by the chair of the Belgian Centre for Evidence-based Medicine (CEBAM) Dr Patrik Vankrunkelsven and attended by Belgian politicians, senior members of the medical profession, medical trades unions, the Belgian Higher Council of Health and the Board of the BCU. It attracted positive press coverage, with calls for greater funding for chiropractic treatment by the Belgian health insurance providers. Speakers were drawn from across Europe, illustrating the most important aspects of the chiropractic profession: global reach, higher education qualification in accredited institutions, scientific research and Europe-wide quality standards under the European Committee for Standardisation (CEN).

The day drew out the following important lessons:

- Legal regulation of chiropractic is an accomplished fact in 12

European countries; in each chiropractic is integrated into primary healthcare.

- The most important argument leading to recognition is usually that chiropractors are highly-qualified healthcare providers who offer added value in tackling a huge social welfare issue (i.e. back and neck pain).
- This is not a coincidence: the profession has always invested on an international scale in a university-level education. It is about quantity and quality. The high-quality educational programme delivers healthcare providers who can be deployed immediately in a healthcare system. They move with the times through access to research: claims made at the beginning of the last century have either been proven or refuted and by embracing an evidence-based approach the profession has slowly but surely gained

maturity and credibility.

- For over 30 years chiropractic has had an independent accrediting body in Europe (ECCE). In other words, Norwegian chiropractors have been educated to the same standards as Belgian chiropractors, or French or British practitioners. If chiropractors where there is regulation offer added value, so do their Belgian colleagues.
- On the other hand it currently takes time to generate growth in the number of chiropractors, especially when they must go and study abroad for five years. Despite powerful opposition from entrenched interests elsewhere in the healthcare system, the BCU has committed itself publicly to a long process of achieving legal recognition for the profession. Legal recognition is a matter of rights and obligations: rights which we have not been granted

as yet but, equally so, obligations with which we are not required to comply today but which we welcome in the name of our patients. Having listened to the experiences of Danish, Swiss, French and English colleagues in establishing university alliances and exploring new scientific horizons driven by a gigantic social welfare problem, I cannot escape the impression that surely Belgian universities must be interested in this topic as well.

Belgium has world-renowned universities. If British, French, Danish, Spanish, Swiss and Turkish students are being offered the possibility of studying chiropractic on home territory - and soon so will Norwegian and Italian students - surely Belgian universities can rise to this opportunity.

1 An informal seminar for the exchange of views

EU cross-border healthcare report highlights advances

A REPORT ON the state of play with the Cross-Border Healthcare (CBHC) Directive shows significant legislative advances at EU-level in the past two years coupled with genuine efforts at national level. Furthermore, the Directive has contributed to shaping healthcare reform in many EU countries. It has improved transparency and patient mobility throughout the EU and enabled progress on Health Technology Assessment, e-Health co-operation and European Reference Networks.

However, the report clearly

shows that European citizens' awareness about their right to choose healthcare in another EU country remains low. Less than two in ten citizens feel they are informed about their rights in this area, and only one in ten is aware of National Contact Points (NCPs) - offices set up under the Directive to provide information to patients on their rights and on quality and safety issues. Awareness of NCPs varies widely between EU countries, with four times as many Maltese citizens knowing about them (24%) as citizens from the UK (6%)¹.

Amongst other findings:

- Patient mobility for planned healthcare remains low - far below the potential levels suggested by Eurobarometer survey (49% showed willingness to travel in another EU country to receive medical treatment).
- Information to patients about their general rights to reimbursement should be improved.
- The same goes for data collection - to date, only 17 of the 21 member states who introduced a system of prior authorisation were able to supply data on applications for authorisation.

In line with President Juncker's commitment to ensure effective implementation of EU legislation and follow-up on the ground, the Commission will continue an in-depth examination of the measures adopted by member states to implement the Directive, and to explore all possible means for ensuring the correctness of the Directive's transposition into national law so that citizens in all 28 EU countries are able to benefit.

1 Source: Eurobarometer on Patients' rights in cross-border healthcare in the European Union: http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_en.pdf

140 years uncorked

Polly Hand gives an account of a double celebration in the UK – the 90th anniversary of the British Chiropractic Association (BCA) and the 50th anniversary of the Anglo-European College of Chiropractic (AECC).



ON FRIDAY 25 September, I boarded a train in London with a good friend from university, cracked open a bottle of Prosecco and let the weekend commence. We were on our way to Bournemouth for the joint BCA and AECC conference, celebrating their 90th and 50th anniversaries. Being a BCA council member, it is somewhat expected that I attend these events. And I would be lying if I said I was really excited about the weekend. I like my weekends to be full of rest, perhaps a drink or two and catching up with friends. I can, however, safely say that it ended up fulfilling all three of those criteria – and many more too! The setting was beautiful and

perfect and the sun came out for us for the whole weekend. The hotel conveniently included a great health club and spa so we

made the most of it during any down time – I even found myself

in the heated outdoor pool as the sun was starting to go down on Saturday evening – blissful after a day of learning, mingling and getting inspired.

There was a large focus during the weekend on the achievements of both the BCA and the AECC – we really mustn't forget how far the profession has come and how much these two institutions have done for us – meaning we can practise today and continually help our communities.

Throughout the weekend a strong desire for unity grew organically; it became a common theme in many of the talks, and indeed during break time coffee catch-ups. The atmosphere was fantastic – a real mix of ages, experiences, opinions, but again an overriding feeling of all being in this together and essentially that we all want the same things for our profession – growth, acceptance and increased awareness.

The gala dinner on the Saturday evening was fantastic. Champagne on arrival, pretty dresses, dapper suits (many of the men attempting their best Bond impression) and an incredible band who really got the dance floor busy. I have recollections of partaking in a shot or two too many, and dancing like a loon with a helium balloon, but as I said, it was my weekend; I was determined to have fun. And that I did!

Being a dedicated BCA member I am ashamed to say I didn't attend BCA conferences for a few years as I felt they might be somewhat boring. Not any more; the future is bright. The future is chiropractic!



Øystein Ogre and Matthew Bennett, BCA president

The AECC at 50

THIS MILESTONE birthday could be cause for looking back at 50 years as a higher education institution during which time its reputation for excellence, quality and standards has been recognised globally in the profession. But that is not the AECC way. Unashamedly resting on a bedrock of scientific research, it is one of the leaders of the empiricist arm of chiropractic and expects shortly to attain the status of a public independent university college in the UK. It prefers to think of the next 50 years of chiropractic.

For instance, the AECC relevance to practising chiropractors does not stop with graduation. It offers career-long support for practitioners to remain relevant through a range of postgraduate programmes and a portfolio of CPD seminars and courses. The profession, not just in the UK, recognises the AECC as a reliable and ready source of CPD events, helping busy people keep abreast of current developments and come together to debate the way ahead.

Some 20 years ago the College recognised that the profession would start to develop postgraduate specialisations. The first postgraduate master's degree in chiropractic in the world was established in 2000 (MSc Clinical Chiropractic), and it focused on the new rehabilitative approaches of the time. This was followed by a wider range of postgraduate master's degrees including paediatrics and medical ultrasound, open to all qualifying healthcare professionals. For details see www.aecc.ac.uk/postgraduate-cpd.

Postgraduate education and training in diagnostic ultrasound has been a notably successful venture and now recruits large numbers of students from a range of healthcare professions, including medical consultants, sports physicians, GPs, radiographers, physiotherapists,

nurses and midwives. Using a multidisciplinary teaching team this is inter-professional learning at its best. Most successful, as one might expect, is musculoskeletal ultrasound and AECC is now arguably the leader of training in this field in the UK with unparalleled equipment and facilities. Nor is it confined to the British Isles. As with the postgraduate MSc in paediatrics, the College now runs the MSc in ultrasound in Norway with the support of the Norwegian Chiropractic Association.

In the past 12 months, the College has started short courses in diagnostic ultrasound for Premier League football clubs in the UK. Three satellite training facilities have been set up, and medical staff from clubs such as Arsenal, Southampton, AFC Bournemouth and Leicester are being trained. This exciting development at AECC reflects the College's drive and motivation to build bridges to potential alliance partners. For a small profession with a strong sense of identity could this be a fruitful way forward? One thing is certain, the AECC will not stand still and will push the boundaries of knowledge as far and as hard as it is able.



Haymo Thiel, AECC principal and Øystein Ogre

General news

Delivering the right message

Over the years the *Associazione Italiana Chiropratici (AIC)* has organised various press conferences to represent and promote the chiropractic profession in Italy, but with only between 300 and 400 chiropractors in a country with 450,000 medical doctors, the association found it difficult to create sufficient interest to convince the journalists to disseminate the message. AIC president **John Williams** explains how they solved the problem.

IN THE past, we had concentrated on presenting chiropractic as a recognised primary healthcare profession with a top-notch five-year academic preparation, and quoted statistics concerning cost-effectiveness, diffusion in Europe, political situations and all the familiar problems experienced by our profession in Europe.

I must say that all those present were sincerely touched by our presentations and vicissitudes, and the conference lasted much longer than foreseen, but none of this enthusiasm carried over to the mass media and the only announcement that was communicated was the future opening of a chiropractic course in Italy, which was only a footnote in the three hours of discussion. At the end of the session though, several of the journalists approached me and said they would like to be invited to our next press conference, but would like to choose the theme to be discussed. They all had back problems and wanted to hear what chiropractic could do for them that was different than what they had already tried.

We took their request to heart and at the end of 2015, held a press conference in Rome on the complexities of low-back problems. On this occasion, we invited other health professionals

who collaborate with chiropractors in order to demonstrate the complexity of diagnosing and treating back problems, but also to better illustrate how chiropractors fit into the healthcare team. The speakers consisted of two chiropractors, one MD/DC, an orthopaedic doctor and a nutritionist, and all presentations reflected the importance of the individual patient in the treatment process. The session was moderated by a journalist of Italy's top newspaper and there was ample time for interaction between the speakers and the journalists.

This time was definitely more productive than in the past, and within one hour of the conference, I was interviewed on Italy's top medical television programme, to be followed one week later by a live appearance on a news talk show with other health professionals.

This caused me to reflect on the reasons why the media were so responsive this time, and I realised that, while our previous encounters generated enthusiasm among the journalists, the message that we were delivering was not newsworthy, nor of direct and personal interest to the general public concerned with their own health problems, but was more suited for an institutional audience.

The Netherlands Chiropractors' Association turns 40

Around 250 chiropractors and colleagues from other healthcare professions gathered in Almere to celebrate the 40th anniversary of the Netherlands Chiropractors' Association (NCA) on World Spine Day, 16 October 2015. This report is from **Gitte Tønner**.

THE MORNING started with gentle exercises to wake the muscles and prepare participants for the stimulus to come. President of the ECU, Øystein Ogre, and Secretary-General of the WFC, Richard Brown, put the Netherlands into an international context. Dutch Olympic skating legend Jochem Uytendhaage gave an inspiring and energetic talk, and was followed by the esteemed professor of surgery from Erasmus University, Hans Jeekel, who openly supported chiropractic as a complement to other medical procedures.

The NCA organising team introduced a novel way of showing the many faces and facets of the Association: NCA president Reem Bakker interviewed colleagues from across the years, including Walther van Os, who is still in practice and has seen the NCA pass all kinds of milestones, the first PhD chiropractor Sidney Rubinstein and heads of NCA committees, ending with our

newest and youngest member with her hopes for the future.

The afternoon programme appealed widely and made extensive use of local specialists: neurology, paediatrics, sports, cervical radicular syndrome, pharmacology, the dangers of a sedentary lifestyle and world record holder for remaining in an ice bath, Wim 'The Iceman' Hof!

From the lively atmosphere and from survey it was clear that the vast majority of attendees were very happy to be present and proud NCA members.

Around the time of the anniversary it was made known that following a campaign by the NCA, Dutch chiropractors are once again VAT exempt – a splendid result which will encourage growing ambition for the profession in the Netherlands, including title protection, recognition, legislation, more PhD students and a domestic undergraduate programme in chiropractic. For the NCA and its members life begins at 40!





The future of chiropractic education

In the light of continuing arguments about vertebral subluxation and what constitutes ethical patient management, six leading chiropractic colleges in Europe and South Africa issued a statement at the Athens ECU/WFC Convention last May declaring where they stand on these and other questions. As part of student recruitment the Colleges want to leave no doubts as to what they are and what they teach. We reproduce their statement for the record below.

WHEREAS, THE welfare of the patient is paramount; and
Whereas, chiropractic education should be of the highest quality and be founded on the principles of evidence-based care¹; and

Whereas, curricula should be responsive to changing patient, societal and community needs and expectations within a modern health care system;

we, the undersigned chiropractic educational institutions, state as follows:

1. Chiropractic education and training must acknowledge the biopsychosocial model of healthcare and be underpinned by biologically plausible theories and peer-reviewed research. It should embrace the value of clinical experience, shared decision-making and a patient-centered approach to care.
2. Upon graduation, chiropractic students should be equipped to work effectively and collaboratively to deliver improved quality of life outcomes for patients with musculoskeletal disorders. This will, of necessity, incorporate:
 - a. An evidence-based approach to the case history, physical examination, diagnostic imaging, diagnosis, report of findings and management plan that may include a range of clinical interventions
 - b. Effective communication in a language that is clearly understood by all stakeholders in healthcare, thereby facilitating interprofessional practice and promoting effective collaboration between health care teams
 - c. Knowledge of preventative measures including but not limited to musculoskeletal care, encompassing wider public health and health promotion initiatives
3. Wherever possible, chiropractic educational programs should form or develop affiliations with established public and private universities preferably within a medical or health science faculty. Such links may develop opportunities for interprofessional education and collaborative practice.
4. Chiropractic educational institutions should support their faculties in the provision of innovative models for the development of knowledge, learning and skills. These should focus on facilitating scholarly activity including research, interprofessional education and teaching within the context of emerging health care models.

5. The teaching of vertebral subluxation complex as a vitalistic² construct that claims that it is the cause of disease is unsupported by evidence. Its inclusion in a modern chiropractic curriculum in anything other than an historical context is therefore inappropriate and unnecessary.
6. Chiropractic education should reflect ethical practice and professional standards throughout the curriculum. Upon graduation, students must understand their responsibilities to their patients, their communities and to the profession.
7. Practice styles³, which may contribute to inappropriate patient dependence, compromise patient confidentiality or require repeated exposure to ionising radiation are not part of an undergraduate chiropractic curriculum. Students should be taught to recognise that such approaches are not acceptable in terms of the best interests of patients or the chiropractic profession.

On behalf of the following chiropractic educational institutions:

- Anglo-European College of Chiropractic, Bournemouth University
- The Welsh Institute of Chiropractic, University of South Wales
- The Education of Clinical Biomechanics, University of Southern Denmark
- Chiropractic Medicine, University of Zürich
- Institut Franco-Européen de Chiropraxie
- Department of Chiropractic, University of Johannesburg
- Department of Chiropractic and Somatology, Durban University of Technology
- Department of Chiropractic, Macquarie University
- Discipline of Chiropractic, Murdoch University

- 1 Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. BMJ. 1996;312(7023):71-2.
- 2 Specifically the form of vitalism as distinct from holism that proclaims 'If the specific vertebral subluxation is correctly adjusted, interference is released, pressure is eliminated, carrying capacity restored to normal, tissue cell is re-established, and life and health begin to regrow back to normal. All this is directed, controlled, and performed by INNATE INTELLIGENCE' (Ref: BJP Fame and Fortune Vol. XXXIII)
- 3 Practice styles refers to routine 'high volume' chiropractic care models, 'open plan' chiropractic care models and the delivery of unsubstantiated 'treatment packages' or clinical techniques.

Improving everyday practice

Test yourself

A quiz set by **Bert Ameloot** of the Belgian Chiropractors' Association. Find the answers on page 20.

Ben is a 42-year old competitive footballer, who presents to your practice with a five-month history of right-sided anterior hip and groin pain. The pain started during the course of pre-season training and gradually worsened over a two-month period. The hip feels sore and very stiff after he has been playing and training for football. When it flares up it is difficult for him to sleep on his right side.

It is important to note the patient played professional football from the age of 19 until 29 years of age. His commitment to football involves about 1.5 hours of training twice a week and a 90 minute match on Saturday. At the moment he is coping reasonably well and can still run quite freely and performs reasonably well during the game. Despite his symptoms he still wants to continue playing as he loves the game. Therefore he went to his medical practitioner for this, who ordered plain medical imaging and diagnostic ultrasound. The MRI is planned to happen in two weeks. The general practitioner referred him to a physiotherapist, but as the team physiotherapist could not alleviate this pain with his usual treatment the patient went to see you.

The nature of the pain was a constant dull ache during the first two months of pre-season, which became intermittent after the patient noticed a greater level of fitness. Lately it has become a sharp catchy sensation accompanied by clicking or popping in the joint located mainly in the anterior aspect of the hip and the groin. The intensity was reported at 3/10 on a visual analogue scale. No other symptoms were reported. There is no previous medical history and no history of any other serious lower extremity injuries.

During the course of his career Ben has had numerous soft tissue injuries to the hamstrings, calf muscles and hip flexors, which were successfully managed by the team physiotherapist.

Ben is a social drinker and does not smoke. He has no other symptoms of any kind.

Questions

1. Lumbar/lumbosacral referral
2. Soft tissue injury
3. Intra-articular hip lesion
4. Sacroiliac referral
5. Extra-articular hip lesion

1. Select the option that displays the most likely order of possible general causes of Ben's hip pain.

- A. 35214
- B. 52134
- C. 14325
- D. 41235
- E. 23145

2. Which one of the options below is NOT an extra-articular hip disorder?

- A. Internal snapping hip
- B. Deep gluteal space syndrome, previously known as piriformis syndrome
- C. External snapping hip
- D. Abductor tendon tears
- E. Acetabular dysplasia

3. What quality of pain may suggest intra-articular hip lesion?

- A. Diffuse and aching
- B. Burning
- C. Sharp and catching
- D. Shooting

4. Which sports are placing hip soft tissue structures under most stresses?

- A. Swimming and running
- B. Running and cycling
- C. Squash and tennis
- D. Spinning and stepping

Physical Examination

Vitals: not needed

Observation: Muscular and healthy looking.

Palpation: tenderness of hip musculature and spasm of right piriformis, gluteus medius and iliotibial band. Soft tissue adhesions were palpated at muscular insertion points on the greater trochanter and anterior superior iliac spine.

Hip range of motion: global reduced range of motion of the right hip compared with the left. Especially adduction and internal/external rotation. There is also pain and limited flexion and abduction, with a reproducible painful click on the right.

Orthopaedic exam:

Pain on Patrick's FABERE test on the right

Painful click on the Thomas test on the right

Trendelenburg negative, bilateral adductor test negative (resisted adduction in 30° flexion)

No abnormalities in the evaluation of the lumbar and sacroiliac joints on orthopaedic testing, except for tenderness by springing and palpating the right sacroiliac joint.

Whereas imaging is clearly important for correct diagnosis, false positives with MRI and MRI with arthrogram (MRA) are common, requiring providers to determine whether a distinct pathology is actually symptomatic, further relying on accurate and efficient physical examination.

To look up background information to refresh your knowledge before continuing: you may use this source:

<http://bjsm.bmj.com/content/49/6/357.full>

5. Which one of the following statements is NOT correct?

- A. Trendelenburg test is a test for hip strength and gluteal tendinopathy on the weight bearing leg
- B. Gluteal tendinopathy can be tested by the resisted external derotation test
- C. Flexion, adduction and internal rotation cause an abutment between the femoral head and anterior acetabulum
- D. Flexion-adduction-internal rotation test has low sensitivity and high specificity compared to MRA and arthroscopy
- E. The Thomas test creates relative hip extension in the testing leg

6. Why was the Thomas test evident/positive on the right?

- A. Most football players have short hamstrings.
- B. Short iliopsoas on the right compared to the left.
- C. Short quadriceps group on the right compared to the left.
- D. Iliotibial band shortening and tenderness due to tensor fasciae latae/gluteus maximus imbalance.
- E. Pain in the groin or painful click possibly due to intra-articular disorder.

Investigations

The findings of the plain X-ray revealed early arthritic changes with osteophytic spurring of the femoral neck junction and superolateral joint space loss. Marginal changes at the acetabulum raise the possibility of labral injury. No other abnormalities were detected.

Ultrasound demonstrated a normal appearance of the gluteal tendon insertions with

Improving everyday practice

no evidence of tendinopathy or tear. There is no significant trochanteric bursitis.

7. What is the most likely diagnosis of the case presented based all information received so far?

- A. Athletic pubalgia
- B. Anterior snapping hip syndrome (iliopsoas tendon snapping)
- C. Iliotibial band proximal friction syndrome
- D. Labral hip tear / femoroacetabular impingement
- E. Advanced hip osteoarthritis

8. Select the only correct statement

- A. A cross-over sign on plain

X-ray of a supine pelvis is an indicator for CAM type impingement

- B. Athletic pubalgia should be differentiated from hip impingement, hence cannot occur together
- C. Acetabular retroversion as a cause of pincer impingement is indicated by a shallow posterior wall
- D. The minority have a mix of cam and pincer type impingement
- E. Cam type impingement is more common in females

9. Select the only statement that is incorrect

- A. The hip joint receives innervation from the L2 to S1 branches of the lumbosacral plexus but predominantly from

the L3 nerve root.

- B. The L3 dermatome crosses the anterior thigh and extends distally along the medial thigh to the level of the knee.
- C. The 'C' sign is described when a patient shows deep interior hip pain. The hand is cupped above the greater trochanter with the thumb posterior and the fingers gripping deep into the anterior groin.
- D. More commonly, posterior impingement may be encountered and is assessed by external rotation of the extended hip.
- E. Athletic pubalgia (or "sports hernia") is a condition that often occurs in athletes

10. Conservative management of anterior

femoroacetabular impingement: select the only option below that is inappropriate.

- A. Initially, the patient is educated on avoidance of compromising positions such as extremes of hip flexion and internal rotation.
- B. Generally, at least 4–6 weeks of conservative intervention should be employed prior to surgical treatment.
- C. Any measures that aims to reverse the iliopsoas being long and weak, the TFL being short and dominant, and the gluteus maximus being short and weak.
- D. Lumbopelvic stabilisation
- E. Manipulation or mobilisation to increase the anterior glide of the hip joint

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Feature

Small country – large ambition

After ten years in the wilderness the Danes are back at the table as members of the ECU. But what is the situation for chiropractors in this small country which likes to call itself a chiropractic superpower?

The DCA in numbers

- 550 chiropractors
- 260 clinics
- 250 students
- 30 work at hospitals
- 10 work in administration or education
- 20 are engaged in research

DENMARK IS indeed a small country, with only 5.7 million inhabitants. However, with 550 practising chiropractors and 250 chiropractic students it is in the top ten countries in the world as far as access to chiropractic care is concerned. Conditions are unique for both chiropractors and their patients. Danish chiropractors have most of the things other chiropractors can only dream about: licence, title protection, laws and regulations, a recognised position inside the national healthcare system, tax-funded patient subsidies for all chiropractic fees (although only 20%), a research fund that is partly publicly financed, a research institute with outstanding faculty and a publicly-funded chiropractic education programme at a medical faculty.

How did all this come about? Let's consult the history book for a moment. The first Danish chiropractor settled in Copenhagen in 1920 and already by 1925 there were 11 practising chiropractors who formed the Danish Chiropractors' Association (DCA). The same year the Danish chiropractic patients' association was also formed. There were growing pains, with resistance especially from the doctors, and attempts to gain recognition through licence failed. But as the patients' association grew stronger and began to campaign for chiropractic legal rights, results began to show in the 70s. The breakthrough was not with a chiropractic licence, which came later on, but happened in 1978 when chiropractors became part of the agreed system underpinning Danish primary healthcare. That meant that chiropractic patients could get a public contribution in the shape of a limited subsidy for treatment – and a lot more.

Central to primary healthcare are agreements between the different health professions (the chiropractors, the GPs, the medical specialists, the physiotherapists and four more professions at present) and the public healthcare administration. These agreements not only determine the size and coverage of the different subsidies, but are part of an agreed complex of arrangements that fix the level and extent of public authorities' involvement in the exercise of health treatments.

Since 1978 the agreement between the DCA and the public healthcare administration, which is renegotiated every third year, has developed. Today it has several components, including the framework for and size of public funding, involvement in chiropractic research, development projects, graduate education programmes (GEP) as well as postgraduate education.

The agreement establishes both rights and obligations. For



The ECU Executive Council meeting was hosted at the DCA offices in March 2016

example, it establishes a right to subsidies for patients attending clinics and a right for chiropractors to refer patients for imaging diagnosis at public hospitals. On the other hand chiropractors are obliged to follow fixed fees for services (negotiated by the DCA with the national authorities), follow national clinical guidelines, and, though they have been voluntarily supporting research since 1987, will be required to undertake postgraduate education and to contribute to the financing of chiropractic research and education. A further obligation will soon be to engage in a public quality control programme.

1989 was a further turning point as the DCA and the public healthcare administration agreed to establish a common fund called the Foundation for Advancement of Chiropractic Research and Postgraduate Education – and agreed to share its funding. Consequently the fund gets its means directly from Danish chiropractors and the public healthcare system (tax money). Each of the 260 enrolled chiropractic clinics pays 2% of their turnover to the fund – the national healthcare system contributes an amount one-third smaller. The fund finances the research institute, the Nordic Institute of Chiropractic and Clinical Biomechanics (NIKKB), which was established one year after the creation of the fund. But the fund also finances other research activities, development projects and postgraduate education – including the GEP, quality control development and other activities determined in the agreement creating the fund.

Enrolment of the DCA in the public healthcare system paved the way for achieving first a chiropractic licence and title protection (1991), then a publicly-funded chiropractic education programme (1993). Not to say that this was easy! These important and giant steps required enormous efforts from chiropractors and manpower in both the DCA and the patients' association.

To sum up, the success in integrating chiropractors as specialists in the formal healthcare sector is the result of the investment

Feature

by all Danish chiropractors, who presented a politically unified profession and a firm dedication to what one could call 'the academic road'. They were ready to pay the costs of influence up front. That is evident in their continued support in financing the research fund, but also in the 1980s when the DCA, as one of the first European associations, decided to professionalise its secretariat. Today the DCA office employs seven full-time professionals, most of them highly educated. This secures many activities and important continuity, but it does not come free. Most of the members' fees sustain the wages and costs linked to this level of secretariat.

What is the next mountain to climb for the Danes? On the national level the DCA wants to get even more integrated into both primary and secondary healthcare. More patients should have a chiropractor to take care of their musculoskeletal problems. The strategies therefore aim at making more alliances and joint ventures with other health organisations and increasing the branding of chiropractors as evidence-based clinicians. At the same time the DCA looks forward to playing an active part in ECU deliberations, helping to promote the profession's political goals in a European context. And, as we speak, the finishing touches are being put to The European Centre for Chiropractic Research Excellence which will combine funds from the Danish Fund and the Research Fund of the ECU.

Danish chiropractors have

- licence to practise on the same level as MDs and dentists
- protection of the title 'chiropractor'
- reimbursement from both the state and all private insurance
- recognition by the public Patient Compensation Association and The National Agency for Patients' Rights and Complaints
- acknowledgement as an integrated part of the primary sector in close collaboration with general practitioners and physiotherapists
- acceptance of a 'prolapse package' - a structured procedure for patients with acute lumbar disc herniation
- employment as chiropractors at hospitals, both in spinal clinics and imaging departments
- a strong research environment with more than 20 chiropractors having been awarded PhDs
- a publicly-funded chiropractic programme, known as clinical biomechanics, at a medical faculty at the University of Southern Denmark

For more information see:

www.danskkiropraktorforening.dk/english

Improving everyday practice

Answers:

1. A: It is most likely an intra-articular hip lesion, with concurrent soft tissue abnormalities based on the quality of the pain, site of pain, relationship to movement, presence of referral pattern (even though hip conditions are notorious for masquerading as lumbosacral, sacroiliac or knee conditions), long-term sports related history.

2. E: acetabular dysplasia is an inadequate development of an individual's acetabulum. The resulting acetabulum is shallow and 'dish shaped' rather than 'cup shaped'. Option A may have confused you, but the snapping sound comes from the tendon of the iliopsoas muscle as it moves through its normal motion across the extra-articular bony structures of the hip joint

(iliopectineal eminence, femoral head, or lesser trochanter).

3. C: diffuse and aching may suggest muscular pain, burning would be more sensitisation of a part of the nervous system, shooting could be sclerotomal or nerve structure related.

4. C: sports that involve a lot of cutting or short movements with changing direction put the hip and related soft tissues structures under high loads. These involve repetitive internal or external rotation of the hip under loading in less stable kinematic formation. You could add football, rugby, etc to option C

5. D: the FADDIR test has a high sensitivity and a low specificity compared to MRA and arthroscopy. Pooled diagnostic accuracy: MRA criterion reference sensitivity 94%, specificity 8%, across four studies

with 128 patients. Arthroscopy criterion reference sensitivity 99%, specificity 7%, across two studies with 157 patients. You should put this test in context with other orthopedic testing.

6. A positive test is reproduction of painful click or concordant groin pain. Monitor for tightness/compensation of the lumbar spine arching, tested leg abducting and externally rotating. Although this test does not reproduce the mechanical abutment between the femoral head and acetabulum similar to the FADDIR or flexion internal rotation test, it does recreate hip extension, which has been shown to recreate the greatest forces on the hip joint. The Thomas test has value as both a screen and diagnostic test as both sensitivity and specificity are high.

7. D: Considering the patient's symptoms were reproduced by

hip orthopaedic tests, including the anterior hip and groin pain as well as the painful clicking and popping, this would suggest the most likely diagnosis involves intra-articular derangement of the hip. The investigations confirm femoroacetabular impingement syndrome with possibly a hip labral lesion.

8. C: cross-over sign can be an indicator of pincer impingement; athletic pubalgia can occur together with hip impingement; about 80% have a mix of cam and pincer type impingement; pincer type is more common in females.

9. D: posterior impingement is less common.

10. E: manipulation or mobilisation of the hip joint for an anterior femoro-acetabular impingement should aim to increase the posterior glide of the joint.

Feature

Newell's notes

Dave Newell, Director of Research at AECC, writes the first of a new regular series of features.

RECENTLY AT the Annual General Meeting of the Royal College of Chiropractors (RCC) in the UK, Professor Charles Greenough, national clinical director for spinal disorders in NHS England outlined a new pathway for the management and treatment of low back and radical area pain that may see national coverage in the next few years. This pathfinder project was commissioned by NHS England and involved a range of stakeholders including representation of the chiropractic profession.

This new pathway is aimed squarely at the needs of the patient and avoids the specific inclusion of professional specialities and sub specialities. To quote the report: *'The pathway is based on the needs of the patient at every point and on the structures of the services that might meet these needs. It was acknowledged that throughout England many different services and many different pathways of care exist.'*

Instead it co-opts clinicians with identified competencies at each of the stages in the pathway thus allowing the inclusion of suitably qualified clinicians from a range of professions that can include chiropractors. The key point here is that professional inclusion in a national pathway for major MSK conditions is being based on clinical competency and knowledge, not the traditional 'go to' professions already within the system.

Additional to these individuals who may include suitably qualified chiropractors at initial consultation and those delivering core treatments including manual therapy and manipulation within the pathway, is the creation of a group of specialised clinicians called triage and treat practitioner (TTP) or triage and management practitioner (TMP). These individuals will have high-level skills and competencies. The report states that: *'The function of the triage and treat practitioner is to direct the pathway of care and provide continuity of care across the pathway ... This clinician is highly trained and has significant skills, competencies and high autonomy ...'*

Importantly, the RCC has produced a set of competencies in the wake of these initiatives and they very much align with what a good proportion of chiropractors possess, albeit with some notable upskilling perhaps needed.¹ An important question about the role of the chiropractic profession was raised at the end of the talk. The pathway clearly states that any number of suitably qualified clinicians can and should take a role at initial presentation and delivery of core treatments, including manual therapy. What was noteworthy was that Professor Greenough also suggested that the key post of triage and treat, responsible for directing and providing continuity of care throughout the pathway, could and should, where a suitably qualified individual with the requisite competences is found, be a chiropractor. No professional boundaries, no automatic exclusion, only the requirement that chiropractors as individuals step up to the plate in terms of skills, competencies and knowledge. I found this both striking and groundbreaking.

There is, and has been, a historical tension in Europe between those in the chiropractic profession who do not want to be included in mainstream healthcare such as national health systems and those who feel this is the direction the profession should take. There are understandable disagreements and anxieties over tariffs,



"Professional inclusion in a national pathway for major MSK conditions is being based on clinical competency and knowledge, not the traditional 'go to' professions already within the system"

scope of practice and autonomy to name just a few when considering whether to engage with the system or not. In some European countries, notably in Northern Europe, those problems have been solved at least to the point where the chiropractic profession are ostensibly embedded to varying degrees within the national health system of the country. This I believe, as do many others, brings legitimacy and influence to a profession that is struggling to expand in Europe and in some countries is still at the margins of the healthcare community.

Notwithstanding the considerable barriers that have stood, and still stand, in the way of such inclusion, this UK initiative with its emphasis on competency not professional identity is a welcome change in rhetoric and seems to hold the promise of greater visibility for the chiropractic profession. There is one key caveat however, and this I think is a general qualification on excessive optimism.

This new pathway may be defined nationally but it is local decisions that determine who will lead the patient along it; and that points to a major challenge. Chiropractors need to be known at a personal level to those who will be involved as clinical directors or administrators and they must show determination to step up to such positions – including where necessary, the commitment to develop additional competencies and knowledge. As members of the profession we need to get up close and personal and to show our curiosity about where wider healthcare is going rather than focus on introspection within the profession about what it thinks it does.

Someone once said: "If you're not part of the solution, then you're part of the problem." I guess in the end we will have to choose to articulate what and who the profession is in this regard.

¹ <http://tinyurl.com/h5bnf24>

Identity and determination

The secretary-general's interview

IT'S 7PM in the players' lounge at Queen's Park Rangers Football Club on a very wet Tuesday in December. QPR are to play Brighton & Hove Albion, currently top of the Championship. As the evening unwinds, the word is that this is the best game so far this season - which means, of course, that it's the best performance by the home team so far. Their star player, Charlie Austin, is in the starting line for the first time in a month following a calf injury and pulls back a two-goal deficit after Brighton scored twice in the space of three minutes. Sky Sports calls the game fantastic entertainment, and it is. The players' lounge is full of wit, warmth and winding up aimed at the Brighton supporters who are just outside the (hopefully) reinforced glass between us and the pitch.

I am the guest of Catherine Quinn, the chiropractor member of the QPR medical team. She is clearly very popular with the others in the room who show a warm, friendly respect for her. Tonight she's off duty. Normally she has 32 first team and 30 under-21 players to keep available for training and selection.

Beneath the treatment room banter, she tells me, the players have learnt to trust her professional judgement: "You have to be strong but not bossy or aggressive, so the players recognise that you fully back the advice and treatment you are giving to help their performance or bring them back from an injury. They recognise that they are able to perform to their full potential when they feel at their best, which at the top levels makes all the difference." And as if to prove the point, the second of Charlie Austin's goals is a powerful header when he rises higher than the defenders to power home a cross from a corner. It happens at the far end of the pitch



but Catherine knows where each of the home team is, by name, simply by the way they run and move.

Her role at QPR seems like a dream complement to Catherine's other position at the busy Waldegrave clinic with Tom Greenway, who was the lead chiropractor for the 2012 Olympic and Paralympic Games in London and previously spent 10 years working in professional football with QPR and Chelsea Football Clubs. How did it come about? The answer is clear – Catherine knows where she wants to be and that to get there means being in the right place at the right time. That's not accidental, she has worked successfully at just that. Perhaps it is no coincidence that her first sport was karate with its emphasis on counter attack, discipline and persistent effort.

She took a BSc in sports science at St Mary's University, Twickenham, and volunteered at Harlequins Rugby League (now the London Broncos), helping with massage and taping. For 12 months she worked at the Barron Clinic and then secured one of four FICS scholarships in 2010 – two Americans, one person from France and Catherine. The result was a Master's in Chiropractic at the AECC, again volunteering at Southampton FC whilst a student.

Almost immediately she joined the medical staff at London Irish, the Premier League rugby club after which she joined the QPR team in 2014. And between times she volunteered at the 2012 London Olympics, where she first met Tom Greenway. Not all of this was planned – Catherine knows the value of signing up to a professional identity and networking with people who are already doing the kind of work you want to do. That way it is possible to make the most of opportunistic openings if you show energy and enthusiasm.

How does she fit into the QPR medical team, which also includes a sports therapist, two physiotherapists and a massage therapist? She is seen as the spinal specialist and is mostly consulted over degenerative or acute onset spinal conditions, particularly lower back and neck problems. Once again, a clear identity and standpoint for the day-to-day debate and the bouncing-off of ideas with the other members of the medical team.

A few weeks after the interview Catherine found herself in the right place at the right time once again. At the end of January she was going to the MatchRoom boxing event at the Copper Box in the Olympic village. Before taking her seat she looked in on

one of the fighters, John Wayne Hibbert, who is trained by Alex Breeding, the brother of a friend. While they were sitting and having some food he turned his head and went into muscle spasm around his shoulder and neck. He was due to be fighting the biggest fight of his career defending the Commonwealth Light Welterweight belt in four hours! Alex asked Catherine to have a look at him as he was unable to turn his head, so she ended up assessing and treating him back at their hotel. Thankfully he was then fit enough to fight and went on to win by a knockout in the 12th round. Here's his subsequent posting:



The transition from student to practitioner is not easy and we don't all want to go down the same route. Nevertheless, the lessons here have a general application. Sports chiropractic has a glamour and offers an obvious potential benefit to patients with a strong (some would say obsessive) competitive streak. As a general patient I may not fit that model. But I still need an answer to the question why I should trust you, the chiropractor, with something so fundamental to my well-being and happiness. Catherine offers her answer: "You have to back your own judgment during a multi-disciplinary debate, but you also have to interact with and learn from your medical colleagues as we all have the single aim of looking after the players in the best way possible."

She leaves me inspired but also asking myself whether we do enough to create a distinctive chiropractic identity that speaks to the public at large.

People

Bruce Walker honoured by the Australian government

IT WAS announced on Australia Day 2016 that associate professor Bruce Walker of Murdoch University Perth had been appointed a Member of the Order of Australia (AM). The award is made for achievement and merit in service to Australia or humanity.

Bruce graduated in 1975 from Melbourne. After graduation, he spent 30 years in clinical practice as a chiropractor in Melbourne and Townsville, Queensland, also completing a master's and a doctorate in public health. He has held a number of executive board positions in the Chiropractic College of Australasia, the United Chiropractors' Association, the Australian Chiropractors' Association and the Chiropractors' Association of Australia. One of his major achievements was the development of the Chiropractic & Osteopathic College of Australasia (COCA) - the leading vocational college for graduate chiropractors. It started in 1959 and now has over 1000 members nationally.

Bruce has long campaigned for chiropractic to become a part of mainstream allied health medicine and has encouraged the profession to ensure that science and research are at its core. Bruce himself has over 66 peer-reviewed articles which have been cited over 2,500 times.

He is editor-in-chief of the open access journal *Chiropractic & Manual Therapies*



(C&MT) which is supported by the European Academy of Chiropractic (the academic arm of the ECU) and is available for all ECU members. The other European partners in the C&MT venture are the Royal College of Chiropractors, where Bruce has just been elected a Fellow, and the Danish research institute NIKKB.

Bruce has also devoted much of his time in the past six years to researching the health and education needs of aboriginal peoples in the Pilbara region of Western Australia. An outcome of his work has seen advanced planning for a mobile health clinic for remote aboriginal communities. When fully funded, this Murdoch University project will add considerable value to the existing health and health education services available to aboriginal communities in these remote areas.

Bruce said that the award was a tribute to the chiropractic profession at large and in particular to those evidence-based chiropractors who have fearlessly pursued science and guided the profession in the right direction. He said the award was the result

of a team effort and belongs to all the very motivated and talented teams of people who supported him throughout his career and paid particular tribute to his wife Dr Alison Hogg.

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People

Obituary: Raymond Sandoz



Priska Haueter, President of Chirouisse writes:

RAYMOND SANDOZ passed away unexpectedly in January 2016, aged 86. In a full and rich life his influence on the chiropractic profession was immense. He made a considerable mark on several generations of Swiss, as well as international, chiropractors.

In Switzerland, he was instrumental in the legislation for chiropractic at both national and cantonal levels. He was a member of both the executive board of the Swiss Chiropractors' Association and the Intercantonal Examining Commission. He was responsible for developing continuing education and organised the postgraduate courses (CE courses) for chiropractors in Switzerland. He was one of the founders of the Annals of the Swiss Chiropractors' Association. From the very beginning, the courses and the Annals earned great recognition internationally. He

initiated and managed the central course for chiropractic assistants, the forerunner of the Swiss Chiropractic Academy and in 2001 he was made an honorary member of the Swiss Chiropractors' Association.

Internationally, Raymond lectured at many seminars and chiropractic colleges. His presentations were always scientifically based but also entertaining. He was respected and appreciated not only by the chiropractic profession, but also by other health authorities and legislators. He contributed significantly to the recognition and legislation of chiropractic in Europe. He actively sustained the evolution of the AECC in Bournemouth and of the ECU, where he held, among other duties, the position of president of the Professional Council for several years. We are proud to have known him and enriched by his wisdom.



Obituary: Simon Bird

Matthew Bennett, president of the BCA, pays tribute to a passionate and energetic chiropractor.

CHIROPRACTOR SIMON Bird, who has died aged 47, was one of the liveliest of his generation. Not only was he a highly-skilled chiropractor, but also an inspirational leader, a stirring speaker and a loving father. A 1998 graduate from AECC, he served with distinction on the BCA Council from 2012-14 and on the board of SOTO Europe. He was a regular on the lecture circuit at AECC and WIOC as well as BCA and ECU conferences.

He had boundless zest for being in practice, both the clinical and business side of things, which made him unusual amongst his peers. His energy had him up at five most mornings and practice meetings in his five clinics started early too.

To know Simon was to experience enthusiasm and fun. He was always looking to the future and trying to improve his own performance and that of those around him. His relaxed approach belied a keen and inquiring mind. His energy and insights shaped the lives of many chiropractors who will forever be in his debt. Simon combined his passion for his profession with compassion for his patients, transforming their lives. He was so young and had so much to give to the world; his patients must feel bereft at his untimely death.

Simon touched the lives of all who came in contact with him. A bright light has gone out and we will miss him greatly. Our thoughts go out to his loved ones.

Obituary: Lindsay Rowe

Stephen M Perle offers an appreciation of a life less ordinary

DR ROWE died of cancer on Monday January 25, 2016.

I was fortunate enough to meet him in the early 80s, when I was a student at Texas Chiropractic College. Lindsay had come to do a lecture; in an attempt to gain employment he was travelling around from college to college. He told us that as he travelled the US he would arrange meetings with the heads of radiology departments at medical schools. He would play 'name that disease' sharing his and the department chair's interesting cases. Only when this exercise was done would he reveal he was a chiropractor and not a medical physician. They were often dumbfounded because

they couldn't believe any chiropractor could read films as well as he could.

As he told us, they think we are stupid until proven intelligent, so prove yourself intelligent first.

Two years ago at the WFC biennial meeting in Durban, randomly I sat next to a doctor I didn't recognise; it was Lindsay – it had been 30 years after all. We had a lovely opportunity to see each other. For me it was the highlight of a great trip to Durban for FICS and WFC. I told him how I had successfully used that technique for years and had been teaching it to students for the past 25 years I've been an academic. He took great joy in hearing about this.

I recently heard an anecdote about when Lindsay was in medical school. One of his professors said, in what Lindsay described as a 'supercilious tone': "I heard you've written a textbook. You know that the average medical textbook sells 2,000 copies; mine has sold 3,000. How many copies did your book sell?" Lindsay said: "20,000."

Lindsay was someone who wanted to make a difference and while his textbook with Dr Yochum has clearly had an impact, anyone who interacted with him knew they were in the presence of someone who was extraordinary but never ever considered himself to be more than someone who was just, in his

understated way, trying to exceed expectations. He brought out the best in those he met, worked with and taught and he wanted our profession to be better than it knew.

Having dinner together in Durban is a special memory for me. Our profession will sorely miss him. I know we are all better chiropractors and our profession is immeasurably better because we were fortunate enough to have had Lindsay Rowe as one of us. I hope that everyone reading this, as Lindsay would want, thinks about how they can do better as a chiropractor and make our profession better – exceed expectations and make your life less ordinary.

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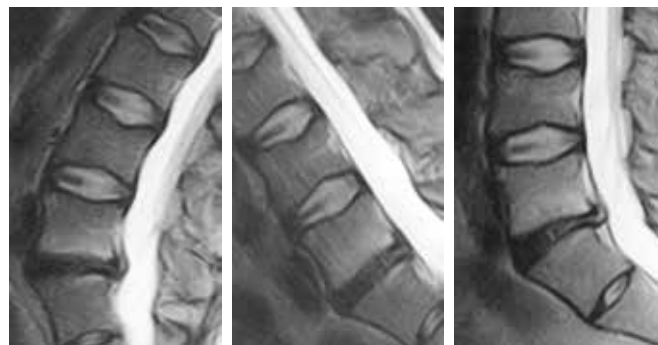
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The Concise Book of Trigger Points 3rd edition

Simeon Niel-Asher (2010) Lotus publishing; ISBN: 978-1-905367-51-1

THE FIRST chapter usefully targets self-help to those with trigger points (that's nearly all of us!). Trigger point therapy can be effective in a number of conditions so it's a refreshing start that the book targets the reader's potential pain first. One thing I do note at the end of this chapter is the list of potential signs and symptoms supposedly linked with possible sites of trigger points. Clearly some of these should remain conjecture only as I am not aware of strong evidence necessarily linking all of the conditions (for example cardiac arrhythmia associated with trigger points in pectoralis major) with particular trigger point positions, so would caution a little against assuming strong correlations in all cases.

The next chapter lays out an overview of skeletal muscle structure and physiology which is followed by a review of what trigger points are thought to be and how they might come about. This attempts, successfully in my view, to review what is known about the generation and maintenance of trigger points in a concise and accessible way with some nice unanswered research questions hopefully stimulating those

of you who might want to get on with that MSc or PhD you always meant to do! It goes on to explore classifications of trigger points and physical findings in a comprehensive fashion although the diagram of an 'ideal' sitting posture at the end of this chapter does tend to give the impression that such a thing exists whereas the reality is that there is little evidence that such an 'ideal' actually does.

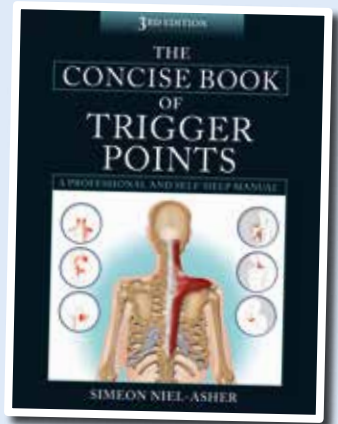
Chapters 4 and 5 look at therapeutic interventions whilst chapter 6 makes a somewhat courageous leap into the complexities and simplicities of chaos theory. Having published something on this area myself I was intrigued as to the suggestions put forward, particularly the notion that strange attractors of neural firing may help to maintain local and painful muscle contraction. However, notwithstanding the tentative use of complexity theory in this chapter, it's probably wise to keep this as an interesting possibility rather than fact at this stage.

The remainder of the book then goes on chapter by chapter to examine each of a large number of muscles with their associated common trigger points, an overview of

indications, causes (which perhaps should remain speculative in some cases), hands-on techniques and self-help as useful single- or double-page quick reference guides.

Overall then, this book is thin (always a good starting point for students), colourfully illustrated and well laid out, providing quick and easy reference to a whole range of muscles and associated trigger points. Whilst relying probably more on clinical experience than evidence in some areas and the forgivable whimsical leap into speculation, it does a good job in providing quick access to the identification and therapeutic modalities associated with these common and sometimes painful and disabling muscular phenomena.

David Newell



Does cervical lordosis change after spinal manipulation for non-specific neck pain? A prospective cohort study

Michael Shilton, Jonathan Branney, Bas Penning de Vries and Alan C Breen

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SPINAL MANIPULATION is a common treatment for mechanical or 'non-specific' neck pain but the mechanism(s) by which it affects pain remains unknown. One mechanism proposed in the literature is that neck pain might be alleviated by changing or 'correcting' the alignment of the cervical spine. This study aimed to determine whether cervical spine alignment changes to the lordotic curve occur after a course of spinal manipulation for neck pain.

Twenty-nine patients with mild-moderate neck pain of at least two weeks' duration had low-dose cervical spine x-rays taken while seated in a standardised position. X-rays were re-taken after a four-week course of spinal manipulation. Thirty healthy volunteers (no

neck pain) matched for age and gender also had cervical spine x-rays at baseline and at four weeks. On each of these x-rays the lordotic angle was measured to find out whether this angle had changed in the patient group, and whether any change was greater than that in the healthy volunteer group who received no treatment.

The study determined that this measurement method was reliable and that a measurement repeated could be expected to be within 3.6° of the original measurement.

No difference in cervical lordotic angle was found between patients and healthy volunteers and there was no significant change in lordotic angle in patients after four weeks of manipulation. In only four patients did the

change in lordotic angle exceed the minimum detectable change of 13.5°. This study's findings suggest that the angle of the cervical spine lordosis is not a good indication for treating mechanical neck pain with spinal manipulation.

While the measurement method was reliable and participant positioning highly standardised, the observer interpretation of x-rays may still have been an important source of measurement variability. Further, while no significant differences were found that does not preclude differences being detected in a study with a sufficiently large sample size.

Editor's note: This article has had over 2000 accesses



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