



## Chiropractic – Information for Healthcare Professionals - Research

Chiropractic is a primary health-care profession that specialises in the diagnosis, treatment and overall management of neuromusculoskeletal conditions that are due to mechanical dysfunction of the joints and muscles.

The profession has statutory regulation through the General Chiropractic Council (GCC); it is illegal to practise as a chiropractor without being registered with the GCC. [www.gcc-uk.org](http://www.gcc-uk.org)

The British Chiropractic Association (BCA) is the largest and longest-standing association for chiropractors in the UK, requiring the highest standards of education, training and conduct from its members.

### *Research and Researched Guidelines Support Chiropractic*

Numerous studies throughout the world have shown that chiropractic treatment, including manipulative therapy and spinal adjustment, is both safe and effective. Since 1990, there have been three Medical Research Council funded research projects - with results published in the BMJ – that have clearly demonstrated the efficacy and cost effectiveness of the chiropractic management of back pain. European-wide guidelines for the management of back pain reinforce the chiropractic approach. This is centred on: clinical assessment and triage, emotional support, exercise and using techniques such as manipulation and mobilisation.

[UK Beam Trial; Back pain, exercise and manipulation \(UK BEAM\) randomised trial: effectiveness of physical treatments for back pain in primary care. British Medical Journal Nov 2004; 329; 1377 \(doi: 10.1136 /bmj. 38282. 669225.AE\)](#)

The publication of the results of the United Kingdom back pain exercise and manipulation (UK BEAM) trial in the British Medical Journal highlight the benefits of including manipulation and/or exercise in the treatment of low back pain. The study involved 1334 patients with back pain who attended primary care settings throughout the UK. All participating practices were trained to offer patients 'best care' that consisted of advice to stay active, avoiding bed rest and to use 'The back book' (Roland M, Waddell G, Klaber Moffett J, Burton AK, Maine CJ, Cantrell T. The back book Norwich: Stationery Office, 1996).

Additionally, groups of patients were randomised to groups receiving exercise advice, spinal manipulation or manipulation followed by exercise advice. Chiropractors were amongst the practitioners administering the manipulation, which was delivered both within NHS and in private practice settings.

All interventions were compared with 'best care' and the result showed that manipulation and exercise achieved a significant benefit over and above that of 'best care' at three months and a smaller benefit at 12 months. Similarly, manipulation alone produced a benefit at three months and a smaller benefit at 12 months, whilst exercise alone achieved a small benefit at three months only. These benefits were all statistically significant, although there was no difference in outcome between groups receiving manipulation in private or NHS settings. There were no serious adverse events.

[Medical Research Council; 'Low Back pain of mechanical origin: randomised comparison of Chiropractic from hospital outpatient treatment'; Meade et al. British Medical Journal 2nd June 1990 - Volume 300 Pages 1431-1437.](#)

#### *Objective*

To compare chiropractic and hospital outpatient treatment for managing low back pain of mechanical origin on a randomised controlled trial basis involving 741 patients aged 18-65 who had no contraindications to manipulation and who had not been treated in the past month. The RCT was undertaken in Chiropractic and hospital outpatient clinics in eleven centres.

#### *Interventions*

Treatment provided at the discretion of the Chiropractors who used Chiropractic manipulation in most patients, or of the hospital staff who most commonly used Maitland mobilisation or manipulation, or both.

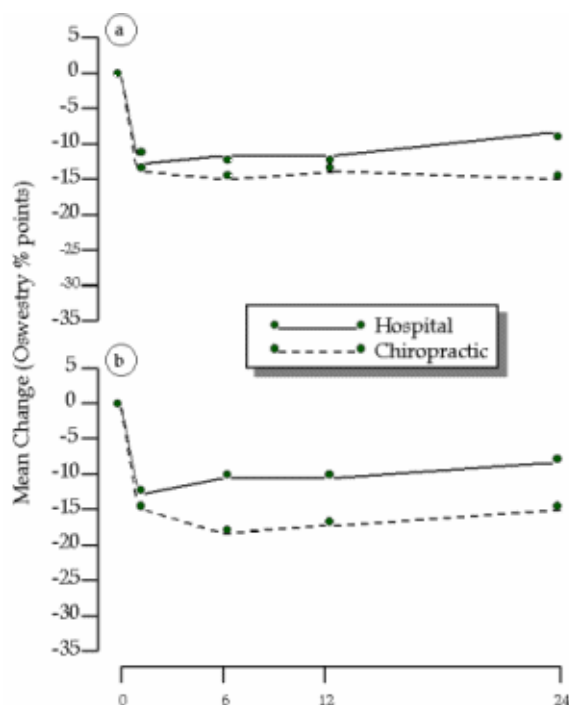
#### *Main outcome measures*

Changes in the score on the Oswestry pain disability questionnaire and in the results of tests of straight leg raising and lumbar flexion.

#### *Results*

Chiropractic treatment was more effective than hospital outpatient management, mainly for patients with chronic or severe back pain. The benefit of chiropractic treatment became more evident throughout the follow up period. Secondary outcome measures also showed that chiropractic was more beneficial.

Fig 1 - Mean changes in Oswestry scores: a = for all patients, b = for all patients who had been followed up for two years



### Conclusions

For patients with low back pain in whom manipulation is not contraindicated chiropractic almost certainly confers worthwhile, long term benefit in comparison with hospital outpatient management. The benefit is seen mainly in those with chronic or severe pain. Introducing chiropractic into NHS practice should be considered.

[Medical Research Council \(Follow-up-study\) Trial 'Randomised comparison of Chiropractic and hospital outpatient management for low back pain; results from extended follow up'; Meade et al.](#)

[British Medical Journal 5th August 1995 - Volume 311 - Pages 349-351](#)

### Objective

To compare the effectiveness over three years of chiropractic and hospital outpatient management of low back pain in 741 subjects aged between 18 and 64 years.

### Results

According to total Oswestry scores improvement in all patients at three years was about 29% more in those treated by chiropractors compared with those treated by the hospitals. The beneficial effect of chiropractic on pain was particularly clear. Those treated by chiropractors had more further treatment for back pain after the completion of trial treatment. Of those patients initially referred from chiropractors

and from hospitals more rated chiropractic helpful at three years than hospital management.

Figure 1 - Number (percentage) of patients at three year follow up considered allocated trial treatment had helped their back pain:

Referral	Hospital Treatment		Chiropractic Treatment	
	Help	No Help	Help	No Help
Hospital	71 (60.2)	47 (39.8)	103 (79.3)	27 (20.8)
Chiropractic	76 (65.5)	40 (34.5)	127 (84.7)	23 (15.3)

### Conclusions

At three years the results confirm the findings of earlier report (1990) that when chiropractic or hospital therapists treat patients with low back pain as they would in day to day practice those treated by chiropractic derive more benefit and long term satisfaction than those treated by hospitals.

### RCGP - Royal College of General Practitioners: Clinical Guidelines for the Management of Acute Low Back Pain

Following development of the CSAG Management Guidelines, in 1996 the Royal College of General Practitioners, in collaboration with the Chartered Society of Physiotherapy, Osteopathic Association of Great Britain, British Chiropractic Association and the National Back Pain Association, published brief Clinical Guidelines to assist General Practitioners in the management of acute back pain. The guidelines presented a synthesis of up to date international evidence and made recommendations on case management, primarily in the first six weeks of an episode. The guidelines present a diagnostic triage which enables differential diagnosis to be made between:

- simple back ache (non specific low back pain)
- nerve root pain
- possible serious spinal pathology.



The key recommendations relate to advice on staying active and consideration of manipulative treatment within the six weeks for patients who needed additional help with pain relief or who were failing to return to normal activities. The evidence base states 'the risks of manipulation are very low in skilled hands'. Bed rest is not recommended as a treatment for simple back pain. The guidelines were reviewed in February 1999 and again in 2001.

### Clinical Standards Advisory Group; Backpain Report 1994.

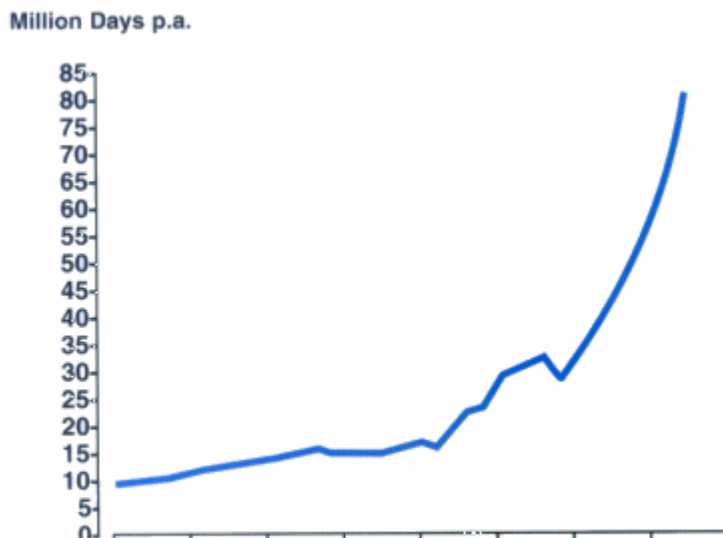
In 1992 the Clinical Standards Advisory Group (CSAG) was asked by the UK Health Ministers to 'advise on the standards of clinical care for, and access to and availability of services to NHS patients with back pain'.

CSAG examined the epidemiological evidence on back pain and noted that back pain is reported by about 60% of people at some time in their life. DSS statistics for 1991-1992 showed 81 million days Sickness and Invalidity Benefit paid for back incapacitates, estimated to have risen to 106 million days by 1993-94.

In 1993 there were about 14 million GP consultations for back pain. Approximately 1.6 million people attended a hospital outpatient clinic, a five-fold increase in the last decade. 1.0 Million were x-rayed. 1.0 million attended NHS physiotherapy departments. 480,000 attended Accident and Emergency Departments. 100,000 were admitted to hospital and a further 30,000 were treated as day cases. 24,000 had a surgical operation. In addition, approximately 0.5 million people attended for private medical consultations, 0.3 million attended a private physiotherapist, 0.7 million attended an osteopath and 0.3 million attended a chiropractor.

CSAG also commissioned from the Centre for Health Economics at York a study of the cost of back pain to the NHS and society as a whole. It estimated the annual cost of NHS services for back pain to be approximately £480 million in 1993. In addition, lost production costs are very approximately £3.8 billion and DSS benefits £1.4 billion.

*Figure 1 - Total British Sickness & Invalidity Benefit for back incapacities 1955 - 1992:*



In the absence of existing consensus guidelines on the early management of low back pain, CSAG reviewed the scientific evidence on the efficacy of interventions for low back pain and from this drew up management guidelines. The draft guidelines were tested during visits to a sample of Health Districts. CSAG found that the guidelines standards for urgent referrals were often being met, but that access to physical therapists was variable and generally inadequate.

CSAG recommended that the draft management guidelines should be widely disseminated and there should be increased support for the management of back pain in primary care and improved access to physical therapy and active rehabilitation. Back pain should become a key area for Health of the Nation and be a high priority for Research and Development.

*[Note: physical therapies are defined as physiotherapists, osteopaths and chiropractors].*

### Acute Back Pain - Primary Care Project; The Wiltshire and Bath Health Commission.

In 1995 the WBHC had identified £50,000 for a project to examine the implications of the CSAG Reports on back pain.

#### *Method*

89 GP practices in Wiltshire were circulated with the CSAG Management Guidelines for Acute Back Pain and were invited to submit bids for running a five month project. The bids covered the following areas:

- How the practice dealt with back pain; number of patients; consultations and referrals to secondary care
- How the practice proposed involving a chiropractor, osteopath, physiotherapist or other manipulative practitioner in their work.
- A practice protocol for the Management of Acute Back Pain.
- An audit protocol, including patient satisfaction, looking at methods and outcome of treatment
- How the practice propose to spend the funding it might receive.

The project was a success and provided an invaluable look at local data which although previously considered relevant, had never been quantified.

The data confirmed two important aspects of managing Wiltshire patients with acute back pain:

- Wiltshire GP's struggle to adequately treat back pain because there is no current satisfactory provision of therapy available within the NHS and they are not inappropriately referring acute back pain to secondary care.
- The funding required to provide a better service for patients is locked up in the 'system'. This is however not within the NHS, but within the DSS budget.  
(Copyright © the Wiltshire Health Authority - November 1996)

The study broadly confirms the recommendations of the Clinical Standards Advisory Group and an address was given to the World Federation in Chiropractic in Tokyo in June 1997 by Dr. Neil Scheurmier who was, at the time, the Primary Care Medical Advisor to the Wiltshire Health Authority.

[Carter JT, Birrell LN \(Editors\) 2000. Occupational health guidelines for the management of low back pain at work - principal recommendations. Faculty of Occupational Medicine. London.](#)

Occupational health guidelines for the management of low back pain at work - leaflet for practitioners. Faculty of Occupational Medicine. London. 2000. Waddell G, Burton AK 2000. Occupational health guidelines for the management of low back pain at work - evidence review. Faculty of Occupational Medicine. London.

The Guidelines are intended for health professionals undertaking the occupational health management of low back pain (LBP). They focus on interventions that might be considered appropriate for occupational health practitioners to implement. They are designed to complement and to be used in conjunction with the RCGP Clinical Guidelines for the Management of Acute Low Back Pain (Royal College of General Practitioners 1999).

[Chiropractic Treatment in Workers with Musculoskeletal Complaints; Mark P Blokland DC et al; Journal of the Neuromusculoskeletal System vol 8 No 1, Spring 2000](#)

Initiatives aimed at providing evidence through monitoring patient outcomes in the routine clinic setting, as opposed to the traditional research-based setting, are still in their infancy. This study adopts a practice-based observational research design and reports the outcomes of 103 patients presenting with musculoskeletal conditions referred by their employers to a chiropractor. Systematic documentation of self-reported outcomes provided evidence of a decrease in pain intensity, disability in daily living, work, and social activities, anxiety, depression, and work fear-avoidance beliefs. Evidence was also provided of patients' satisfaction with their treatment and perceived self-improvement. Documentation showed that all employees either remained working or returned to work within eight chiropractic treatments. These data support the feasibility of:

a referral system for workers with musculoskeletal complaints;  
documenting outcomes in the everyday practice setting; and  
developing datasets on which to base clinical effectiveness studies in the treatment of patients with musculoskeletal conditions.

[House of Lords Select Committee on Science and Technology report on Complementary and Alternative Medicine November 2000](#)

This Committee, chaired by Lord Walton of Detchant, prepared a report on CAM that addressed issues relating to education, training and regulation, and the provision of CAM within the NHS. The report was commissioned as a result of the widespread and increasing use of CAM across the world and the UK in particular. The report organised the therapies into three separate groups. Group 1 embraces the principal disciplines, including chiropractic, each of which claims to have an individual diagnostic approach.

(Group 2 includes therapies used to complement conventional medicine and do not purport to embrace diagnostic skills. Group 3 embraces those other disciplines which "purport to offer diagnostic information as well as treatment and which, in

general, favour a philosophical approach and are indifferent to the scientific principles of conventional medicine".)

The full report can be downloaded from [www.parliament.the-stationery-office.co.uk](http://www.parliament.the-stationery-office.co.uk)

[British Medical Association – General Practitioner Committee. Referral to Complementary Therapists – Guidance for GPs. March 2006](#)

The BMA welcomes the greater use of the range of specialist skills within the health service; chiropractic, acupuncture, osteopathy, homeopathy and herbalism. A GP may suggest patients visit a particular type of therapist without actually making a formal referral and may then offer to recommend a suitable individual.

[Musculoskeletal Services Framework – Department of Health. July 2006](#)

The main treatment interventions, as recommended by the current evidence review and that of clinical guidelines is a biopsychosocial approach: a) Guidance on activity, lifestyle, prognosis and prevention. b) **Physical treatments drawn from all types of manual therapy, spinal manipulation and rehabilitation exercise.** c) Advice about pain control, including non-prescription medication. d) Psychosocial interventions aimed at resolving cognitive barriers to recovery.

[Non-rigid stabilisation procedures for the treatment of low back pain – National Institute for Health and Clinical Excellence. June 2006](#)

States that chiropractic intervention can be used in the treatment of acute low back pain.

[European guidelines for the management of acute nonspecific low back pain in primary care. 2005](#)

Recommends the consideration of spinal manipulation for patients failing to return to normal activities.

[For more information or to find a BCA chiropractor in your area:](#)

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