The Status of Chiropractic in Europe: a position paper

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Introduction

Chiropractic is a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system and the effect of those disorders on the function of the nervous system and on general health. There is an emphasis on manual treatments including manipulation or adjustment[1].

By restoring normal function to the musculoskeletal system chiropractors can play a major part in relieving disorders and any accompanying pain or discomfort arising from accidents, stress, lack of exercise, poor posture, illness and everyday wear and tear.

Chiropractors take a biopsychosocial approach to health and wellbeing; this means that they consider the physical, psychological and social aspects of health. This approach is consistent with the World Health Organization's definition of health[2].

Chiropractic has existed as a health profession in Europe since the early part of the twentieth century. For over 80 years it has been represented in Europe on a supra-national level by the European Chiropractors' Union.

Article 168 of the Treaty on the Functioning of the European Union[3] demands that '*a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*'. It further states that '*Union action…shall be directed towards*

[1] World Federation of Chiropractic definition of chiropractic, 2001
[2] The World Health Organization defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946, signed on the 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no 2, page 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948.
[3] Consolidated version of the Treaty on the Functioning of the European Union (1957). Official Journal of the European Union C115/50

improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health.'

Significantly, the Treaty goes on to state, '*The Union shall encourage co-operation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage co-operation between the Member States to improve the complementarity of their services in cross border areas*'.

In 2007, the EU adopted a comprehensive Health Strategy[4]. This set out three strategic objectives in order to meet the major challenges facing health in the EU:

1. Fostering good health in an ageing Europe;
2. Protecting citizens from health threats;
3. Supporting dynamic health systems and new technologies.

One of the key themes of the Health Strategy is to create systems to support dynamic and sustainable health systems. This necessitates actions to promote health and prevent disease throughout life.

The Global Burden of Disease Study 2010 (GBD 2010)[5] is the largest ever study to describe the global distribution and causes of a wide array of major disease, injuries and health risk factors. Musculoskeletal conditions were shown to be the second greatest cause of disability globally. They affect over 1.7 billion people worldwide and have the fourth greatest impact on the overall health of the world population, considering both death and disability. GBD 2010 showed that that low back pain is the leading cause of disability and that osteoarthritis is one of the fastest growing conditions.

There are calls around the world for policy changes to address the growing burden of musculoskeletal conditions in general and spinal pain in particular. With the burden having

[4] Together for Heath: A Strategic Approach for the EU 2008-2013. COM 2007 630 final, Brussels. Accessed at http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf.
[5] Vos T, et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet 2012 December 15; 380 (9859): 2163-2196

grown by over 45% in the past 20 years, it is critical that emerging health professions such as chiropractic are included as part of a solution to what is an endemic health concern.

The provision of chiropractic care varies widely throughout Europe. While in some nations chiropractic is established and the public has access to state-reimbursed services from chiropractors, in others chiropractic is unrecognised, unregulated and marginalised. With in excess of 5000 chiropractors practising in Europe to internationally accepted standards of education, the profession is well placed to contribute to the health of European citizens and the promotion of musculoskeletal health.

This paper sets out the status of chiropractic in Europe. It is designed to be a living document, which will be updated as new developments in health policy, research, legislative frameworks and chiropractic education are introduced.

Foreword

Chiropractic is represented in over 90 countries throughout the world. From relatively primitive beginnings, it has evolved as a profession such that there are now in excess of 100,000 chiropractors worldwide.

The European Chiropractors' Union (ECU) is a federation of 20 member national associations. As its President, I am proud to lead an organisation that represents the chiropractic profession on a supranational level and is committed to its development in Europe. With a focus on legislation, regulation, education and research, the ECU seeks to promote access to safe and effective chiropractic services throughout Europe.

It is my vision for chiropractic to be available to all European citizens, regardless of their ability to pay. Its emergence as a profession committed to high standards of education, research and cost-effective healthcare means that in a society where musculoskeletal conditions and associated disability contribute so massively to the burden of disease, chiropractic should be included in the health systems of every European country.

I hope that this position paper will help inform policy-makers and assisting them in recognising the contribution that chiropractic can and does make to the health of Europeans.

Øystein Ogre DC
ECU President
May 2013

European Chiropractors' Union

The European Chiropractors' Union (ECU) is a federation of 20 member national associations (see Table 1).

The ECU was established in 1932 by Belgium, Denmark, Great Britain and Switzerland with the aims of promoting and expanding chiropractic in Europe and the welfare of practising chiropractors. It currently represents the interests of approximately 5000 chiropractors across Europe.

Table 1: Member National Associations, ECU

Country	National Association	Country	National Association
Belgium	Belgian Chiropractors' Union	Italy	Associazione Italiana Chiropractici
Cyprus	Cyprus Chiropractic Association	Liechtenstein	Liechtenstein Chiropractic Association
Finland	Finnish Chiropractors' Association	Luxembourg	Chiroletzebuerg
France	Association Française Chiropractique	Norway	Norwegian Chiropractic Association
Germany	German Chiropractors' Association	The Netherlands	Netherlands Chiropractic Association
Great Britain	British Chiropractic Association	Poland	Polish Chiropractic Association
Greece	Hellenic Chiropractors Association	Spain	Asociacion Espanola Quiropractica
Hungary	Hungarian Chiropractors' Association	Sweden	Swedish Chiropractic Association
Iceland	Icelandic Chiropractic Association	Switzerland	Chirosuisse
Ireland	Chiropractic Association of Ireland	Turkey	Turkish Chiropractic Association

The General Council of the ECU is made up of one representative from each of the Union members. It elects an Executive Council, which currently consists of a President, two Vice-Presidents, a Secretary and a Treasurer[6].

The ECU is registered in the Netherlands. It maintains offices in London, where it employs the

[6] Pictured is the 2012-2013 ECU Executive Council. From left: Francine Denis (second vice-president); Franz Schmid (first vice-president); Øystein Ogre (president); Richard Brown (secretary); Vasileios Gkolfinopoulos (treasurer)

services of support staff to administer the work of the ECU and its academic arm, the European Academy of Chiropractic.

Mission statement

The ECU is established to promote the development of chiropractic in Europe as well as to pursue the interests of chiropractic as a science and a profession by research, teaching, publications and research activities. It represents the chiropractic profession on a supranational level.

Objectives

1. To secure legislation in European countries that do not currently have it;
2. To harmonise legislation across Europe that conforms to and embraces the ECU's professional and educational standards;
3. To promote patient safety and the quality and accessibility of chiropractic healthcare in Europe;
4. To support the establishment of full time, university based education programmes to Masters level that conform to the European Council on Chiropractic Education (ECCE) standards.
5. To represent and defend the principles of the chiropractic profession throughout Europe;
6. To be the political representative body of the chiropractic profession within the European Union;
7. To support and develop a high quality programme of research within Europe.

Undergraduate chiropractic education in Europe

There are currently eight educational institutions providing chiropractic education in Europe. These are set out below in Table 2.

The European Council on Chiropractic Education (ECCE)[7] is an autonomous organisation established by the chiropractic profession in Europe to accredit and re-accredit institutions providing undergraduate education and training. The principal goal of the ECCE is to assure the quality of chiropractic undergraduate education and training against a set of educational standards. Its current President is Tim Raven (pictured below).

The Standards are intended for use by chiropractic institutions, both in the public university and private sectors, predominately (but not exclusively) in Europe, as part of institutional self-evaluation, by the ECCE for external review of institutions and by international committees and bodies involved in the recognition and accreditation of chiropractic institutions worldwide.

Once an institution has demonstrated that it is in substantial compliance with the Standards and has graduated its first cohort of students, the institution is accredited for up to five years. Prior to full accreditation an institution may apply for candidate (for accredited) status; the maximum period an institution can hold candidate status is five years.

The ECCE is, together with the US, Canadian and Australasian Councils on Chiropractic Education (CCEs), a founding member of the Councils on Chiropractic Education International (CCEI)[8]. It is the only external quality assurance agency for chiropractic education and training in Europe that is a member of CCEI and recognised by the

[7] European Council on Chiropractic Education (ECCE). Accessed at www.cce-europe.com
[8] International accreditation standards published by CCEI can be accessed at http://www.cceintl.org/uploads/2010-04-26_CCEI_International_Chiropractic_Accreditation_Standards_vfd_5_09.pdf

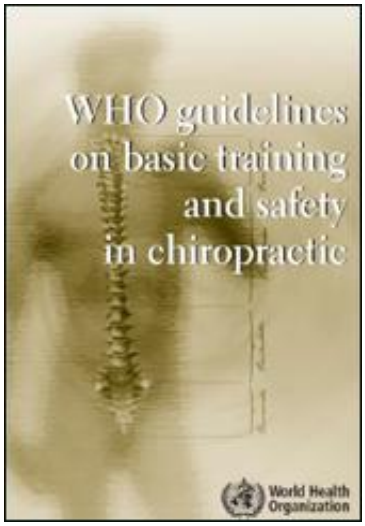
chiropractic profession and other CCEs world-wide, and that adheres to the CCEI International Chiropractic Accreditation Standards.

The ECCE is a member of the European Association for Quality Assurance in Higher Education (ENQA) and adheres to the Standards and Guidelines for Quality Assurance in the European Higher Education Area[9] (ESG).

Table 2: Educational institutions in Europe

Institution	Location	Website	ECCE status?
Anglo-European College of Chiropractic	Bournemouth, UK	www.aecc.ac.uk	Full
Barcelona College of Chiropractic	Barcelona, Spain	www.bccchiropractic.es	Candidate
Institut Franco-Europeen de Chiropractique Francaise	Paris, France	www.ifec.net	Full
McTimoney College of Chiropractic	Abingdon, UK	www.mctimoney-college.ac.uk	Candidate
RCU Escorial Maria Cristina	Madrid, Spain	www.rcumariacristina.com	Full
Syddansk Universitet Odense	Odense, Denmark	www.sdu.dk	Full
Welsh Institute of Chiropractic	Glamorgan, UK	www.glam.ac.uk	Full
University of Zurich	Zurich, Switzerland	www.balgrist.ch	No

Although not currently accredited with ECCE, in Switzerland, chiropractic students train alongside medical students and undertake a six year programme of study. The programme and award is recognised within the Swiss Federal Law on medical professions (MedBG).



The World Health Organization has published Guidelines on Basic Training and Safety in Chiropractic[10]. Part I of the guidelines covers basic requirements for different training programmes, each one designed for trainees with various educational backgrounds, including non-medics, physicians wishing to use chiropractic and primary health care workers. This part provides a reference for the establishment of various training programmes, particularly where no formal education degree has been established. Part II of the guidelines deals with the safety of spinal manipulative therapy and the contraindications to its use.

[9] ENQA. Standards and Guidelines for Quality Assurance in the European Higher Education Area (2009) Helsinki. Accessed at http://www.enqa.eu/files/ESG_3edition%20(2).pdf.
[10] WHO Guidelines on Basic Training and Safety in Chiropractic. Accessed at http://apps.who.int/medicinedocs/documents/s14076e/s14076e.pdf

Postgraduate chiropractic education in Europe

Each year the ECU hosts a scientific convention which attracts delegates from throughout Europe and the rest of the world. This event is a highlight in the European academic calendar and brings together chiropractors from each of the ECU's 20 member nations.

The ECU actively promotes postgraduate chiropractic education (Graduate Education Programmes and continuing professional development) in Europe through the European Academy of Chiropractic (EAC). It aims to expose chiropractors to current best practice, by stimulating reflective learning and by acting as a conduit for research activity. In doing so, the EAC contributes to the facilitation of safe, evidence-based and optimum standards of care.

The EAC hosts post-graduate seminars throughout Europe as well as an annual Graduate Education Programme seminar.

The Dean of the EAC is Martin Wangler (pictured). He heads a Governing Council comprising a Dean, Registrar, Director of Academic Affairs, Secretary General, Chair of the ECU Research Council, ECU Convention Academic Organiser and ECU President.

The objects of the EAC are as follows:

1. To develop key professional competencies through lifelong learning;
2. To provide and co-ordinate access to high quality sources of knowledge and skills;
3. To encourage and actively support the acquisition by chiropractors of higher level postgraduate qualifications and EAC Fellowship awards;

4. To facilitate the formation and development of Graduate Education Programmes (GEP) by national associations;
5. To provide a platform to bring together parties with a diversity of experience and expertise to enable the sharing of best practice;
6. To raise quality standards across the profession and enhance chiropractic's contribution to a healthier society by facilitating a collaboration of European national chiropractic associations, educational institutions, researchers and postgraduate educational providers.

With the Chiropractic and Osteopathic College of Australasia and the Royal College of Chiropractors, the EAC co-owns the online peer-reviewed journal *Chiropractic and Manual Therapies*.

This high quality online journal aims to provide chiropractors, manual therapists and related health professionals with clinically- relevant, evidence-based information. All articles published by *Chiropractic and Manual Therapies* are made freely and permanently accessible immediately upon publication without subscription charges or registration barriers.

There are also a number of other post graduate educational organisations in Europe. These include the Royal College of Chiropractors (UK), the National Institute for Chiropractic and Clinical Biomechanics (Denmark) and the Swiss Chiropractic Academy.

Standardisation of Chiropractic Services

A European Standard (EN) is a standard that has been adopted by one of the three recognised European Standardisation Organisations: CEN, CENELEC and ETSI. It is produced by all interested parties through an open, transparent and consensus based process.

European Standards are one of the key components of the Single European Market. A standard represents a model specification, a technical solution against which a market can trade. It codifies best practice and the state of the art.

Chiropractic was the first health profession to be subject to a European Standard. In 2012, following three years of preparation and the consensus of the chiropractic profession in Europe, the Standard for Healthcare Provision by Chiropractors was published. The reference for this Standard is EN 16224:2012.

This CEN Standard is a landmark document. It sets out what the public should expect from a chiropractor: educationally, professionally and ethically. Importantly, it acts as a guide to those countries seeking statutory recognition and acts as a model template for legislators.

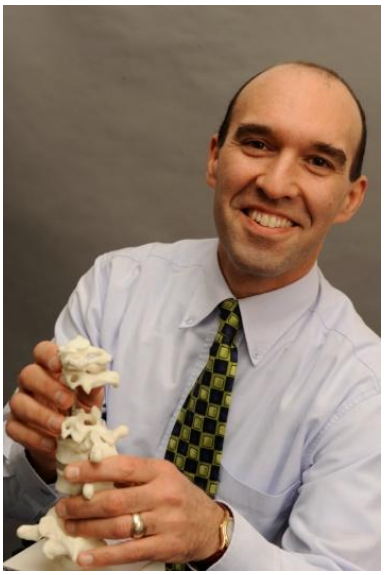
The ECU has adopted the CEN Standard for Healthcare Provision by Chiropractors and has incorporated its Code of Ethics as a dedicated ECU Code of Good Practice[11].

The ECU encourages formal adoption of the Standard by each of its member national associations. It is particularly important that this is the case in countries without chiropractic legislation, so that the Standard can become the default guideline for healthcare provision by chiropractors.

[11] ECU Code of Good Practice. Accessed at http://www.chiropractic-ecu.org/userfiles/files/ECU%20Documents/Code%20of%20Good%20Practice-ECU.pdf

ECU Research Support and Promotion

The promotion of research is a core objective of the ECU. Of each per capita fee that is received by the ECU, a proportion is ring-fenced to fund research. The Chair of the ECU Research Council is Dr Sidney Rubinstein PhD (pictured). He sits as a permanent observer at meetings of the ECU General Council and holds a position as a member of the Governing Council of the European Academy of Chiropractic.



The purpose of the European Chiropractors' Union Research Council is to promote and support scientific research which will improve the knowledge, understanding and practice of chiropractic. Pursuant to a directive ratified by the ECU General Council, the Research Fund is administered by the ECU Research Council. It ensures that correctly submitted applications for research funding have been properly scrutinised and considered prior to formally communicating any recommendations to the ECU General Council.

Each year at its Convention, the ECU hosts a Researchers' Day. This unique event brings together chiropractic researchers from across Europe to discuss ongoing projects, identify areas for future research and to share best practice.

The ECU supports a wide range of projects, granting in excess of €100,000 per year. These include multi-centre trials, PhD projects, systematic reviews and other innovative research.

Table 3 below shows examples of ongoing projects being supported by the ECU Research Fund:

Table 3: Projects currently supported by the ECU Research Fund

Project title	Researcher(s)	Object of study
Morphology and age-related osteoarthritic changes in cervical spine	Uhrenholt L	To investigate characteristics of lower cervical facet joints in subjects aged 20-79
Descriptive study on maintenance chiropractic care on persistent and recurrent LBP patients	Jensen I, Axen I	To describe long term course of patients who have been defined by chiropractors to be suitable for maintenance care.
The relative impact of biopsychosocial factors as predictors of outcomes in patients treated by chiropractors for neck and low back pain.	Ailliet A	To examine the relative contribution of the biopsychosocial model in predicting a poor outcome in patients undergoing chiropractic care for neck and/or low back pain.
The effects of manipulation on cervical spine intervertebral motion patterns and patient reported outcomes.	Breen A, Bolton J, Bronfort G, Branney J	To investigate whether spinal manipulation can improve or normalise aberrant vertebral motion in patients with chronic mechanical neck pain.
Outcomes after chiropractic treatment for patients with low back pain with and without leg pain or neck pain with or without arm pain.	Humphreys K, Peterson C, Muhlemann D, Bolton J	To investigate how different subgroups of patients with LBP or neck pain respond to chiropractic at various time intervals.
Magnetic resonance imaging of the synovial folds of the lateral atlantoaxial joints following whiplash injury	Webb A, Dareker, Sampson	To determine whether changes in the size and signal intensity of the synovial folds of the lateral atlantoaxial joints are present to a greater extent in patients with whiplash associated disorder compared to healthy control subjects.
Normal biomechanics of the lumbar spine – a quantitative fluoroscopy and electromyography study	Breen A, du Rose A	To determine the normal numerical reference limits and relationships between intervertebral motion patterns, erector spinal muscle electrical activity, age and degree of disc degeneration during lateral bending in the lumbar spine and whether chiropractic motion palpation can detect variations.
Evaluation of costs and outcomes in low back patients undergoing chiropractic and general practitioner care in Switzerland.	Houweling T, Humphreys K	To investigate the costs, cost-utility and outcomes in low back pain patients undergoing routine chiropractic and general practitioner care.
Towards measuring the spinal manipulable lesion: comparing neck function in patients without neck pain to those with neck pain before and after HVLA manipulation	Osborne N, Docherty S	To investigate whether there is any difference in function between neck pain patients, before and immediately after spinal manipulation compared to a control group.
Establishing a research agenda for chiropractic in Europe.	Rubinstein S, Hartvigsen J, Bolton J, Webb A, van Tulder M	To establish a research agenda for the chiropractic profession in Europe through consensus involving a Delphi process.

In 2012, the General Council approved a proposal from the Executive Council to financially support the establishment of national chiropractic research foundations in the form of a start-up grant. Financial support has already been granted to the member national chiropractic associations of Norway, France, Sweden and Great Britain. This will both stimulate the growth of research activity and develop the body of knowledge, thus benefiting patients, the public and society.

Public Health

The ECU is committed to contributing to public health in Europe. It recognises the value of healthy populations in determining the economic prosperity of nations, labour supply and public spending. It fully supports the European Commission's commitment to investing in health to contribute towards the Europe 2020 objective of smart, sustainable and inclusive growth.

The ECU recognises that in the field of musculoskeletal health there remain inequalities across Europe in terms of access to effective care. Poor and disadvantaged people die younger and suffer more from disability and disease. The ECU is committed to expanding the availability and accessibility to chiropractors throughout EU and EEA member nations.

With spending on health outstripping GDP growth, to the extent where it is estimated that it will have risen by a third by 2060, there is a need to transform health systems[12]. The ECU maintains that the chiropractic profession should be part of this transformation.

It has a dedicated Public Health Committee (PHC), whose terms of reference are as follows:

a. To be responsible for advising the General Council on public health matters as they relate to chiropractic in general and spine care in particular.

b. To be responsible for advising the General Council on ways in which the ECU can (i) work on public health projects and (ii) forge alliances with other organisations in support of common health objectives.

c. To be responsible for the development, maintenance, review and dissemination of an ECU public health toolkit, which outlines a strategic course for chiropractic's active involvement in programmes, including the

[12] Brown RA. A health system in transformation: making the case for chiropractic. Chiropractic and Man Therapies 2012, 20: 37 doi:10.1186/2045-709X-20-37

identification of key public health priorities, advocacy opportunities and operational strategies for the improvement of health.

d. To collaborate with other committees of the ECU as appropriate for the furtherance of the ECU's objects.

The ECU Public Health Committee is chaired by Baiju Khanchandani (pictured). He is supported by committee members from across Europe.

There are a number of current areas of interest, including ensuring that there is recognition for chiropractors in a European classification of occupations (ESCO).

The ECU is a member of the European Public Health Alliance (EPHA)[13], the leading European non-governmental organisation (NGO) advocating for better health. EPHA is a non-profit organisation which is based in Belgium and includes public health NGOs, patient groups, health professionals and disease groups working to improve health and strengthen the voice of public health in Europe.

EPHA monitors the policy-making process within the EU institutions and supports the flow of information on health promotion and public health policy developments.

The ECU is an associate body of SOLVIT[14], a Department of the European Commission. SOLVIT is an online problem-solving network in which EU Member States work together to solve issues relating to misapplication of Internal Market law within the EU and EEA.

One example of a successful European public health initiative has been the Straighten Up campaign. The Straighten Up program is a bold and innovative health promotion initiative designed to empower the people everywhere toward better spinal health and an improved quality of life.

[13] European Public Health Alliance. Accessed at http://www.epha.org

[14] SOLVIT. Accessed at http://ec.europa.eu/solvit/site/about/index_en.htm

Consisting of a set of simple exercises and taking just minutes to complete, Straighten Up helps improve posture, stabilise core muscle groups, enhance health and prevent spinal disability. It can be completed quite briefly as a regular day-to-day practice. The 2-3 minute routine can counter poor posture, which is a common trigger for general back pain and can be undertaken by all ages.

Studies undertaken have shown that after adopting the routine each day over a five week period, the posture of participants (who ranged in age from teenagers to those in their eighties) improved in eighty per cent of cases. Another 78% reported that they had strengthened their core muscles, whilst 80% reported that they sat and stood more upright whilst saying that their backs felt more comfortable.

The ECU contributes to a number of Europe-wide public health consultations. These are summarised in Table 4 below.

Table 4: ECU participation in European public health consultations

	Date of response
Public consultation on the implementation of European Reference Networks (ERN) under the framework of Directive 2011/24/EU on the application of patients' rights in cross border healthcare.	2013
Consultation on EU VAT Exemption	2013
EU Small and Medium Enterprise consultation	2012
WHO-Europe Health 2020 Questions	2012
Green Paper on modernising the Professional Qualifications Directive	2011
EU VAT Consultation	2011
EU Recognition of Professional Qualifications	2011
Competitiveness and Innovation Framework Programme	2011
EU Single Market consultation	2011
Green Paper on the European Workforce for Health	2009
EU DG SANCO, Future Challenges Consultation	2008
EU Health Portal Reply	2007
EU White Paper, Sports, Survey Reply	2007
EU Telemedicine Survey	2007
EU Community Action Survey	2007

Legislative and Regulatory Status of Chiropractic in Europe

There is wide variation between the legislative and regulatory status of chiropractic in Europe. This inequality creates issues for both patients and practising chiropractors.

Table 5 (below) shows the current status of chiropractic within Europe[15], while Figure 1 displays the status on a geographical level.

What is clear is that chiropractic can be practised legally in many EU member nations, either pursuant to specific legislation or pursuant to general law. In countries that benefit from dedicated legislation, there is statutory registration and protection of title. This serves to protect patients and assure the public that those using the title chiropractor satisfy set standards of competency and education.

It is one of the ECU's primary objectives to promote the statutory regulation of chiropractors throughout Europe. The successful completion of the CEN Standard for Healthcare Provision by Chiropractors sets in place a template for those countries seeking legislation.

The existence of Masters level programmes of study, offered by educational institutions accredited by the European Council on Chiropractic Education, itself a member of the European Association for Quality Assurance in Higher Education (ENQA)[16], should assure government representatives that chiropractic as a distinct healthcare profession is both structured and of high quality.

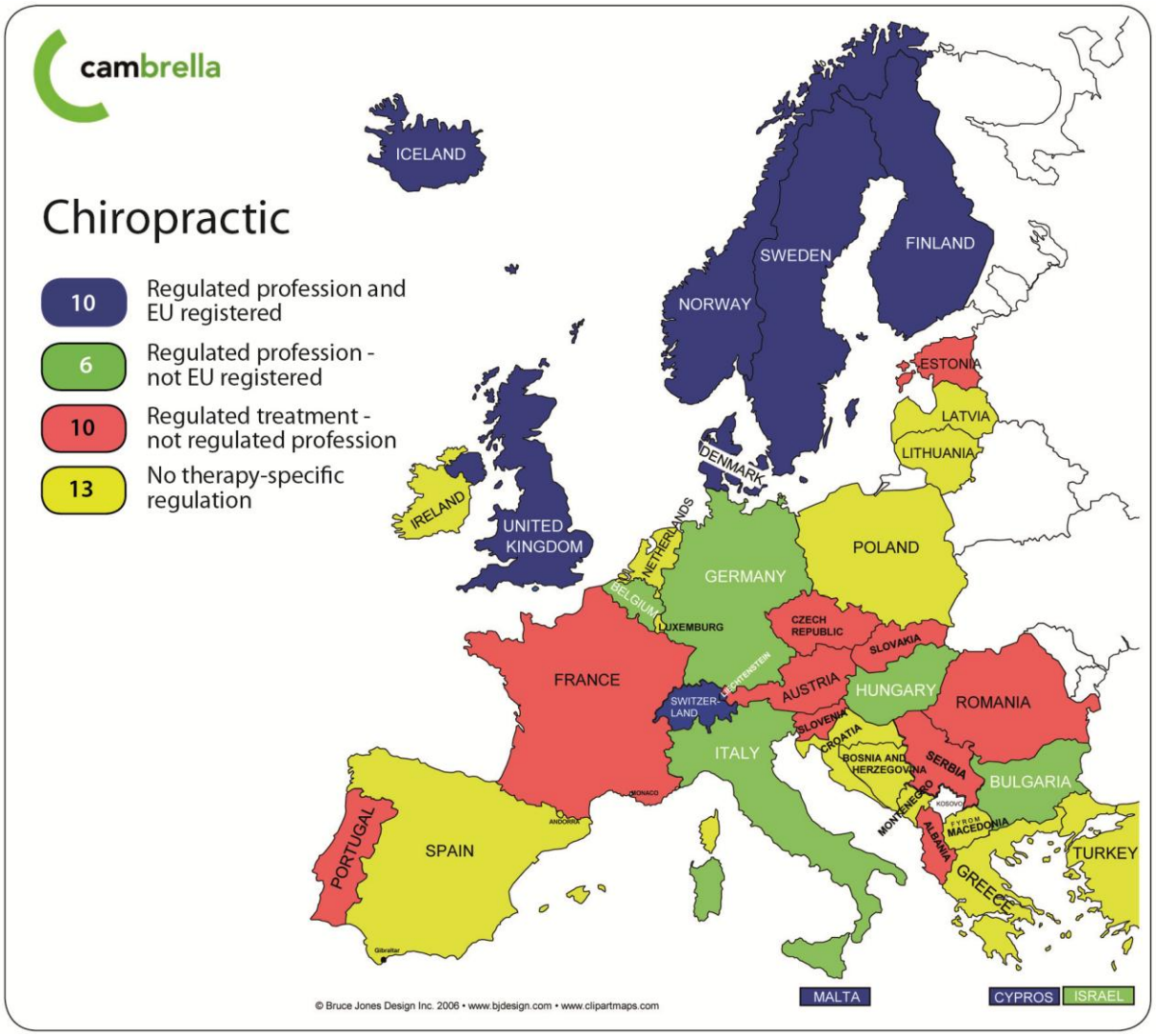
European citizens seeking effective musculoskeletal healthcare in the form of chiropractic have the right to protection by statutory legislation. Such legislation should provide provision for the establishing of a register, protection of title, fitness to practise procedures, educational standards, and standards of conduct and proficiency.

[15] Source: World Federation of Chiropractic. Accessed at http://www.wfc.org
[16] ENQA disseminates information, experiences and good practices in the field of quality assurance (QA) in higher education to European QA agencies, public authorities and higher education institutions. Accessed at http://www.enqa.eu.

Table 5: Legal status of European member nations

Country (*denotes ECU member) (^ denotes EU member)	Legal pursuant to legislation to accept and regulate chiropractic practice	Legal pursuant to general law	Legal status unclear, but de facto recognition	Legal status unclear and risk of prosecution
Austria^				✓
Belgium*^	✓			
Bulgaria^				
Croatia		✓		
Cyprus*^	✓			
Czech Republic^				
Denmark^	✓			
Estonia^		✓		
Finland*^	✓			
France*^	✓			
Germany*^		✓		
Greece*^			✓	
Hungary*^				✓
Iceland*	✓			
Ireland*^		✓		
Italy*^	✓			
Latvia^				
Lithuania^				
Liechtenstein	✓			
Luxembourg^		✓		
Malta^	✓			
Netherlands^		✓		
Norway	✓			
Poland*^		✓		
Portugal^	✓			
Russian Federation		✓		
Romania^			✓	
Serbia	✓			
Slovakia^		✓		
Slovenia^				
Spain*^			✓	
Sweden*^	✓			
Switzerland*	✓			
Turkey*			✓	
United Kingdom*^	✓			

Figure 1: Recognition of chiropractic in Europe



Regulated profession and EU registered (10)	Regulated profession Not EU registered (6)	Regulated treatment Not regulated profession (10)	No regulation (13)
Cyprus	Belgium	Albania	Bosnia & Herzegovina
Denmark	Bulgaria	Austria	Croatia
Finland	Germany	Czech Republic	Greece
Iceland	Hungary	Estonia	Ireland
Liechtenstein	Israel	Romania	Latvia
Malta	Italy	Serbia	Lithuania
Norway	France	Slovakia	Luxembourg
Sweden	Portugal	Slovenia	Macedonia
Switzerland			Montenegro
UK			Poland
			Spain
			The Netherlands
			Turkey

ECU Members: status country by country

Belgium

National Association:
Belgische Vereniging van Chiropractors / Union Belge des Chiropractors
Rugcentrum Gent
De Pintelaan 262
9000 Gent, Belgium
http://www.chiropraxie.org

President
Thyl Duhameeuw
(thyl.duhameeuw@gmail.com)

Demographics

Population:	10,444,268
No. of chiropractors	105
Ratio	1:99,469

History and legal status

The first chiropractors in Belgium started practising in the 1920s and established a journal, *The Belgian Chiropractor*, which was distributed around Europe. Belgium was instrumental in the formation of the European Chiropractors' Union in 1932, when it also established its national association.

Despite opposition from the medical profession, the Belgian Chiropractors Union was successful in obtaining a framework for legislation in 1999.The Chamber of Chiropractic was established based on the Colla Law[17] in 1999, which recognised what were considered the four main complementary health professions.

A Royal Decree was passed in the Belgian Parliament on 12 September 2011 to establish the Chamber of Chiropractic. A Paritary Commission has also been established by Royal Decree on 27 March 2012 to whom recommendations are passed by the Chamber for onward approval by the Minister of Health.

[17] The Colla Law was named after the then Health Minister in Belgium, Marcel Colla.

Pending Ministerial approval, several Royal Decrees in relation to the legal practice of chiropractic (registration, minimum standards of education, practice guidelines, code of ethics) will follow in due course.

Cyprus

National Association:
Syndesmos Heiropracton Kyprou
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Apt. 302 1086
Lefkosia
www.cypruschiropractic.org

President:
Stathis Papadopoulos
epeco@spidernet.com.cy

Demographics:

Population:	838,897
No. of chiropractors:	13
Ratio:	1:64,531

History and legal status

Chiropractic in Cyprus was established in 1967 courtesy of Dinos Ramon, a graduate of Palmer College of Chiropractic. The Cyprus Chiropractic Association was founded in 1984.

As a result of a Court case involving the successful prosecution of the current Vice-President of the Cyprus Chiropractic Association, Phylactis Ierides, for practising medicine without a license, moves to gain statutory recognition were started.

Despite only having three chiropractors at the time when the push for legislation was commenced, Cyprus saw a law passed in 1991, when the Chiropractors' Registration Bill was passed into law.

To legally practise in Cyprus, chiropractors must hold a recognised qualification. It is a criminal offence to practise chiropractic in Cyprus, without being registered.

The Basic Chiropractic Law of 1991 has recently been amended by the Chiropractic (Amendment) Law (62)(12), 2012, which came into effect on 23 October 2012.

The Chiropractic (Amendment) Law establishes a regulatory framework, developing the Basic Chiropractic Law of 1991. This framework comprises the following elements:

1. A statutory regulatory body, to be known as the Chiropractic Council comprising up to five members: three registered Chiropractors and two Ministerial representatives (one of whom shall be from Ministry of Health). Members of the Chiropractic Council shall be appointed by the Council of Ministers.
2. Protection of Title, with illegal use subjected to a fine of up to €1000 and/or up to six months' imprisonment.
3. Mandatory recording of patient records to be held in one of the official languages of the Republic of Cyprus (Greek or Turkish).
4. Fitness to Practise procedures. The Law creates a Disciplinary Council, comprising two lay members appointed by the Attorney General and three chiropractic members appointed by the national chiropractic association.
5. Compulsory membership of the Cyprus Chiropractic Association. The Law permits only a single national chiropractic association.

The Cyprus Organization for Standards (CYS) has adopted the English language version of the CEN Standard (EN 16224 Health Provision by Chiropractors) approved on 10 May 2012.

Finland

National Association:
Suomen Kiropraktikkoliitto
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Finland
www.kiropraktiikka.org

President
Roope Rinta-Seppälä
roope@kirocenter.fi

Demographics

Population	5,266,114
No. of chiropractors	48
Ratio	1:109,711

History and legal status:

The first chiropractor in Finland commenced practice in the late 1920s, but it was not until 1977 that the Finnish Chiropractors' Union was established.

Although covered by the Nordic agreement, which came into effect in the 1980s, chiropractic in Finland became formally subjected to statutory regulation in 1994. Although the title of chiropractor is not protected, trained chiropractors are able to reclaim VAT on their services.

The World Health Organisation comments as follows in relation to the regulatory framework in Finland[18]:

"*Act 559 of 28 June 1994 (176) regulates the licensing of medical practitioners. By Article 4, the right to practise as an independent allopathic medical doctor can be granted to practitioners who have completed basic medical training and who have additional training in primary health care or special training in an allopathic medical speciality. Professional allopathic medical providers who fulfil the required conditions have a number of rights, including the right to use a protected occupational title.*

Only allopathic doctors and, by Decree 564/1994 (172), registered chiropractors, naprapaths, and osteopaths are recognised health practitioners and allowed to practise medicine - specifically, to diagnose patients and charge fees. However, according to Act 559, other medical practitioners may treat patients if they do not practise within public services and do not pretend to be health care professionals. As a result, only allopathic doctors and registered chiropractors, naprapaths, and osteopaths are supervised by the medical authorities in practising complementary/alternative medicine. Other medical practitioners are not supervised, nor is their licensing regulated.

While anyone can use an unqualified title, such as "Chiropractor", by Act 559 only registered chiropractors, naprapaths, and osteopaths may use the descriptor "Trained" in describing themselves. Act 559 also confers title protection to allopathic physicians. Articles 34 and 35 of Act 559 relate to the illegal practice of medicine, punishable by fine or up to six months in prison,

[18] World Health Organisation. Legal status of traditional medicine and complementary/alternative medicine: a worldwide review. 2001. Accessed at http://apps.who.int/medicinedocs/en/d/Jh2943e/7.4.html

although prosecution is rare. The objective of these articles is to protect patients and medical professionals working within public services".

France

National Association:
Association Française de Chiropratique
76 Avenue des Champs Elysees
75008 Paris
France
www.chiropratique.org

President :
Philippe Fleuriau
president@chiropratique.org

Demographics

Population	65,951,611
No. of chiropractors	412
Ratio	1:160,077

History and legal status

The first chiropractors commenced practice in France in the early 1920s.

Chiropractic is legally recognised pursuant to Article 75 of a 2002 law referred to as *Droit de Malades* (Sick Peoples' Rights)[19].

The profession is regulated in France by two Ministerial Decrees:

- No. 2011-32 of 7 January 2011(acts and activity)
- Decree N° 2011-1127 of 20 September 2011 (formation and institutional accreditation).

The law grants the right to permit the title of "chiropracteur" to be used under specific conditions by health care professionals (medical practitioner, midwife, physiotherapist, nurse) and non health care professionals .The title is protected and gives the right to treat patients without requiring a medical referral.

[19] Droit de Malades (2002). Accessed at http://www.ladocumentationfrancaise.fr/dossiers/droits-malades/index.shtml .

A chiropractor has more rights and a wider scope of practice than a massage therapist ("masseur kinésithérapeute"). Under the law chiropractors are permitted to perform medical manipulation, make a differential diagnosis and determine whether or not they accept or reject a patient for treatment.

In September 2011, a new Parliamentary Bill on Chiropractic and Osteopathy was introduced with the aim of establishing a High Council of Chiropractic and Osteopathy. Under the Bill, additional medical qualifications in chiropractic and osteopathy as well as Master's degrees in osteopathy and chiropractic would allow individuals the right to practise these professions as distinct disciplines.

Germany

National Association
Deutsche Chiropraktoren Gesellschaft
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04109 Leipzig
www.chiropraktik.de

President
Timo Kaschel
info@chiropractic-leipzig.de

Demographics

Population	81,147,265
No. of chiropractors	106
Ratio:	1:765,540

History and legal status

The first chiropractors in Germany appeared in the 1920s. Early attempts to establish an educational institution for chiropractors were unsuccessful, with the result that techniques were shared with medical practitioners interested in manual medicine.

In 1978 chiropractors in Germany met in Hamburg and, with the assistance of then ECU President, Arne Christensen, the German Chiropractors' Association was established in 1980.

Two laws regulate the registration and licensing of primary healthcare practitioners in Germany: one for traditional medical practitioners and one for lay medical practitioners (Heilpraktiker).

In 2003, the German Medical Assembly (German Ãrztetag) introduced the term "Chiropractic" in addition to that of "Manual Medicine" and launched a training programme (Muster-Kursbuch – Manuelle Medizin/chirotherapie) for medical practitioners. The terms manual medicine and chiropractic therapy are used interchangeably by medical practitioners in Germany.

A second law regulates the practise of first-degree trained chiropractors. This is the 'Gesetz zur Ausübung der Heilkunde ohne Bestallung' also known as the 'Heilpraktikergesetz[20]'. ECCE/CCEI-accredited chiropractic programmes of study are unrecognised in Germany. Consequently, chiropractors in Germany work under this law.

In Germany, there is therefore the rather confusing situation of three titles:

1. Chiropractor (primarily trained with a degree in chiropractic);
2. Chirotherapeut (academically trained as a medical practitioner with additional programmes of study in manual treatment methods); and
3. Chiropraktiker (non-medical healthcare professionals with limited education in manual treatment techniques).

Greece

National Association
Hellenic Chiropractors' Association
106 Iroon Polytehneiou St
Halandri, 15231
Athens, **Greece**
www.chiropractic.gr

President
Vasileios Gkolfinopoulos
treasurer@ecunion.eu

[20] An English translation of the Heilpraktikergesertz can be accessed at http://translate.google.co.uk/translate?hl=en&sl=de&u=http://www.paracelsus.de/recht/pruef_hpg.html&prev=/search%3Fq%3DHeilpraktikergesetz%26hl%3Den%26biw%3D1024%26bih%3D642&sa=X&ei=N-JWUcCiJYTjOvmOgYAM&ved=0CFIQ7gEwBA

Demographics

Population	10,772,967
No. of chiropractors	21
Ratio	1:512,998

History and legal status

Chiropractic first appeared in Greece in 1924. The first association to represent chiropractors in Greece was the Hellenic Chiropractic, Naturopathic and Osteopathic Physicians Association, which was established in 1977.

In 1988, two chiropractors were denied licences to practise chiropractic by the Ministry of Health on the grounds of a lack of formal legislation. However, this decision was overturned by the High Court of Appeal, which stated that the practise of chiropractic was non-medical and therefore legal. In making its ruling, the High Court urged the Ministry to introduce a relevant law. A second case, charging chiropractors with practising medicine without a licence, resulted in a not guilty verdict. However, under Greek law, chiropractors, as non-medical professionals, are still prohibited from carrying out the diagnosis and treatment of diseases. The Hellenic Chiropractors Association was founded as a separate organisation in 1994.

There is currently no dedicated legislation governing the practise of chiropractic in Greece. Chiropractors practise as non-medical healthcare professionals. Preliminary dialogue has taken place with the Ministry of Health and discussions regarding formal recognition are ongoing.

Hungary

National Association
Hungarian Chiropractic Association
1024 Budapest
Kis Rokus u. 17-19
Hungary
www.kiropraktika.hu

President
Zsolt Kálbori
dr.kalbori@t-online.hu

Demographics

Population	9,939,470.

No. of chiropractors 6
Ratio 1:1,656,578

History and legal status

Chiropractic is recognised, but not regulated, in Hungary.

Although allopathic physicians are the most common providers of complementary/alternative medicine, non-allopathic physicians and non-allopathic practitioners may provide specific complementary/alternative treatments. In February 1997, the Hungarian legislature passed two pieces of comprehensive legislation on natural medicine: Government Decree 40/1997 (IV 5) Korm. r. on natural medicine and the Decree of the Minister of Welfare 11/1997 (V 28) on some aspects of the practice of natural medicine. These two decrees clearly and officially integrate allopathic and non-allopathic physicians who practise complementary/alternative medicine into the national health care system. The Decrees came into force on 1 July 1997.

The Decrees outline precise rules regarding the curriculum of complementary/alternative medical training as well as its practice. Each complementary/alternative discipline has its own training requirements and State exam. Within a legal framework, non-allopathic physicians are allowed to use complementary/alternative medicine once they have passed the exam.

Articles 1 through 7 of the Decrees regulate conditions for practising complementary/alternative medicine. Annexes 1 through 4 list the specific requirements for each form of complementary/alternative medicine.

Article 1 identifies three categories of authorised medical practitioners: allopathic physicians, practitioners with a non-academic higher medical qualification, and other non-allopathic practitioners. Natural doctors are authorised practitioners who have passed the required exams and are permitted to use complementary/alternative medicine.

Article 1 also contains restrictions on the use of complementary/alternative medicine. Allopathic physicians and medical practitioners with a non-academic higher health qualification may provide manual therapies. Practitioners who do not hold a higher health

qualification may provide acupressure, massage therapy, lifestyle counselling, reflexotherapy, bio-energy, phytotherapy, and auriculotherapy.

Article 2 clarifies the legal framework in which natural doctors are allowed to practise. Paragraph 1 of Article 2 states that allopathic physicians are in charge of diagnosis, therapy planning, and patient follow-up. Other practitioners who have the necessary qualifications may participate in patient care at the request of the patient or through an allopathic physician's referral. Natural doctors who are non-allopathic physicians are allowed either to practise under the supervision of an allopathic physician or, more independently, to provide care after an allopathic physician has made a diagnosis. Consulting allopathic physicians may not oppose a patient's choice to seek treatment from a natural doctor.

By Article 3, natural doctors must submit to the same directives as other medical practitioners, such as respecting obligations, abiding by ethical rules, and keeping patient records.

Article 5 gives the Institute of Health, under the authority of the Ministry of Social Welfare, the responsibility of regulating the training and examination of natural doctors.

Under Article 7, allopathic physicians with an academic degree in medicine may ask for a licence to practise as natural doctors without being required to take another exam. They are also allowed to use the title of "Natural Doctor", but to use the title of specialists in particular therapies, they must take the exam. Allopathic physicians are the only practitioners who do not have to pass the exams to practice complementary/alternative medicine. Natural doctors are registered and supervised by a special commission.

Annex 1 contains a complete list of authorised complementary/alternative treatments and of the medical practitioners who are allowed to provide them.

Annex 2 outlines the information that natural doctors must record, such as patient histories and a description of the current treatment.

Chiropractic is regulated, but not defined, by law. The Ministry of Education recognizes the Doctor of Chiropractic degree (*65*).

There have been instances, most recently in 2012, of chiropractors being subjected to criminal proceedings in Hungary for practicing medicine without a license.

There are no known proposals to formally regulate chiropractic as an independent profession in Hungary.

Iceland

National Association
Icelandic Chiropractic Association
Sogavegur 69
Reykjavik 108,
Iceland

President
Bergur Konráðsson (President)
bergur@kiro.is

Demographics

Population	315,281
No. of chiropractors	8
Ratio	1:39,410

History and legal status

The first chiropractors started practising in Iceland in the 1970s. Further developments took place in the 1990s and in 2001 the Icelandic Chiropractic Association became a member of the ECU.

Icelandic chiropractors participated in the founding of the Nordic Institute for Chiropractic and Clinical Biomechanics and are represented on its Board.

Chiropractic has been recognised by a number of workers' unions since the 1990s and in 2000, the Federation of State and Municipal Employees decided to reimburse chiropractic fees for its members.

The Icelandic Government grants licenses to chiropractors wishing to practise in Iceland. Chiropractic falls under the general law on Health Practitioners[21] which contains a specific regulation on chiropractic.

[21] Lög um heilbrigðisstarfsmenn nr. 34/2012 (samþykkt á Alþingi 2. maí 2012

A revised and improved regulation took effect in January 2013[22]. Discussions are ongoing with the Ministry of Health and Social Services in relation to granting authority for chiropractors to refer for and operate X-ray equipment and order advanced imaging.

Ireland

National Association
Chiropractic Association of Ireland
Penrose Wharf
Penrose Quay
Cork
Ireland
www.chiropractic.ie

President
Siobhán Guiry
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president@chiropractic.ie

Demographics

Population	4,775,982
No. of chiropractors	110
Ratio	1: 43,418

History and legal status

The first chiropractors came to Ireland in the 1920s. Between 1920 and 1960 the history of chiropractic is unclear and it appears that numbers dwindled.

By the 1970s, there were still under 10 chiropractors practising in Ireland but numbers steadily rose. The Chiropractors Association of Ireland (CAI) was formed in 1985 and in 1988 the CAI was accepted into the ECU. Membership required members of the CAI to only accept chiropractors who had graduated from CCE/CCEI-accredited institutions

There is no legislation currently governing the practise of chiropractic in Ireland. Chiropractors practise as healthcare professionals under common law. Preliminary

[22] Reglugerð um menntun, réttindi og skyldur hnykkja (kírópraktora) og skilyrði til að hljóta starfsleyfi nr. 1087/2012. This can be accessed in Icelandic at http://stjornartidindi.is/Advert.aspx?ID=2c03bb4c-3248-4edd-8198-00b04e8294ab

dialogue has taken place with the Ministries of Health and Social Services in relation to granting authority for chiropractors to refer for diagnostic imaging.

Chiropractors in Iceland can own and operate their own x-ray equipment.

Italy

National Association
Associazione Italiana Chiropratici
Via Brigata Liguria 1/20
Genova 16121
Italy
www.chiropratica.it

President
John Williams
president.italy@fastnet.it

Demographics

Population	61,482,297
No. of chiropractors	400 (230 of which are AIC members)
Ratio	1: 153,705

History and legal status

Although the first chiropractors in Italy established practices in the 1920s, it was not until 1974 that the Associazione Italiana Chiropractici (AIC) was formed and Italy joined the ECU.

In 1980, the Healthy Ministry formed a commission to examine chiropractic and concluded that it was both safe and effective. It recommended that chiropractic be accepted as a legitimate healthcare occupation. In common with a number of other European nations, the medical profession opposed the profession and alleged that chiropractors were practising medicine without a license. However, despite this opposition, a 1998 judgement by the Constitutional Court ruled that chiropractic is an autonomous profession and that chiropractors cannot be considered to be practicing medicine without a license until such time that Parliament regulates the profession.

Following surveys demonstrating that over 9 million Italians were utilizing alternative medicine, the Italian "National Federation of the Orders of Doctors and Dentists"

(FNOMCeO) 2002 and various rulings of the Italian Courts declared the practice of chiropractic as being the responsibility of a medical doctor.

Formal provision for a statutory Register of Chiropractic Doctors has been made within the Italian Labour, Health and Social Policy Ministry (Article 2, comma 355, of Law N° 244/2007), but has not yet been opened.

The 2002 FNOMCeO Guidelines were superseded in 2009 by revised Guidelines having no legal or regulatory status. They excluded chiropractic and osteopathy from the list of professions considered by them to be medical acts.

In Italy, Court rulings regarding chiropractic have been ambiguous. While some rulings have made a clear distinction between a medical act and a chiropractic intervention, they have failed to rule that an internationally recognised chiropractic degree must be a prerequisite to practising chiropractic in Italy. This remains impossible until chiropractic is regulated and the a Register of chiropractors is opened, but all non-EU candidates seeking a work permit are obliged to have graduated from accredited institutions.

Under the Guidelines for training in Medicine and Practice of Non-Conventional Medicine, December 12, 2009 the first paragraph may be translated:

> *"Law n.244 of 2007, art.2, paragraph 355 has defined a chiropractor as having earned a Laurea Magistrale, (five year degree) in Doctor of Chiropractic to qualify as an autonomous primary health care practitioner. The Register of Chiropractors, to be kept by the Health Ministry is still in the phase development and is not operative."*

Liechtenstein

National Association
Verein Liechtensteiner Chiropraktoren
Eschenerstrasse 9
9494 Schaan
Liechtenstein

President
Christopher Mikus
cmikusdc@powersurf.li

Demographics

Population	37,009
No. of chiropractors	5 (4 in VLC)
Ratio	1: 7402

History and legal status

The first chiropractic practice in Liechtenstein was opened in 1984. Under existing law, known as the Sanitaetsgesetz), educational and scope of practice issues were regulated. In 1985, local insurance companies recognised chiropractic for the purposes of reimbursement.

The national association was founded in 1995 and in 1998, Liechtenstein was accepted as a full member of the ECU.

Historically, the national regulation of chiropractors followed the health law from 2007 art.6, 1c and E art. 27a, b. According to "Gesundheitsgesetz Art. 7 ff sowie Gesundheitsverordnung Art. 29 bis 31" educational demands for chiropractors practising in Liechtenstein were:

(a) a diploma documenting the accomplishment of the chiropractor educational programmes prescribed in Switzerland; or

(b) an external diploma according to the list of approved international educational programmes (gemäss der nach Art. 33 des schweizerischen Medizinalberufegesetzes durch Verordnung des Departements des Inneren (EDI) and a minimum of two years supervised by a chiropractor.

As a consequence of legislation ("Chiropraktoren", health law E art. 27), a chiropractor is legally entitled to refer patients for physiotherapy, prescribe sick leave, and order x-rays and advanced imaging. Pursuant to further legislation passed in 2004, chiropractors enjoy the same legal status as other regulated health professionals. This portion of the law is covered by a different portion of the law (Article 27 and 28 of the Gesundheitsgesetz)[23].

[23] The German version can be found at the following link https://www.gesetze.li/DisplayLGBl.jsp?Jahr=2008&Nr=300 . An English translation is expected shortly.

The legislative reference for chiropractic in Liechtenstein is: Art. 6 Abs. 1 lit. c Gesundheitsgesetz, LGBl. 2008 Nr. 30 iVm. Art. 29 ff Gesundheitsverordnung, LGBl. 2008 Nr. 39.

Luxembourg

National Association
Chiroletzebuerg
239 Val des Bon Malades,
L-2121 Kirchberg
Luxembourg

President
Scott Oliver
scott@luxchiro.com

Demographics

Population	514,862
No. of chiropractors	5
Ratio	1: 171,621

History and legal status

Due to legislation outlawing the diagnosis and treatment of diseases by anyone other than a medical practitioner, patients seeking chiropractic treatment historically had to travel to neighbouring countries. However, pursuant to a positive decision in 2004, chiropractic was recognised as a profession, yet formal changes in the law have yet to be enacted. In 2005, Chiroletzebuerg joined the ECU.

There is therefore no legislation governing the practise of chiropractic in Luxembourg, although chiropractors practise freely as healthcare professionals. Preliminary dialogue has taken place with the Ministries of Health and discussions regarding statutory recognition are ongoing.

Netherlands

National Association
Nederlandse Chiropractoren Associatie
Waagplein 4a

85601 Be Joure
The Netherlands
www.nca.nl

President
Vivian Kil
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Demographics

Population	16,805,037
No. of chiropractors	263
Ratio	1: 63,897

History and legal status

In the Netherlands, chiropractic is classified under the heading of "alternative or complementary medicine". To date, the profession has not been officially recognised or regulated by the government.

The *Stichting Chiropractie Nederland* (SCN) is an independent institute established by the NCA, which focuses on quality assurance and performance monitoring for chiropractors in the Netherlands. Its actions are largely governed by the Individual Health Care Act (BIG).

The nature of chiropractic has been made more transparent for patients and healthcare professionals by quality statements issued by the SCN. The quality of registered chiropractors by the SCN is periodically checked. Chiropractors must re-register with the SCN every five years.

The "Nederlandse Chiropractoren Associatie" is a member of the European Chiropractors' Union. It was established in 1968 and formally registered in the Netherlands in 1975.

Norway

National Association
Norsk Kiropraktorforening
Storgata 10A
0155 Oslo
Norway
www.kiropraktikk.no

President
Jakob Lothe
jaklothe@online.no

Demographics

Population	5,033,675
No. of chiropractors	620
Ratio	1: 8,118

History and legal status

There is evidence that chiropractic has been represented in Norway since 1906. In the mid-1920s, through the work of one chiropractor, Arthur Lundh, chiropractic developed and by the 1930s there were around twenty chiropractors in Norway. As a consequence of aggressive criticism from the medical profession and unsuccessful attempts to have chiropractors convicted of practising medicine without a license, the Norwegian Chiropractors Association was founded in 1935.

In 1974, legislation was passed that allowed for reimbursement of chiropractors' fees on medical referral. In 1988, legislation to create statutory regulation of the chiropractic profession was passed. Since 1990, chiropractors have been officially recognised as health care professionals. Only licensed chiropractors are permitted to use the title of chiropractor. To be licensed, a candidate must have completed a training programme and passed examinations at an approved institution; undertaken additional training in Norwegian health law and chiropractic disciplines; completed one year of practical training; and not be in a position that would lead to withdrawal of the authorization - for instance, the candidate must not be found unsuitable for practising chiropractic due to old age, illness, alcohol/drug abuse, or other circumstances.

Further developments included a highly successful trial to determine the effectiveness of chiropractors prescribing sick leave and referring patients to hospital specialists, including physiotherapy. As a consequence of this trial, which showed high levels of patient satisfaction and both fewer and shorter episodes of sick leave, in 2005 the Norwegian Parliament voted to extend the rights of chiropractors.

Chiropractic is therefore recognised in Norway as a highly structured and mainstream health profession. Its success has been down to the foresight and persistence of key individuals who set out and achieved key goals in terms of legislation and regulation.

The current President of the ECU, Øystein Ogre, is a past president of the Norwegian Chiropractors' Association.

Poland

National Association
Polish Chiropractic Association
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81-844 Sopot
Poland

President
Arek Mazur
arekmazur@hotmail.co.uk

Demographics

Population	38,383,809
No. of chiropractors	6
Ratio	1: 65,397,301

There is no legislation governing the practice of chiropractic in Poland, although chiropractors practise freely as healthcare professionals. In 2012, the Polish Chiropractic Association formally adopted the CEN Standard on Healthcare Provision by Chiropractors.

There is currently no institution providing chiropractic education in Poland, although preliminary talks are taking place with medical schools with a view to offering a chiropractic programme.

Spain

National Association
Asociación Española de Quiropráctica
Marqués de Cubas 25, 3° ext. izq., of. 228014
Madrid
Spain

President
Carlos Gevers Montoro
carlosgevers@hotmail.com

Demographics

Population	47,370,542
No. of chiropractors	218
Ratio	1: 201,577

The first chiropractor came to Spain in the 1920s. It was the late 1950s before its second chiropractor commenced practice in Barcelona. The Spanish Chiropractic Association (AEQ) was founded in 1986 and joined the ECU that same year. Since this time, the numbers of chiropractors practising in Spain has risen substantially.

There is no dedicated legislation governing the practice of chiropractic in Spain, but there is *de facto* recognition. Chiropractic has been subjected to complaints by regulated health professions in Spain, particularly the physiotherapy profession, which has endeavoured to subsume chiropractic into its scope of practice.

The AEQ Executive has engaged in extensive dialogue with the Spanish Ministry of Health such that the first steps towards formal recognition commenced in September 2010.

There are two chiropractic educational institutions in Spain, with the first of these, Real Centro Universitario Maria Cristina, having graduated its first students in 2012. RCU Maria Cristina was also the first chiropractic institution in Spain to be granted ECCE accreditation. The second chiropractic institution, Barcelona Chiropractic College, has candidate status with ECCE and will graduate students from its Masters programme in 2014.

Sweden

National Association
Legitimerade Kiropraktorers Riksorganisation
Ăsögatan 102
11829 Stockholm
Sweden
www.lkr.se

President
Tobias Lauritsen
tobias.lauritsen@lkr.se

Demographics

Population	9,119,423
No. of chiropractors	760 licensed (186 members of LKR)
Ratio	1: 12,000

History and legal status

The first chiropractors in Sweden started practising in 1921. Numbers grew and drew the attention of the medical profession, which through newspaper articles made accusations of improper practice. As a consequence, the *Diplomerade Chiropraktorers Förening*, the forerunner of the Swedish Chiropractors Association, was formed in 1936.

Attitudes towards chiropractors became more accepting over time, to the extent that there was an acceptance of their effectiveness for disorders of the spine.

Following formal proposals by the Committee of Alternative Medicine, in 1989 a law was passed that authorised chiropractors as regulated health professionals. As a consequence, they were listed as health professionals under the Patient Safety Act[24], Chapter 4, §1 and §5.

This legislation enabled patients to obtain partial reimbursement in some regions.

One of the bigger challenges facing the chiropractic profession in Sweden is the rise of chiropractic/naprapathic schools. In 2004, their quality of education was criticised by the National Agency of Higher Education.

Switzerland

National Association
Chiro Suisse / Schweizerische Chiropraktoren- Gesellschaft

[24] The Swedish Government passed the Patient Safety Act in 2011 and was aimed at creating safer healthcare by reducing the number of healthcare injuries. The Act makes it easier to report mistakes to the National Board of Health and Welfare. For further information, please go to http://www.government.se/sb/d/15471/a/184679

Steinbruchstr. 12
7000 Chur
Switzerland
www.chirosuisse.info

President
Gian Joerger
joerger_and_oman@gmx.net

Demographics

Population	7,996,026
No. of chiropractors	263
Ratio	1: 30,060

History and legal status

The first two known chiropractors to practise in Switzerland were female and worked in Berne and Interlaken during the 1920s. As a consequence of fierce criticism from the medical profession, resulting in fines and imprisonment, the Swiss Federation of Chiropractors was founded in 1932. Its members were instrumental in the formation of the European Chiropractors' Union.

In the late 1930s chiropractic became accepted as a health profession in the Cantons of Lucerne and Zurich. The laws that were passed were the first in Europe to statutorily regulate chiropractic as an independent profession. By 1963, over 70% of the Swiss population were covered by established chiropractic legislation.

As a consequence of strong lobbying by the Swiss Pro-Chiropractic Association (including a 400,000 strong petition to the Government) chiropractors became regulated as a conventional health profession by the Federal Law on Medical Professions (MedBG). This allowed chiropractors to practise independently without the need for medical referral for the purposes of insurance reimbursement.

Revision of the Law on Health and Accident Insurance in 1964 meant that chiropractic was covered by mandatory social insurance in cases of sickness and accident. Coverage was later extended to also include Military and Disability Insurance.

Chiropractors have the right to diagnose and treat patients and have also been granted privileges similar to medical practitioner, including limited prescribing rights, referral for laboratory tests and the ability to prescribe sickness absence.

As a consequence of strong legislation governing the practice of chiropractic in Switzerland, chiropractors must undertake a two year assistantship programme before entering independent practice.

Post graduate education is well developed in Switzerland and mandatory postgraduate education has existed since 1960. The Swiss Chiropractic Institute was established in 1985.

Legislation passed in 2007 now affords Swiss chiropractors recognition as medical professionals (alongside medicine, dentistry, veterinary science and pharmacy).

Education for chiropractors in Switzerland is a six-year programme provided at the University of Zürich[25]. Here, chiropractic students train in the basic medical sciences alongside medical students before specialising in chiropractic in the latter years of the degree.

Turkey

National Association
Turkish Chiropractic Association
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www.kayropraktikdernegi.org

President
Mustafa H Agaoglu
agaoglu@kayropraktik-turkiye.com

Demographics

Population	73,722,988
No. of chiropractors	7

[25] The University of Zurich (accessed at http://www.uzh.ch/studies/application/medicine_en.html) offers medical programmes, including chiropractic. Professor Kim Humphreys currently holds the Chair of Chiropractic at the University.

Ratio	1: 10,531,855

History and legal status

As a consequence of sweeping health reforms in 2003, healthcare in Turkey has improved over the last decade. There has been a rise in the provision of private healthcare facilities that has improved access to care and prompted improvements in the state provision of health. It remains that there are inequalities in the provision of care, with the western part of Turkey enjoying better standards of care than the eastern region.

The Turkish Chiropractic Spinal Health Association was founded in 2007. Turkey is the newest member of the ECU, having joined in 2010. There is currently no dedicated legislation relating to chiropractic in Turkey. Medical doctors with an additional qualification may practise chiropractic medicine, while primary trained chiropractors practise under the supervision of a medical doctor.

There has been interest in establishing a chiropractic educational programme in Turkey and discussions are ongoing.

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British Chiropractic Association
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President
Richard Brown
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Demographics

Population	63,395,574
No. of chiropractors	2700 state registered (1386 in BCA)
Ratio	1: 23,479

History and legal status

The first chiropractors returned to Britain after completing training at Palmer College of Chiropractic in around 1910. By 1922, the Chiropractors' Association of the British Isles held its first meeting in Belfast, but this organization did not last, being replaced by the British Chiropractic Association in 1925. Despite having fewer than 20 members, it established an insurance scheme for its members and drew up a code of ethics.

In 1931, following a dinner at the BCA Annual Conference, talk of a pan-European organization led to the establishment of the ECU.

With practical difficulties prohibiting aspiring British students from travelling to the USA to train, the numbers of chiropractors practising in Great Britain decreased to around 35 after the Second World War.

The first chiropractic educational institution in Europe, the Anglo-European College of Chiropractic (AECC), opened in Bournemouth, England in September 1965. In 1997, the first University-based programmes for chiropractors were established at the Universities of Surrey[26] and Glamorgan. Chiropractors are also trained at the McTimoney College of Chiropractic, based in Abingdon, Oxfordshire[27]. As a consequence, the number of chiropractors practising in the UK has grown dramatically such that it now boasts the largest national association in Europe.

In 1990, the profile of chiropractic rose following the publication of a study in the British Medical Journal which favourably compared chiropractic with physiotherapy for the management of low back pain. Royal patronage and the publicity surrounding chiropractic treatment of high profile personalities further enhanced chiropractic's reputation.

[26] The Masters programme in chiropractic at the European Institute of Health and Medical Science, University of Surrey, ran from 1997 to 2002. The programme gained full accreditation by the ECCE for the period 2003-2006. This programme is no longer offered at Surrey.

[27] Although graduates of the MCC are permitted to practise as registered chiropractors in the UK, they do not enjoy the same portability of qualification as graduates of ECCE/CCEI accredited institutions. The full time Masters programme at MCC currently has candidate status with ECCE.

In 1991, the educational programme at AECC was awarded degree status by the Council for National Academic Awards. All chiropractic programmes of study in the UK now offer education to Masters level.

The Chiropractors Act of 1994[28] established a statutory regulator, the General Chiropractic Council (GCC), and a Register was opened in 1999. The Act gives protection of title and made it an offence for any person not registered with the GCC to call themselves a chiropractor. The Act also provided for mandatory standards of education and patient protection through a Code of Practise and Standard of Proficiency[29].

Most chiropractors in the UK operate in the private sector, but health legislation has led to chiropractic being utilised within the National Health Service. Most private health insurers recognize chiropractic for the reimbursement of patient fees.

[28] The Chiropractors Act 1994, ch17. Accessed at http://www.legislation.gov.uk/ukpga/1994/17/pdfs/ukpga_19940017_en.pdf
[29] General Chiropractic Council. Code of Practice and Standard of Proficiency (2010). London. Accessed at http://www.gcc-uk.org/files/link_file/COPSOP_2010.pdf

Chiropractic in other European nations

Denmark

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http://www.danskkiropraktorforening.dk

President
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Demographics

Population	5,574,000
No. of chiropractors	565
Ratio	1: 9865

History and legal status

The Danish Chiropractors Association was founded in 1925. Chiropractors in Denmark practise in private clinics and in hospitals, primarily at hospital centres for patients with back problems. There are about 550 practising chiropractors in about 250 chiropractic clinics and approximately 15 chiropractors are employed in hospitals.

In Denmark chiropractors have the right to diagnose patients independently and no medical referral is required as a condition of treatment or as a condition for reimbursement from the national health service. Chiropractors are trained both to take and read X-rays, and all practising chiropractors have access to X-ray facilities. The national health service subsidizes chiropractic treatments.

Chiropractic education in Denmark is delivered at the University of Southern Denmark in Odense. Completion of the 5-year Master's Degree in Clinical Biomechanics authorises chiropractors to practise in subordinate positions in hospitals or clinics under the supervision of a chiropractor with authorization to practise independently. Authorization to practice independently is issued by the National Board of Health after an additional one-year practical training (internship).

The Nordic Institute of Chiropractic and Clinical Biomechanics (NIKKB), is a research institute and centre of scientific information and post-graduate education facilitator. In close collaboration with the University of Southern Denmark and Spine Center South at Lillebælt Hospital, NIKKB produces and disseminates internationally renowned health care research pertaining to the chiropractic profession and clinical biomechanics. NIKKB was established in 1990 and is financed directly from Danish chiropractors[30] and the Regions' Board for Wages and Tariffs.

In Denmark there are currently 15 chiropractic PhDs with a further 10 chiropractic PhD candidates. Two chiropractors are currently employed as professors at the University of Southern Denmark.

Denmark has an active chiropractic patients association, *Kiropraktik og Sundhed*. The association is responsible for disseminating information about chiropractic in Denmark.

Portugal

National Association
Associacao Portuguesa dos Quiropracticos
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President
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Portugal
presidenteapq@gmail.com

Demographics

Population	10,637,000
No. of chiropractors	22
Ratio	1: 483,500

[30] Finance for research in Denmark is co-ordinated by the Foundation for Advancement of Chiropractic Education and Postgraduate Research. For more information, see http://www.danskkiropraktorforening.dk/English/.

History and legal status

The first chiropractor to settle in Portugal and establish a practice was the APQ's current president, Antonio Alves. In 1986 he began work to found a national chiropractic association. This became a reality in 1999 and in 2000 a patients association, Pro-Quiro, was also formed.

Four legal actions took place between 1993 and 2000, each of which was unsuccessful. IN delivering their verdicts, a number of judges spoke favourably about the education and training of chiropractors. Chiropractic was finally legalised in Portugal in 2003, yet chiropractic was part of a number of non-medical health professions that were included under the same legislation.

In 2008, the ECU responded to a comprehensive questionnaire about chiropractic in Europe sent by the Directorate General of Higher Education and Technology (DGEST). In November 2009, it published a resolution (No 1493/2009) granting recognition to various degrees including Doctor of Medicine (Medical), Doctor of Medicine in Dentistry (dentist) and other health professions and sciences which studies were conducted in the United States of America but which carry on their profession currently in Portugal. This included chiropractic.

Acknowledgements

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Richard Brown

Appendix 1

CEN Standard: Healthcare provision by chiropractors

CEN/TC 394

Date: 2012-06

EN 16224:2012

CEN/TC 394

Secretariat: ASI

Healthcare provision by chiropractors

Bereitstellung von Gesundheitsleistungen durch Chiropraktoren

Prestation de soins de santé par les chiropracteurs

ICS:

Descriptors:

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Foreword

This document (EN 16224:2012) has been prepared by Technical Committee CEN/TC 394 "Project Committee - Services of chiropractors", the secretariat of which is held by ASI.

This European Standard shall be given the status of a national standard, either by publication of an identical text or by endorsement, at the latest by December 2012, and conflicting national standards shall be withdrawn at the latest by December 2012.

Attention is drawn to the possibility that some of the elements of this document may be the subject of patent rights. CEN [and/or CENELEC] shall not be held responsible for identifying any or all such patent rights.

According to the CEN/CENELEC Internal Regulations, the national standards organizations of the following countries are bound to implement this European Standard: Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

Introduction

The World Health Organisation (WHO) defines chiropractic as a primary contact healthcare profession concerned with disorders of the neuromusculoskeletal system, particularly the spine, and the effect of these disorders on the function of the nervous system and on general health. Treatment encompasses a wide range of interventions, but emphasis is placed on manual methods of care.

The chiropractic profession has evolved in Europe and occupies an important position in both primary and secondary healthcare provision. It is therefore imperative that chiropractic services are delivered at the highest attainable level.

The principal objective of any standard for healthcare services ought to be that users of any given service can be confident of a level of care that assures reproducible quality throughout the profession. Clinical governance, the determination of monitoring healthcare provision and ensuring maintenance of standards therefore form one of the cornerstones of care.

This standard is concerned with the provision of chiropractic services. It aspires to set a standard that provides optimum levels of patient management, patient safety, clinical and cost effectiveness and ethical practice. It also defines a level of education consistent with producing chiropractors who are competent to comply with the standard. It is not intended to be a guideline, although information contained might inform the development of guidelines for individual nations and national organizations.

Finally, this standard encourages that services provided by chiropractors be subjected to regular review through an evidence-based approach and a commitment to supporting and acting upon clinical research.

This European Standard does not supersede national legislation.

Scope

This European Standard specifies requirements and recommendations for healthcare services provided by chiropractors.

Terms and definitions

For the purposes of this document, the following terms and definitions apply.

2.1
assessment
health professional's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, along with the objective findings including examination, laboratory tests, diagnostic imaging, medical history and information reported by family members and other health professionals

2.2
audit
review and assessment of healthcare procedures and documentation for the purposes of comparing the quality of care provided with accepted standards

2.3
biopsychosocial model
model that refers to the interactions between biological, psychological and sociological factors

2.4
capacity
ability of a patient to understand, remember and consider information provided to them

2.5
care
interventions that are designed to improve health

2.6
case history
detailed account of a person's history which results from the acquisition of information through interview, questionnaires and assessment of appropriate medical records

2.7
chaperone
person who is present during a professional encounter between an health professional and a patient

EXAMPLE Family members or another member of the healthcare team.

2.8
chiropractic
health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the function of the nervous system and general health

Note 1 to entry: There is an emphasis on manual treatments including spinal adjustment and other joint and soft-tissue manipulation.

Note 2 to entry: Taken from WFC Dictionary definition [11].

2.9
chiropractic institution
educational establishment dedicated to the provision of chiropractic education and training

2.10
clinical guidelines
systematically developed statements designed to assist both practitioner and patient decisions about the appropriate healthcare for specific clinical circumstances

2.11
clinical record
document which relates to the diagnosis, assessment and care of a patient

2.12
consent
acceptance by a patient of a proposed clinical intervention after having been informed of all relevant factors relating to that intervention

2.13
continuing professional development
CPD
means by which members of a profession maintain, improve and broaden their knowledge and skills and develop the personal qualities required in their professional lives

2.14
delegation
asking someone who is not a regulated health professional to provide care on a chiropractor's behalf

2.15
diagnosis
identification of a disease or illness resulting from clinical assessment

2.16
diagnostic procedure
structured procedure that exists to enable a chiropractor to arrive at a diagnosis which may include physical examination, diagnostic imaging and laboratory tests

2.17
discharge
release of a patient from a course or programme of care

2.18
evidence-based care
clinical practice that incorporates the best available evidence from research, the expertise of the practitioner, and the preference of the patient

2.19
formal education
educational activity at established recognized formal systems of elementary, secondary or higher education

Note 1 to entry: Compare with the ISO 29990:2010, definition 2.15 "non-formal education" [4].

2.20
further investigation
additional clinical study which contributes to the assessment of a patient and which may include diagnostic imaging and laboratory tests

2.21
graduate education programme
GEP
dedicated framework for the continuing education of new graduates of chiropractic institutions during their initial period in practice

2.22
health
state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity

Note 1 to entry: Specified in the preamble to the "Constitution of the World Health Organization" [6].

2.23
health promotion
provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community

2.24
medical device
instrument, apparatus, appliance, material or other article, either used alone or in combination, including the software necessary for its proper application and intended by the manufacturer to be used for human beings

Note 1 to entry: This definition is in accordance with Council Directive 93/42/EEC [7] and with EN ISO 13485:2003 [1].

2.25
neuromusculoskeletal
interaction between the nervous system, musculature and skeletal framework of the body

2.26
patient confidentiality
right of an individual to have information about them kept private

2.27
patient examination
assessment of a patient with the intention of reaching or reviewing a diagnosis or plan of care

2.28
plan of care
plan designed to deliver therapeutic benefit to patients following diagnosis

2.29
primary contact practitioner
healthcare professional qualified to undertake a process of assessment, diagnosis and care in the absence of a formal referral from another registered healthcare provider

2.30
professional development
continuum of education, embracing undergraduate and postgraduate studies and regular refresher training

2.31
referral
transferring of responsibility for care to a third party for a particular purpose, such as additional investigation, care or treatment that is outside the chiropractor's competence

2.32
undergraduate chiropractic education
acquisition of knowledge and skills by students at chiropractic institutions leading to an accredited qualification in chiropractic

Service requirements

Clinical practice

Clinical records

Clinical records shall be maintained in accordance with good professional conduct and shall contain relevant and necessary information about the patient and the patient's healthcare (see also Annex A).

Case history

The chiropractor shall acquire and document current and past information on a patient related to their health (i.e. physical, psychological and social wellbeing) by asking specific questions, either of the patient, responsible adult or legal guardian with the aim of obtaining suitable clinical information useful in formulating a diagnosis and leading to a plan of care for the patient.

Patient examination

a) Following the taking of the case history, the patient shall be investigated for signs of disease, abnormality or dysfunction.

b) The chiropractor shall use examination methods that include, but are not limited to, physical examination procedures; orthopaedic, neurological, and chiropractic tests, as clinically indicated.

Further investigation / diagnostic imaging

The chiropractor shall:

a) identify when further investigations are needed and act on this need in the patient's best interests;

b) use further investigations when the information gained from such investigations will benefit the management of the patient;

c) undertake and/or interpret the results or, if this is not possible, refer the patient for appropriate further investigations;

d) record the outcomes of the investigations in the patient record.

Clinical decision making and diagnosis

The chiropractor shall:

a) evaluate the patient's health status and health needs from the information gained during the case history, physical examination and further investigations;

b) formulate and document a working diagnosis and/or differential diagnosis and a rationale for care, based on the evaluation of this information. The diagnosis, or rationale for care, shall be kept under review while caring for the patient;

c) interpret all of the information available about a patient and then make and record decisions about the patient's health and health needs and how these change over time;

d) consider the natural history and prognosis of any presenting complaint, or emergency situation that might need immediate action, and the likelihood of preventing recurrences or managing any long-term healthcare needs.

Plan of care

The chiropractor shall:

a) develop and record an agreed plan of care, taking into account the wishes and preferences of the patient. The plan of care should encourage the patient to participate in improving their own health. The plan of care shall have specified aims and be consistent, appropriate and safe with the patient's identified health and health needs;

b) be knowledgeable about the underlying theories of the care they provide and be competent to apply that form of care in practice. The chiropractors' provision of care shall be evidence-based. The patient shall have given informed consent to the form of care provided;

c) review with patients the effectiveness of the plan of care in meeting its agreed aims.

Referrals

The chiropractor shall consider onward referral to another appropriately qualified healthcare professional when it becomes clear that a patient

a) is not appropriate for chiropractic care, or

b) requires concurrent or additional investigation or care, or

c) is failing to respond to chiropractic care, is deteriorating or has developed additional symptoms outside the field of expertise of the chiropractor.

Referrals should be in writing or done verbally and should detail the reason for the referral, the care provided by the chiropractor and any relevant aspects of the patient's health. Referral details shall be noted in the patient record.

Use of equipment

All medical devices used by chiropractors shall be CE-marked [7].

In case of X-ray equipment, management shall fulfil Council Directive 96/29/Euratom [8].

A maintenance record shall be kept for each piece of equipment or device.

Core competencies

a) The chiropractor shall have knowledge and understanding of:

   1) normal structure and function of the human body;

   2) aetiology, pathology, symptoms and signs, natural history and prognosis of neuromusculoskeletal complaints, pain syndromes and associated conditions presenting to chiropractors, including the psychological and social aspects of these conditions;

   3) evaluation of the health and health needs of a patient, including common diagnostic procedures, their uses and limitations, and appropriate referral procedures;

   4) management of neuromusculoskeletal conditions using manual therapies, physical rehabilitation, general nutritional advice, and the principles of health promotion and disease prevention;

   5) scientific methods to provide and understand the evidence-base for current chiropractic practice, and to acquire and incorporate the advances in knowledge that will occur throughout professional life;

6) history, theory, philosophy and principles of chiropractic practice in a contemporary context, including the biopsychosocial model of illness, its limitations, and its role in the healthcare setting;

7) principles of ethics related to chiropractic care, legal responsibilities and codes of professional conduct and practice;

8) nature of professional accountability and duty to protect and promote the interests of their patients, including not abusing their position, avoiding psychological dependence and maintaining patients' trust.

b) The chiropractor shall have developed the following abilities:

1) ability to obtain appropriate consent before assessing individuals and for providing chiropractic care;

2) ability to take a comprehensive and problem-focused case history and perform an accurate physical examination;

3) ability to integrate case history, physical examination and diagnostic imaging to arrive at an appropriate diagnosis and/or differential diagnosis;

4) ability to interpret diagnostic procedures and make an appropriate response;

5) ability to select appropriate clinical skills and to formulate a management plan in concert with the patient;

6) ability to apply appropriate clinical skills in the treatment of a patient, and to provide information and advice for recovery and continued health;

7) ability to communicate clearly with patients, their families, other healthcare professionals, and the general public, and to ensure patients are fully informed of their treatment choices and care;

8) ability to interpret scientific evidence in a critical manner, and to find and use information relating to healthcare.

c) The chiropractor shall demonstrate the following essential abilities for safe and competent chiropractic practice:

1) recognition that the chiropractor's primary professional responsibilities are the health and care of the patient;

2) respect for the values and attitudes of the patient, and a commitment to patient-centred care;

3) commitment to safe and ethical practice, and to maintain standards of chiropractic practice at the highest possible level throughout professional life;

4) appreciation of the need to recognise and work within the limits of their own knowledge, skills and experience and, when a condition exceeds their capacity to deal with it safely and effectively, to refer patients to other healthcare practitioners;

5) appreciation of the need to continually update knowledge and skills throughout professional life, apply continuous quality improvement in their practice, and to contribute towards the generation of knowledge and the education of colleagues;

6) willingness to work in the wider healthcare context, and in a team with other healthcare professionals.

Education

Undergraduate chiropractic education

The chiropractor shall have a formal, comprehensive undergraduate chiropractic education of a minimum of five years full-time or equivalent.

NOTE An example of a suitable framework for undergraduate chiropractic education is provided by the European Council on Chiropractic Education (ECCE) [10]. (See also Annex B.)

Graduate education programme

The graduate education programme (GEP) normally follows immediately after successful completion of the undergraduate programme and is the period of transition from safe and competent practice to autonomous and independent professional practice. It shall be clinically based and last a minimum of 12 months.

a) The graduate education programme shall prepare graduates to:

   1) maintain and improve on best and safe chiropractic care for lifelong, self-directed learning for continued professional development;

   2) further professionalism (i.e., knowledge, skills, attitudes and behaviour expected by patients and society).

b) During the graduate education programme the graduate should:

   1) demonstrate a defined body of knowledge, understanding, clinical and procedural skills, as well as professional attitudes for providing effective, patient-centred care;

   2) show that they effectively facilitate the chiropractor-patient relationship and the dynamic exchanges that occur before, during and after the chiropractic encounter;

   3) show that they effectively work within a healthcare team to achieve optimal patient care;

   4) demonstrate that they are an integral participant in the provision of healthcare;

   5) show responsibility to use their expertise and influence to advance the health and wellbeing of individual patients, communities and populations;

   6) demonstrate a lifelong commitment to reflective learning as well as the creation, dissemination, application and translation of chiropractic/medical knowledge;

   7) show that they are committed to the health and wellbeing of individuals and society through ethical practice, profession led regulation and high personal standards of behaviour.

c) The graduate education programme should:

   1) encompass integrated practical and theoretical instruction;

   2) guarantee best and safe care by deliberate practice and valid feedback.

Continuing professional development

Continuing professional development (CPD) is a process of lifelong learning. As well as enabling chiropractors to provide better healthcare services to patients, it should also help chiropractors to fulfil their potential. The learning needs and interests which individuals identify should be in the

context of their own development and the practice/organization in which they work. The individual chiropractor shall:

a) have a minimum of 30 hours learning activities a year, of which at least 15 hours is to be learning with others – colleagues or other professionals; The different forms which learning with others can take include, but are not limited to, courses, lectures, discussions, seminar groups and conferences; being coached or mentored by another healthcare professional and peer group reviews;

b) maintain their own records of CPD;

c) be responsible for reflecting on and identifying their own learning interests and needs and how these are met.

Code of ethics

The provision of healthcare shall be based on trust, assurance and safety. In society, chiropractors possess a position where they are trusted; this trust is acquired by education and experience and with this trust comes the responsibility to conform to standards of conduct and behaviour. The Code of Ethics sets out the principles and values of chiropractors in their work as providers of professional healthcare. While the Code is written for chiropractors, the public has a right to know what can be expected of chiropractors and the boundaries of their professional practice.

While it does not seek to define scope of practice, it may have this effect by virtue of the limitations it places on types of behaviour and practice. Chiropractors shall act in line with the principle that the wellbeing of the patient is paramount. It necessarily follows that the nature and delivery of chiropractic care shall be consistent with this value.

The Code recognises that chiropractic is practised in a range of jurisdictions, each having different legislative frameworks and regulatory processes. Where a country is regulated by statute, this Code cannot supersede the Codes of Practice and Standard of Proficiency for that nation. In jurisdictions without statutory regulation, it is recommended that this Code be adopted for use to ensure a minimum consistent standard throughout European states.

NOTE See Annex C for further details.

Organization

Practical organization of clinic facilities

Facilities where chiropractic care is provided:

a) shall be organized in such a way that health personnel are able to comply with their statutory duties;

b) shall be organized in such a way that systems are in place to detect deficiencies in order to improve quality;

c) should be organized in such a way that access for the disabled is provided.

Facility requirements

General

The clinic in which chiropractors practice may vary considerably in size, position and environ in accordance with national requirements and legislation.

Clinic and hygiene

The clinic provider should ensure that:

a) the clinic is clean;

b) hygiene procedures are written down and followed throughout the clinic;

c) all areas of the clinic have a comfortable working temperature and sufficient ventilation to assure the comfort of the patient;

d) all rooms have adequate sound proofing, low ambient noise level and good lighting.

The facilities of the clinic should meet professional standards.

Access to the clinic

The chiropractor should be contactable by accepted means of communication. The clinic shall be clearly signed for anyone wishing to access the facilities. It should provide access for people with disabilities.

Reception and waiting areas

The reception and waiting area should have a reception desk and sufficient seats for the number of people expected in the clinic, including those accompanying the patient. The reception area should be designed so that patients are comfortable when giving private information, whenever possible.

The prices for treatment shall be clearly displayed.

A written complaints procedure shall be available for the patient on request.

The clinic shall give access to drinking water.

Toilet

There should be facilities for disabled available, whenever possible.

Consultation and treatment room

The size of the consultation and treatment rooms shall be sufficient to allow the free movement of the chiropractor and patient. There should be a desk, and seating for at least the patient and a companion or chaperone.

The consultation and treatment rooms shall be sufficiently sound-proofed to ensure privacy of conversations.

Rooms for exercise or group activities shall be large enough to accommodate the designated activities.

Any facility for dressing/undressing shall be large enough for the comfort of the patient, with direct access to the treatment room and the privacy of the patient ensured.

A wash hand basin shall be readily accessible.

Equipment requirements

Equipment

The following pieces of equipment are the minimum required for the proper provision of chiropractic services:

a) Treatment table:

   1) A relevant table with paper or textile cover, which is changed or cleaned for each patient, shall be available.

a) Equipment for examination:

   1) Instruments required for proper examination and treatment shall be readily available.

   2) Anatomical models and/or other patient education materials should be available.

Maintenance

The chiropractor shall ensure that all equipment (see 3.1.8) is maintained in accordance with manufacturers' recommendations. Maintenance records shall be kept.

Incident reporting and learning

Where they are available, the chiropractor should engage in chiropractic and/or multidisciplinary patient incident reporting and learning systems.

Quality assurance

a) The chiropractor should review the effectiveness of services they provide. This may be achieved by participation in relevant quality assurance programmes.

NOTE References to quality management system standards can be found in the Bibliography [2], [3] and [4].

b) The chiropractor shall have a written complaints procedure in place in their practice which is easily accessible to patients. Any complaint or claim made by a patient shall be dealt with promptly and fairly. Patients shall be told about their right to refer any unresolved complaint to the relevant authority.

Insurance

The chiropractor shall hold:

a) professional indemnity insurance to cover any liability to patients that may arise in connection with the performance of their profession;

b) employers and public liability insurance to cover their practice, employees and the public in the event of a claim.

Professional association membership

The chiropractor is strongly encouraged to join a national chiropractic association.

Annex A
(informative)

Patient records

A.1 Duty to keep patient records

a) The chiropractor should record information in a patient record for each patient.

b) Patient records should be written in an official language of the country.

c) Patient records should be stored by either paper or electronic means and the security maintained such that they are only accessible to authorized personnel.

d) The chiropractor should ensure that provision is made for the safe-keeping and secure storage of patient records upon ceasing work at their practice address or in the event of their death.

A.2 Content of patient records

Patient records should contain the following information:

1) patient's name, address, date of birth, contact details, marital status, gender, occupation;

2) if the patient is not competent to give consent, the name and status of the person giving consent;

3) notification if treatment or advice is given in contradiction with clinical guidelines;

4) advice given to the patient;

5) reason a patient has required access to records or required corrections of records;

6) information given to or received from other healthcare providers, institutions, laboratories, insurance companies, police, child welfare, etc.;

7) patient's general medical practitioner;

8) notes on sick leave, reports.

Patient records should be an accurate reflection of each clinical encounter and should include any factors relevant to the patient's ongoing care, including their general health.

All records should be understandable to another chiropractor who may be called upon to assume the care of the patient. Records should be stored securely in accordance with local legislation.

A.3 Correction of patient records

Any errors within a patient record should be corrected by the addition of the correct information without deletion of any previously entered information and noting the source of the correction.

Annex B
(informative)

Recommended programme curriculum [31)]

B.1 General

A programme curriculum should include:

1) curriculum model and educational methods;
2) basic biomedical sciences;
3) behavioural and social sciences, ethics and jurisprudence;
4) clinical sciences and skills;
5) clinical training;
6) assessment methods and regulations;
7) curriculum level, structure and composition.

B.2 Curriculum model and educational methods

The chiropractic institution should define a curriculum model and educational (teaching and learning) methods consistent with the objectives of the curriculum. The curriculum and educational methods should ensure the students have responsibility for their learning, and prepare them for lifelong, self-directed learning throughout professional life.

Curriculum models should include discipline, system, integrated, problem or case-based learning models, using organizing principles such as themes and domains.

Instructional methods should encompass teaching and learning methods that, while not neglecting the transmission of factual knowledge and skills, also stimulate enquiry, critical analysis and problem-solving abilities. The curriculum should encourage active participation through the principles of self-directed learning, and foster the concept that the curriculum is not only 'taught' based solely on didactic models.

Teaching and learning methods should be diverse and include a variety of methods, e.g. prosection (or dissection), computer assisted methods, and large and small group classes.

The curriculum and educational methods should foster life-long learning skills and an appreciation of the need to undertake CPD.

The chiropractic institution should describe the content of courses that guide both staff and students on the learning outcomes expected at each stage of the programme, and the level of integration between the basic sciences and clinical sciences and include:

31) Based on ECCE Standards, version 4, 2011 [10].

— the theory of chiropractic and the scientific method;

— the theory and principles of chiropractic practice, other forms of research inquiry and evidence-based practice, including analytical and critical thinking.

The curriculum should include elements for training students in scientific thinking and research methods.

Theory of chiropractic should include concepts and principles of practice, and the role of empirical evidence in informing chiropractic knowledge.

Training in scientific thinking and research methods should include the use of research projects (or equivalents) to be conducted by chiropractic students.

The curriculum and educational methods should foster the ability to participate in the scientific development of chiropractic as professionals and future colleagues, and to keep up to date with evolving knowledge through an appreciation of research inquiry and the skills to identify, find and critically evaluate information including research evidence.

B.3 Basic biomedical sciences

The chiropractic institution should identify and include in the curriculum those contributions of the basic biomedical sciences that enable a knowledge and understanding of the basic sciences applicable to the practice of chiropractic.

The basic biomedical sciences should include anatomy, biochemistry, physiology, biophysics, molecular biology, cell biology, genetics, microbiology, immunology, pharmacology, pathology and biomechanics.

As basic science teaching is relevant to the overall objectives of the chiropractic curriculum; its relevance should be apparent to students.

Sufficient integration of the biomedical sciences with the clinical elements of the programme should be ensured, highlighting the relevance of the basic sciences to clinical practice.

Basic science and clinical tutors should collaborate in combined teaching sessions based around clinical problems.

B.4 Behavioural and social sciences, ethics and jurisprudence

The chiropractic institution should identify and include in the curriculum those contributions of the behavioural sciences, social sciences, ethics, scope of practice and legal requirements that enable effective communication, clinical decision-making and ethical practice.

Behavioural and social sciences should include:

1) psychology, sociology, and the biopsychosocial model of chronic pain and non-specific neuromusculoskeletal pain conditions;

2) aspects of patient-centred care models, practitioner-patient encounters and oral and written communications skills, and the transferable skills including IT and reflective practice skills;

3) all aspects regulating professional practice including legal requirements, requirements of local national regulatory bodies and codes of ethical practice;

4) other areas of professional practice including management and administration issues and current practice models in a multidisciplinary healthcare setting;

5) ethical practice including the principles of clinical governance, clinical audit, clinical guidelines, and risk assessment and management.

B.5 Clinical sciences and skills

The chiropractic institution should identify and include in the curriculum those contributions of the clinical sciences that ensure students have acquired sufficient clinical knowledge and skills to apply to chiropractic practice in a primary contact setting.

The clinical sciences should include general diagnosis, diagnostic imaging, physical, clinical and laboratory diagnostic procedures, orthopaedics, obstetrics and gynaecology, paediatrics, geriatrics, nutrition, dermatology, pathological anatomy, neurology, spinal analysis including motion palpation, manipulative-, mobilization- and supportive- techniques, and rehabilitation.

To reflect the most common conditions treated by chiropractors, the curriculum should emphasize pain management, particularly as it relates to neuromusculoskeletal conditions.

Clinical skills should include diagnostic imaging, history taking, physical examination, procedures and investigations, communication skills, treatment procedures, patient care and management, patient advice and education, disease prevention and health promotion.

Clinical skills should include competency in general diagnosis and referral procedures consistent with scope of practice in a primary contact setting.

B.6 Clinical training

The chiropractic institution should identify and include a period of supervised clinical training to ensure the clinical knowledge and skills, communication skills and ethical appreciation accrued by the student can be applied in practice, and so enable the student to assume appropriate clinical responsibility upon graduation.

Every student should have early patient contact leading to participation in patient care.

As an essential component, the curriculum should offer a significant period of time devoted to the students' one-to-one contact with patients. This should be a minimum of one academic year spent primarily in contact with patients. The clinical training period provides the opportunity to undertake the role of primary contact practitioner within a supervised outpatient clinic, and develop clinical competency and clinical judgment.

A minimum of forty (40) complete new patient assessments, of which no more than five (5) may be direct clinical observation, plus a minimum of four hundred (400) treatment (patient) visits and a case-mix of patients should be sufficient to achieve the outcomes of the curriculum, and prepare the student for safe and competent practice as a primary contact practitioner. Above all, this period should develop a level of clinical sophistication to enter practice and a period of postgraduate training.

This period of training should reinforce issues of good record keeping, teamwork, communication with other healthcare practitioners, responsibilities of clinic management, ethics and jurisprudence.

This period of training should reinforce issues of self-evaluation through reflective practice, self-directed learning principles and an appetite for life-long learning.

The importance of tutor role models and the influence of standards in chiropractic practice set at this stage should be recognized in the clinical training facility offered to students.

Close supervision of students, which is of paramount importance at this stage, should include formative and summative feedback mechanisms.

A clinic observation programme should be in place to provide opportunities for students throughout the curriculum to observe clinical procedures in practice, to learn from more experienced colleagues, and to maintain the motivation for becoming a chiropractor.

B.7 Assessment methods and regulations

The chiropractic institution should define and document the methods used for assessment, including the criteria for progression and appeals procedures. Assessment methods should be regularly evaluated, and new assessment methods developed as appropriate.

The definition of methods used for assessment should include consideration of the balance between formative and summative assessment, the number of examinations and other tests, the balance between written and oral examinations, the use of normative and criterion referenced judgements, and the use of special types of examinations, e.g. objective structured clinical examinations (OSCE), and the role of external examiners.

Evaluation of assessment methods should include an evaluation of how they promote learning. Evaluation of assessment methods should include the quantity and quality (reliability and validity) of assessment methods, in particular the reliability and validity of assessments in clinical skills and competencies.

The assessment principles, methods and practices should be appropriate to the educational aims and objectives, and promote appropriate learning practices.

Assessment methods and assessment criteria should be made known to students at the outset of the programme, or course component, and clearly reflect the course objectives.

The number of assessments should not require excessive amounts of learning of detailed information to the detriment of time to reflect and assimilate the material.

The type of assessments should encourage an integrated approach to learning, and encourage material delivered earlier in the programme to be revisited at later stages.

All students should carry out an undergraduate research project appropriate to the level at which the degree is being awarded. This research project should consist of a research enquiry in a specified topic area using either a qualitative and/or quantitative approach. Irrespective of the design of the project, it should show clear evidence of critical thinking and appraisal of the current research evidence and of the findings from the research project.

B.8 Curriculum level, structure and composition

The chiropractic institution should describe the content, duration and sequencing of courses that guide both staff and students on the learning outcomes expected at each stage of the programme, and the level of integration between the basic sciences and clinical sciences.

Chiropractic programmes may be diverse in points of entry reflecting prior learning achievements. The length of the undergraduate programme however, should be a minimum of five (5) full-time (study) academic years. In terms of academic credits, this is equivalent to 300 credits where 60 credits equals one academic year. The clinical training period should also be delivered on a full-time basis.

The duration and modes of delivery of the programme should satisfy national requirements for graduates to practise as a chiropractor.

The integration of disciplines should include both horizontal (concurrent) and vertical (sequential) integration of curricular components. The process of integration can enhance student learning by demonstrating the relationship between programme material and future chiropractic practice. There should also be opportunities to revisit and further develop material covered earlier in the programme.

The curriculum should develop as well as educate and train students through models of self-directed learning, and by presenting them with opportunities to develop in particular areas of interest, e.g. in the research project (or equivalent).

All courses within the curriculum should have explicit learning outcomes in terms of the level of knowledge and understanding, skills and attitudes expected on completion of the course.

Annex C
(informative)

Code of ethics

C.1 Working with patients

C.1.1 Good clinical care

a) Good clinical care should include the following:

   1) adequately assessing the patient's condition, taking account of the case history, the patient's views and, where necessary, examining the patient;

   2) providing or arranging advice, investigations or treatment where necessary;

   3) the chiropractor should not misrepresent the gravity of a patient's condition;

   4) referring to another healthcare professional when this is in the best interests of the patient.

b) When the chiropractor provides care they should do so:

   1) within the limits of their competency;

   2) with regard to the fact that the welfare of the patient is paramount;

   3) in keeping with evidence-based care;

   4) with a view to improving health and quality of life.

c) The chiropractor should ensure that their records are accurate, legible and attributable. They should be an accurate reflection of the clinical encounter and should include any factors relevant to the patient's ongoing care, including their general health. All records should be understandable to another chiropractor who may be called upon to assume the care of the patient. Records should be stored securely in accordance with local legislation.

d) The chiropractor should respect the right for patients to seek a second opinion, either from another chiropractor or from another health professional.

C.1.2 Health promotion and self care

a) The chiropractor should encourage patients to care for themselves. They should advise patients on appropriate self-help measures.

b) The chiropractor should support health promotion initiatives that reduce reliance on health professionals. This can include advising patients on the impact of lifestyle choices on their health and wellbeing.

C.1.3 Raising concerns about patient safety

a) Where the chiropractor has concerns about the safety of patients, they should report those concerns to the appropriate body after having made every effort to ascertain the facts.

b) If the chiropractor has concerns about the safety of patients, they should document them, along with the steps they have taken to try to resolve them.

C.1.4 Equality and diversity

The chiropractor should act in accordance with legislation to ensure fair access to assessment and care. They should not discriminate on the grounds of colour, race, age, disability, ethnic origin, lifestyle choices, gender, sexuality, marital status, socioeconomic status, religion or beliefs.

C.1.5 Keeping up to date

a) The chiropractor should keep their skills and knowledge up-to-date throughout their professional life.

b) The chiropractor should be aware of practice and clinical guidelines that impact their work and should apply these in their practice.

c) The chiropractor should be aware of and comply with codes of practice relevant to their jurisdiction.

d) To enhance the quality of the care they provide, the chiropractor should liaise with colleagues and patients and conduct clinical and practice audits. They should be prepared to modify their practice where it is clear that any particular intervention is not working.

C.1.6 Teaching, training, appraising and assessing

a) Where the chiropractor is involved in teaching, training, appraising or assessing they should ensure that the information they provide is accurate. They should be clear when making use of theories which have not yet been verified or subjected to academic or scientific investigation or research.

b) Where the chiropractor is involved as a teacher, they should ensure that they develop the skills, attitudes and practices of a competent teacher.

c) When writing reports about colleagues, the chiropractor should be honest and objective. They should not unfairly criticize a colleague nor use language that unjustly casts doubt on their character or integrity.

C.1.7 The chiropractor-patient partnership

In order to optimize the chiropractor-patient relationship the chiropractor should:

a) be polite and considerate with their patients;

b) show respect for cultural differences;

c) treat them with dignity;

d) treat each patient as an individual;

e) respect privacy and the patient's right to confidentiality;

f) support patients in maintaining their health.

C.1.8 Communicating with patients

a) As clear communication is central to the relationship between the chiropractor and their patients, patients should be involved in their care and the chiropractor should encourage them to take an active role.

b) The chiropractor should take account of any special needs when communicating with patients. These may include physical or learning disabilities.

c) The chiropractor should explain clearly to their patients information about what will happen during their assessment and care. They should also tell them about the results of the assessment, their plan of management and when their care will be reviewed.

d) Prior to commencing treatment, the chiropractor should inform their patients about the relevant risks and benefits of the treatment they will provide, and any other options for care.

e) The chiropractor should inform their patients how information about them will be recorded and stored. Chiropractors working in jurisdictions where data protection legislation exists should ensure that they are registered with the relevant body and comply with the provisions of that legislation.

f) The chiropractor should inform their patients who will have access to their records and the measures in place to ensure confidentiality.

g) The chiropractor should have in place a clearly documented complaints procedure. Patients wishing to make a complaint about their assessment or care should be provided with information to enable them to do so.

h) Patients should be informed about the arrangements that chiropractors have in place to provide assessment and care if they are unavailable.

i) Where the chiropractor works with others, patients should be given information on who has responsibility for their day-to-day care and, if this is different, who is accountable for their overall care.

j) If the chiropractor delegates work to others, they should ensure that patients understand the relationship and the responsibilities of the person delivering the assessment or care.

k) Patients should be informed about the need for sharing of information to enable effective care to be provided. If patients decline to give consent for information to be shared, they should be informed about the implications of this and how it may affect their care.

C.1.9 Communicating with other health professionals

a) The chiropractor should share information with the general medical practitioner or any health professional from whom a referral has been received.

b) With the patient's consent, the chiropractor should disclose all relevant information requested by another health professional.

c) The chiropractor should correspond promptly with other health professionals when it is clear that onward referral should take place.

d) In emergency situations, the chiropractor should produce a clear and comprehensive record of events to enable the healthcare team to understand fully the chiropractor's involvement in providing assessment and care and the precise nature of events.

e) Where further investigations are required, the chiropractor should ensure that all relevant information is provided to those undertaking diagnostic procedures.

C.1.10 Preparing reports for third parties

a) Where reports are required by third parties, consent should be obtained from the patient for disclosure of information to take place.

b) The disclosure of information should be limited to only that which includes information requested by the third party.

c) The chiropractor should ensure that they understand the reason for the request for information and should discuss the request with the patient.

C.1.11 Children and young people

a) Within their practice, the chiropractor should safeguard and protect the health and wellbeing of children and young people.

b) The chiropractor should act where they think that the rights and welfare of children and young people have been denied or abused.

c) The chiropractor should consider how information provided to them may be understood and adapt their communication to take account of this.

d) The chiropractor should identify when there is a need for another person to be present when they are assessing or caring for patients. This is particularly relevant in the case of children and young people, where another person (who may be a parent or guardian) should be present unless express consent is given for the child or young person to be seen in the absence of a chaperone.

C.1.12 Vulnerable adults

a) The chiropractor should consider whether a patient is vulnerable by virtue of their health and circumstances and take steps to ensure that their wellbeing is safeguarded during the provision of assessment and care. They should also consider the capacity of patients to understand information provided to them and the validity of consent in relation to this.

b) The chiropractor working with vulnerable adults should consider whether it is appropriate for another person to be present when providing assessment and care.

c) The chiropractor should not exploit the vulnerability of patients by expressing their personal beliefs, or their religious or political views in any way that might cause them distress or make them feel uncomfortable.

C.1.13 Dealing with relatives, carers and partners

a) The chiropractor should be considerate to relatives, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died.

b) In providing information, the chiropractor should be mindful of confidentiality and the implications of disclosing information about patients to others.

C.2 Openness and honesty

C.2.1 General

a) The chiropractor should be open and honest with their patients.

b) The chiropractor should not misrepresent the gravity of a patient's condition.

c) The chiropractor should not withhold information that may influence the patient to decline assessment or care. This may include information on risks or side effects of treatment.

d) All information provided should be tailored to the patient's specific needs and be delivered in the best interests of the patient.

e) The chiropractor should recognize when a patient's condition is beyond their scope of practice and communicate this to patients openly and honestly.

C.2.2 Maintaining trust in the profession

The chiropractor should not abuse their professional position to pursue a sexual or improper relationship with a patient or someone close to the patient. Improper behaviour may include words and gestures of a sexual nature.

Where a chiropractor finds they are sexually attracted to a patient or the patient is sexually attracted to them, they should immediately seek alternative care for the patient.

C.2.3 Consent

Consent is an ongoing process, not a one-off event. The chiropractor should ensure that they communicate with patients throughout the clinical encounter and should ensure that privacy is provided to facilitate this process.

The chiropractor should ensure that the patient receives information about the assessment and care that is available to them and that it is presented in a way that is easy for them to follow and use. This allows the patient to be involved in their care and make decisions that are appropriate for them. Consent may not be valid if the patient does not understand the nature of the information given to them about the proposed assessment or care.

The chiropractor should be satisfied they have the valid consent of the patient (or someone able to act on their behalf) before they proceed with:

- examination;
- investigation;
- treatment;
- involving the patient in teaching or research.

The chiropractor should not use their professional position to persuade a patient to consent against their will.

Information to be provided to the patient to allow them to make informed decisions about their assessment and care should include:

a) purpose of and need for any assessment or investigation;

b) diagnosis;

c) proposed treatment or management of the condition;

d) options for care that are available to them;

e) likely outcomes with or without care;

f) any foreseeable risks and likely benefits;

g) who will be involved in and responsible for the assessment and care;

h) any reasons for referring the patient to another health professional;

i) any reasons why another healthcare professional may need to be involved in assessment or care;

j) whether the care is linked to a research programme;

k) financial implications of the recommended care.

The chiropractor should assume that the patient has the capacity and is competent and capable of making decisions unless there is clear evidence to suggest that they are not. The chiropractor should consider any factors that may affect a patient's ability to give informed consent. These may include language issues and physical or learning disabilities.

Unexpected decisions do not prove that a patient is incompetent or lacks the required capacity to provide consent. It may, however, indicate that further information needs to be given to the patient. Capacity is also 'decision-specific'. This means that patients may be capable of making some decisions but not others.

If there is any doubt as to whether a patient has the capacity to consent, advice should be sought from a suitably-qualified health professional.

The chiropractor should exercise their professional judgement in assessing the capacity of children and young people to give consent to assessment and care.

The chiropractor should understand and comply with the legislation in their jurisdiction in relation to issues surrounding consent and young people.

C.2.4 Providing access to patient health records

When a patient requests access to their personal health records, it should not be unreasonably withheld.

NOTE Patient health records are subject to European data protection [9].

Where statutes include provisions for access to medical records, the chiropractor should ensure that they are familiar with relevant legislation and comply promptly with any requests for access.

C.2.5 Confidentiality

The chiropractor should respect patient confidentiality at all times. This includes their personal details, information about their health and healthcare needs, their management and any information disclosed to the chiropractor during the course of their assessment and care.

The chiropractor should not employ any style of practice that may compromise the duty of confidentiality. Where circumstances exist in which confidentiality cannot be assured (for example, on the sports field) the chiropractor should confirm with the patient that they are content to undergo assessment or care.

The chiropractor should ensure that information contained on paper or electronically is kept secure and that access by non-authorized personnel is prevented.

NOTE There are exceptions to the rule of confidentiality. These include:

a) where disclosure is required by statute;
b) where disclosure to the appropriate authority is clearly within the public interest;
c) where the patient or others are at risk of death or serious harm;
d) where an official with power to order disclosure makes an order.

Where disclosure takes place, the reasons for the disclosure should be recorded, as well as the nature and extent of the disclosure.

C.2.6 Discharging patients

The chiropractor should not treat the patient unnecessarily and should be able to clinically justify decisions to continue care.

When care can no longer be justified on the basis of clinical need, the chiropractor should discharge the patient without delay.

When the chiropractor discharges the patient, they should explain the reason for them discontinuing care. The chiropractor should not discharge the patient purely on the grounds that they have raised issues about their care or have complained about their chiropractor; however, in some circumstances such complaints may render the ongoing chiropractor-patient relationship unworkable.

Unless a programme of care has ended and the patient is being discharged on clinical grounds, the chiropractor should ensure that, where it is practicable, information is provided to the patient about where care may be continued. This may involve referral to another healthcare professional (who may be a chiropractor).

The chiropractor should document their reasons for discharging the patient.

C.3 Working with colleagues

C.3.1 General

a) Where the chiropractor works in a team, either with other chiropractors or with other health professionals, they should respect the skills and contributions that others bring to the care of the patient.

b) The chiropractor should communicate effectively with colleagues inside and outside of the clinical team.

c) The chiropractor should support colleagues who have problems with performance, conduct or health.

C.3.2 Colleagues' conduct and performance

a) Where the chiropractor has concerns about the conduct, performance or health of colleagues they should act without delay to address these concerns so that patients are protected.

b) If there are no local systems in place to report or address concerns, they should be addressed to the regulatory body. Where no regulatory body exists, concerns should be addressed to the relevant national association.

C.3.3 Respect for colleagues

a) The chiropractor should treat colleagues fairly and with respect. They should not unfairly criticize them or discriminate against them. In particular, the chiropractor should not engage in behaviour that undermines patients' trust in the care they receive or in the judgement of those treating them.

b) The chiropractor should not allow their personal beliefs to affect their professional relationships with colleagues.

C.3.4 Sharing information with colleagues

a) Where appropriate, information should be shared with other health professionals. This is important for safe and effective patient care.

b) When a patient is referred to another health professional, the chiropractor should ensure that all relevant information is provided to the health professional receiving the referral.

c) Consent should be sought from the patient to provide this information.

C.3.5 Delegation and referral

If responsibility is delegated, the chiropractor will remain responsible for the overall management of the care of the patient. The chiropractor should ensure that the person to whom care is delegated possesses the qualifications, experience, knowledge and skills necessary to provide the care. Information should be provided by the delegating chiropractor to facilitate effective delegation.

Any person to whom a chiropractor makes a referral should be accountable to a regulatory body.

C.3.6 Honesty and trustworthiness

a) The chiropractor should never abuse the trust of a patient.

b) A chiropractor who has been the subject of criminal convictions or who has received a caution or has been refused membership of any other professional body should report these facts to their national association and statutory regulator where one exists.

C.3.7 Providing and publishing information about chiropractic services

a) If the chiropractor publicises their practice, or asks another person to do so on their behalf, they should ensure that the materials that are used are honest, decent, legal, factual and verifiable.

b) The chiropractor should not market their practice in a manner that undermines public trust and confidence in the profession.

c) No claims about treatment or outcomes should be made that are unjustifiable. There should be no guarantees of a cure.

d) No pressure should be placed on people to use chiropractic services, for example by arousing ill-founded fears about their current or future health.

e) The chiropractor should not use any title in a way that might mislead the public as to its meaning or significance.

C.3.8 Writing reports and giving evidence

a) The chiropractor should respond promptly and courteously to requests for information from other health professionals and third parties. They should seek the consent of the patient for the information being provided.

b) Where the chiropractor has been asked to give evidence or produce statements they should be honest in all spoken and written testimony. Where matters are outside the scope of practice or competence of the chiropractor, they should declare this.

c) In writing reports, the chiropractor should mention all relevant facts and only provide their opinion on matters that are within their expertise.

C.3.9 Research

a) The chiropractor who is involved in research should always prioritize the interests of the research participants (who may or may not be patients of the chiropractor).

b) Research design should be consistent with accepted scientific and ethical principles.

c) In conducting research, the chiropractor should act with honesty and integrity and should not misrepresent the findings of research. The chiropractor and their staff should carefully comply with procedures detailed in the research protocol.

d) The chiropractor should keep the identity of research subjects confidential and should at the outset of research obtain their informed consent to be part of any trial or experiment.

e) A patient should be informed of their right to withdraw from the research at any time.

C.3.10 Financial dealings

The chiropractor should be open and honest in their financial arrangements with patients. In particular,

a) the chiropractor should make clear to the patient information about their fees and charges;

b) to avoid dependency, prepayment programmes should not be utilized;

c) the chiropractor should not exploit the vulnerability or ignorance of a patient about chiropractic care when making charges for care;

d) the chiropractor should not encourage a patient either directly or indirectly to give or bequeath gifts or money for personal gain;

e) the chiropractor should be open and honest with employers, insurers and other organizations or individuals;

C.3.11 Conflicts of interest

a) The chiropractor should always act in the patient's best interest when making referrals and providing care. They should not ask for nor accept any inducement or gift that may affect or be seen to affect the way the chiropractor treats or refers a patient. The chiropractor should not offer inducements to colleagues or other health professionals.

b) The chiropractor should make clear to the patient any financial or commercial interests they have in recommending products or services.

C.4 Health and safety

C.4.1 General

a) The chiropractor should manage and deal with risks to health and safety in the work environment and comply with any health and safety legislation.

b) The chiropractor should have in their practices contingencies for managing emergency situations involving either patients or hazardous materials.

c) In terms of controlling and managing infection risk the chiropractor should have systems in place to protect the health and wellbeing of their patients, employees and visitors to their place of work.

d) The chiropractor should comply with legislation relating to the use of ionizing radiation. In particular, the chiropractor should not employ any technique or practice that requires the routine use of X-rays.

C.4.2 Evidence-based care

a) The services provided by the chiropractor should be consistent with evidence-based care. The chiropractor should have an updated knowledge within the field of chiropractic research as well as research within the neuromusculoskeletal area in general.

b) The care delivered should comply with what is expected of a reasonable and competent chiropractor, and should be based upon the best available evidence.

c) Recommendations from appropriate national and/or international clinical guidelines within the neuromusculoskeletal area should be incorporated in the clinical procedures.

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