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Introduction to Public Health, Public Health Agencies, and the APHA

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DEFINITIONS AND DESCRIPTIONS OF PUBLIC HEALTH

This book is designed to be used as a textbook for teaching public health courses to chiropractic students and as a professional reference for doctors of chiropractic during their careers, whether in private practice settings, in teaching and educational administration, or related employment. For these purposes, a common language or lexicon, nomenclature, and terminology to facilitate communication with all the various disciplines involved in public health is essential. And a common definition of “public health” might be ideal.

Public health, however, is a broad and diverse multidimensional field that includes many health-related

disciplines. One universally accepted standard definition of public health does not exist. Instead there are many acceptable definitions of public health available from various authoritative sources. And all of the definitions of public health have a precursor in the definition of “health,” which according to the World Health Organization (WHO) is: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”¹

Some years ago, the American Public Health Association (APHA) emphasized the following definition of public health: the *application* of medical, social and allied disciplines in an organized *community* activity designed primarily to *protect* and advance the health of the people (*italics* added). The word *application* is used because public health is practical, not just theoretical; *community* is used because

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the unit of concern and the intervention target is the group or larger community as a whole rather than just the individual patient; and *protect* is included because the focus is on prevention rather than treatment or curative care. More recently, APHA publications seem to prefer the 1988 Institute of Medicine definition for public health: “Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.”² The APHA website in 2008 stated: “Public health is a series of individuals, communities, activities and programs working to promote health, to prevent disease, injury and premature death and to ensure conditions in which we all can be safe and healthy.”³

Some experts have pointed out that public health is a fusion or amalgam of two other disciplines, clinical medicine and epidemiology. There are many other good definitions of public health; each has a somewhat different emphasis, perhaps depending on the background of the definer because public health is so multidisciplinary and includes so many experts from so many diverse areas of expertise. Some emphasize the target for intervention and define public health as community medicine or community health; others emphasize the methodologies and simply define public health as “preventive medicine.” Some emphasize the social justice aspect of public health: “what we do as a society to provide an environment for health and to protect those that cannot protect themselves.”⁴ Many experts define public health as any and all aspects of government’s involvement in health, whereas others stress the importance of collaboration, of partnerships formed between government and the private sector. Public health is primary care integrated with community actions. Many public health terms, including the term *public health* itself, are better explained by lists of what is included under the definition rather than by a pure dictionary definition alone, and the categories that help characterize a term are not always completely mutually exclusive. Public health is like a diamond with many facets, and no one facet defines the entirety. A more recent modern trend is to emphasize the health promotion and wellness aspect of public health, with *wellness* being the buzzword of the day.

Still in wide use today, C. E. A. Winslow’s classic definition of public health from the 1920s is:

the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which

will ensure to every individual in the community a standard of living adequate for the maintenance of health.⁵

Mary-Jane Schneider, PhD, in her 2000 book *Introduction to Public Health* claims that public health is “. . . an abstract concept, hard to pin down . . .”⁶ and states further that, “Public Health is not easy to define.”⁷ Likewise, Bernard Turnock, MD, MPH, former director of both the Illinois and Chicago Departments of Public Health, in his 1997 book *Public Health: What It Is and How It Works*, says, “What has become clear to me is that the story of public health is not simple to tell.”⁸ These comments by noted authorities who work and teach in the public health field are an understatement, and if they cannot define public health, who can? If the definition is, “It is what it is,” in the vernacular, “what it is,” equates to “what it’s all about.” And public health is about many, many diverse things. Besides everything else under this broad umbrella called public health, the public health field, the public health profession, and a public health education course are “all about” the following:

- Politics and political questions; public health is both political *per se* and in its context.
- Primary care, and all the multidisciplinary practitioners who provide it.
- The environment, and the lifestyle choices/components of health.
- Hygiene and sanitation.
- Government’s roles in protecting the health of the people (e.g., the U.S. Surgeon General and his or her recommendations).
- The contagious, communicable diseases, the reportables, the sexually transmitted diseases (STDs), acquired immune deficiency syndrome (AIDS), and safe sex.
- Wellness, and healthy people in healthy communities.
- Prevention, and prevention, and prevention.

This list illustrates one more reason there are so many acceptable definitions for the term *public health*. An operational definition of public health is *what public health does*. This definition has the added advantage of being able to change as public health needs change over time and place, but also has both the strength and the weakness of being rather all-encompassing.

Whether concerned with learning or teaching public health, unlike certain other medical sciences such as anatomy, which are relatively static, it becomes obvious that public health, like personal health status, is dynamic and ever changing, almost like a study of international and global current events as well as domestic ones.

There are valid general indicators or indices of the health status of a community. Defined in this book's Glossary, *incidence*, *prevalence*, *morbidity*, *mortality*, and *life expectancy* are the most commonly used indices for determining the health status of a community as a whole, and for comparisons among communities or even entire nations. Statistical rates (various proportions expressed per a base, most commonly a base of 1000 people) are calculated, and discussions should include both gross rates and the specific rates that are the pieces of the pie described by the overall gross rates. The failure to include both gross rates and the specific rates that *in toto* compose the gross rates, and a lack of homogeneity among communities or nations being compared, often leads to flawed conclusions, but nonetheless the rates and indices are useful descriptive tools.

The so-called triad or triangle, which in normal balance is called *health* and when out of balance is called *disease*, consists of agent-host-environment. To oversimplify, allopathic medicine concentrates on the agent factors, chiropractic care concentrates on host factors, and public health concentrates on environmental factors. Although the general public often associates health with provision of medical care, public health professionals are equally concerned with the other-than-medical-care determinants of health (overall living conditions, nutrition, degree of environmental sanitation, educational levels, war and peace, lifestyle choices, socioeconomic status, racial and ethnic categories, gender, and other disparities and inequities). Health is typically discussed as an entity, but in reality health is less of an entity and more of a status, an ever-changing, moving target, not static but dynamically changing on a continuum or sliding scale from before birth to death. The level of health care intervention is geared to the level of health need, ranging from prenatal care to postmortem care. Public health decision makers must be cognizant of this continuum and its ranges when formulating health policy.

The scope of public health goes through an ongoing evolution over time and is still changing. Among other things, it includes the traditional contagious communicable diseases; health problems, projects, or programs that affect large population groups having some characteristic in common to form a community of patients; programs funded by government or tax dollars or public funds; noncommunicable health threats having high frequency with resultant high societal costs of morbidity and mortality; the catch-all category of any health need that is being unmet or not even addressed by the private sector, such as medically underserved populations or geographic areas, so that government must step in, almost by default; and any disease or situation that is defined as preventable, or any disease

or health situation that by its very nature is preventable or having high potential for *preventability*, and any and all efforts that focus on prevention rather than treatment. Public health is both theoretical and practical, based on strong science and balanced by pragmatic realities.

Hygiene is a term currently more commonly used to refer to personal cleanliness; however, it formerly was used to describe the science of preserving and promoting health in general. The term was often joined or used in conjunction with public health (e.g., public health and hygiene classes). The term *hygiene* can also mean anything that a person or patient does to alleviate their own health issue or prevent its recurrence. In clinical practice, including chiropractic clinical practice, there is a long tradition of recommending individual patient hygiene and simply calling it "patient dos and don'ts." A variation of hygiene, *social hygiene*, is used to describe the hygiene and prevention of disease for groups rather than individual patients.

On a broader level, the term *sanitation* is used to describe control of the environmental risks to health. Although originally used to refer to garbage, filth, or unclean or dirty conditions (i.e., unsanitary), sanitation risks now also include microbial hazards, pathogens, toxins, and over time have come to include physical hazards as health threats in the physical environment. Sanitization refers to the process of efforts to perform sanitation on inanimate objects and surfaces. The phrase *environmental hygiene and sanitation* is still in common use in public health.

Within public health, whether discussing the field of public health, the practice of public health, or formal education programs in public health, it is customary to refer to the various branches, tracks, or areas it encompasses. There are various ways to group or classify these branches. One common list of the branches is:

- Epidemiology
- Biometry and biostatistics
- Environmental health sciences
- Health care services
- Health resources management
- Occupational or industrial medicine
- Population sciences and international health

Other equally good classifications combine health care services with health resources management, or combine epidemiology and biometry, or separate population sciences from international health. But all are ways to group various areas of specialized expertise and knowledge into logical components and a structured conceptual framework.

It is said that public health has a philosophy and a goal (or goals). Its philosophy is to prevent disease by treating the community to provide an environment for health, to

care for the community at large as a whole, to emphasize lifestyle and environmental factors in health, and to take a multidisciplinary team approach to care. And its goal is simply *to prevent*—to prevent by having the greatest possible positive impact on morbidity and mortality within a community, to prevent by doing the most good for the most people while spending the least amount of money, to prevent by providing some basic health care for all people as opposed to a higher level of health care for the select few, to prevent by protecting the health and providing the social justice of care for those who can neither protect themselves or obtain their own, to prevent by providing an environment in which health can occur, and simply to prevent whatever can be prevented.

Public health also has a vision (Healthy People in Healthy Communities) and a mission (To promote health and prevent disease). As mentioned earlier, a unique feature of the public health philosophical approach is that it attempts to prevent disease by treating the community to provide an environment for health. To a public health practitioner, the community is the patient. The unit of study and of concern is not the individual, but rather larger population groups. And the community is increasingly international (i.e., the global community concept).

The public health methodology has several characteristics:

- Recognition of group responsibility
- Reliance on teamwork, interdependence, and multidisciplinary referrals
- Acknowledgment of prevention itself as a major program objective
- Recognition of disease as a multifactorial problem requiring multidisciplinary solutions
- Declaration that health care leading to maximally attainable health is a right of every citizen of every country and of every person on the planet
- Utilization of epidemiology to determine a host of factors and their interrelationships
- Dependence on biostatistical methods
- Education of the public
- Adaptation of programs to local community culture
- Recognition of the agent-host-environment triad, but with emphasis on environment

The public health approach, reiterated by former U.S. Surgeon General David Satcher, MD, PhD, from an earlier Centers for Disease Control and Prevention (CDC) report, involves “. . . defining and measuring the problem, determining the cause or the risk factors for the problem, determining how to prevent or ameliorate the problem, implementing effective intervention strategies on a large scale, and subsequently evaluating the impact.”⁹ An oversimplification of the public health approach is

simply to identify the risk factors and the high risk population groups, and then somehow devise barriers or ways to keep them apart.

Public health originally had four so-called classical functions: (1) control of communicable diseases, (2) provision of health care services including clinics and labs, (3) environmental sanitation, and (4) health education and research. These four have now been condensed and summarized into the three modern core functions of public health: (1) assessment, (2) policy development, and (3) assurance.

In 1990, the Public Health Practice Program Office of the Centers for Disease Control and Prevention published a list of what it termed “The 10 Essential Public Health Services,” which are listed in **Table 1-1**.

As a body of knowledge, public health includes some important concepts and many important facts. This book’s Glossary lists some key terms and their definitions. To make further reading more comprehensible, the reader is advised to become familiar now with at least the following terms: high risk group(s), and both generic and health hazard-specific subgroups; rates; incidence and prevalence; morbidity and mortality; primary, secondary, and tertiary care; sanitation and sanitization; environment and ecology; hygiene and social hygiene; prophylaxis; gatekeeper; triage; and health promotion.

Chiropractic and Public Health

There is a unique aspect to chiropractic students and chiropractic doctors learning about public health. Every

Table 1-1 The 10 Essential Public Health Services

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1. Monitor health status to identify community health problems.
 2. Diagnose and investigate health problems and health hazards in the community.
 3. Inform, educate, and empower people about health issues.
 4. Mobilize community partnerships to identify and solve health problems.
 5. Develop policies and plans that support individual and community health efforts.
 6. Enforce laws and regulations that protect health and ensure safety.
 7. Link people with needed personal health services and ensure the provision of health care when otherwise unavailable.
 8. Ensure a competent public health and personal health care workforce.
 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
 10. Research for new insights and innovative solutions to health problems.
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other course in their chiropractic curriculum or postgrad seminars has the goal of preparing them for the one-on-one encounter with each of their respective patients. Only their public health courses or extra training have a different and unique focus: preparing them for their broader role as primary health care providers within the health care delivery system. Although in one sense they are “limited” primary care providers, nonetheless all caregivers have limitations, including those with less restricted licensed scopes of practice.

Likewise, the challenge of teaching public health to chiropractors or chiropractic college students is to take material that is not necessarily intrinsically interesting, and perhaps not even of obvious current or future professional relevance, and to present it in such a way that learning occurs, learning objectives are met, learning is enhanced, and the student becomes motivated and excited about future participation and the integration of chiropractic into mainstream public health activities. A public health class in a chiropractic college is like that in any other institution of higher learning, and the nature of the material is such that many of the topics presented are contemporary international current events. Recognizing the importance and the need for high quality standard education in public health concepts for chiropractic students, Michael Perillo, DC, MPH, and his project participants and collaborators obtained a Health Resources and Services Administration (HRSA) grant for 2000–2002 to research this topic, and constructed *A Model Course for Public Health Education in Chiropractic Colleges*.¹⁰ The Chiropractic Health Care section of the American Public Health Association assembled a task force that provided some suggestions for the content and syllabus for the proposed model course. Several trends in the chiropractic profession in the various areas of public health were noted in this model, including the following:

- Chiropractors already utilize some public health skills in practice, particularly in the area of clinical preventive services.
- There is room for improvement. Enhanced public health training should represent an important tool for the chiropractic health professional to meet 21st-century challenges.
- There is an indication of a small population impact, primarily as complementary to conventional medical care. Impact may be a function of practice functions as well as geographic location. Further assessment of this impact is warranted.
- There appears to be a need and desire for more training in the public health area on the part of students and field chiropractors.
- To help achieve inclusion as a practice characteristic, public health knowledge and skills in chiropractic education should emphasize clinical learning over classroom learning, and be included in various examinations, including the National Board Exam.
- Public health training may have direct implications for the profession’s wellness model.¹⁰

Doctors, including doctors of chiropractic, have certain legal, ethical, and moral responsibilities to public health. These include registering themselves and their practice locations with their local health department (often not done as commonly now as in the past); reporting communicable diseases encountered, whether suspected, known, or diagnosed, even if not treated; educating their patients in hygiene and sanitation as it relates to their condition; observing good personal and environmental hygiene and sanitation in the practice setting; and counseling or teaching patients how to prevent or ameliorate health problems.

PRIMARY, SECONDARY, AND TERTIARY LEVELS OF CARE AND PREVENTION

The Three Levels of Care

Public health is concerned with primary care, secondary care, and tertiary care, and in particular with primary prevention, secondary prevention, and tertiary prevention, whether for acute or chronic conditions. See the Glossary for more comprehensive definitions for the relative terms *primary care*, *secondary care*, and *tertiary care*. In 1976 the National Academy of Sciences reviewed 38 different but acceptable definitions or variations on the theme of primary care. For the sake of introduction, these variations, and those for secondary and tertiary care, can be paraphrased to the following working definitions:

- *Primary care* is office setting-based; is concerned with outpatients who are ambulatory (or in their customary state of ambulation); emphasizes preventions, health promotion, and health maintenance; has a pattern of care that is more general than specialized; is rendered by a physician or provider of first diagnostic or therapeutic encounter or first contact who is considered a portal of entry and referral; deals with more minor health issues or more serious health problems in their earlier stages; and includes basic public health screenings and a degree of comprehensiveness of services either directly or by referral.

- *Secondary care* is hospital setting–based; is concerned with inpatients who have been rendered at least partially nonambulatory by their health problem(s) and are hospital bed-ridden for at least a portion of the day; includes so-called routine surgeries; and is more specialized, intensive, and costly than primary care.
- *Tertiary care* is also hospital setting–based, but is rendered in specially designated areas of general hospitals or at specialty hospitals or major medical centers; uses more advanced techniques, technology, equipment, personnel, staff, and other resources; includes more complicated surgical operations; and is qualitatively and quantitatively more specialized, intensive, and expensive than either primary or secondary care.

Note, however, that an equally good paradigm of defining these levels of care reserves the term *tertiary care* for care rendered in tertiary care facilities such as nursing homes and skilled nursing facilities. Its emphasis is on rehabilitation and restoration, or simply ongoing care, even if in the ambulatory setting, that is continued after a patient is discharged from a hospital or other facility (i.e., tertiary care equals postdischarge care).

Although the focus of this chapter is public health in the United States, mention should be made that other countries have different nomenclature for the divisions of their health care. Using just one example, in England most physicians are either exclusively office-based or exclusively hospital-based, so that becomes the duality of its primary and secondary care.

Chiropractic care is clearly a type of primary care or may even be called limited primary care. In a society that has come to recognize great value in pluralistic and multidisciplinary team approaches, chiropractic adds another dimension of freedom of choice, alternative and complementary methods, and wide applicability. It is likely the specific treatment of choice for many ailments and provides a measure of general palliative relief to many others where it is not the preferred treatment of choice. Chiropractic is most known and recognized for treatment of nonsurgical spinal disorders and neuro-musculo-skeletal conditions, but there is also considerable anecdotal evidence for its usefulness in many visceral or somatic conditions.

Depending on which of the many definitions and how stringent the criteria, chiropractic care would appear to satisfy most of the components of the primary care definition, or at least be in substantial compliance with it—stronger on some elements while weaker on others.

Both proponents and opponents of considering chiropractors as deliverers of primary care might arguably agree that it is not necessary to meet all aspects and components in order to qualify under a definition; rather, most criteria should be met in full or in part to achieve substantial compliance and achieve the objectives of defining a category. An obvious but salient point is that no provider of primary care can be all things to all ill, injured, and needy people. Only a *degree* of comprehensiveness in caregiving is required by most definitions for primary care, with referral to a specialist when indicated being one of the key parts of the primary care definition. Chiropractors already function as gatekeepers and triage points for sorting and acting as portals of referral into the health care system. There is even an old chiropractic adage: “Chiropractic first, medicine second, surgery last,” which somewhat parallels primary, secondary, and tertiary care, at least in its consideration of three levels based on severity of illness and intensity of services. There are both traditional and nontraditional primary care providers; in fact, if some groups of nontraditional primary care providers, particularly chiropractors, were offered additional training and formal recognition with defined roles within primary care, then some of the shortage of primary care providers would likely be alleviated.

Chiropractic care is a form of conservative, noninvasive, nondrug, nonsurgical primary care. Chiropractors are primary care providers who use adjustment or manipulation of the spine and other articulations as their preferred treatment of choice, and utilize other forms of manual therapies or so-called “body work” for diagnosis, analysis, treatment, and prevention. Without arguing semantics, specific adjustments to reduce or correct subluxations, general and specific manipulation to improve joint function or relieve nerve pressure, and the other natural and holistic interventions performed by chiropractors have gained widespread public support and ever-increasing scientific community and medical world acceptance as well.

Of course the terms *primary care*, *secondary care*, and *tertiary care* are relative one to another, and not completely mutually exclusive; rather, they are comparative and without sharp demarcations between them, each blending and overlapping into the others. In a more nearly perfect world there would be less need for secondary or tertiary care because primary care would be so much more effective.

For several years one of the biggest compound problems in health care delivery in the United States was physician overspecialization, a shortage of primary care providers, and a geographic maldistribution of providers. Chiropractic doctors had always been a source of primary

care for certain populations, making them a natural component of a solution to this compound problem. In some geographic areas and in some medically underserved areas, chiropractors historically have been the only primary care providers serving a given community. The multidecade shortage of primary care doctors in the United States continues to the current day.¹¹ This shortage is detrimental and may cause harm to the health of a nation. It is postulated that chiropractic doctors can serve as primary care doctors or even be designated as limited primary care doctors. Certainly it is reasonable that the strengths of any given profession can help alleviate the weaknesses in another area of the overall health care delivery system. It is a very fair contention then when one profession provides a logical and rational, reasonable answer or partial answer to questions, issues, and problems raised by another profession, by government, or by society, it behooves all to collaborate on joint solutions. And although chiropractors are trained as limited primary care providers, much of their training also easily translates into those settings where secondary and tertiary care is rendered. In its *WFC Consultation on the Identity of the Chiropractic Profession*, the World Federation of Chiropractic (WFC) called for a profession-wide embracing of a patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the self-healing powers of the individual, and individual responsibility for health, and encouraging patient

independence.¹² Certainly this identity is highly compatible with rendering primary care.

It is clear that the chiropractic profession, chiropractic organizations and institutions, and individual or groups of chiropractic doctors have important roles to fulfill in social and community health. The relationship of chiropractic and chiropractors to public and community health should be no different than that of other health care providers in the community. Chiropractic students and doctors of chiropractic (DCs) need an understanding of public health in order to enhance their communication and credibility with the mainstream public health system so as to maximize their participation for the common good of all.

A few selected examples of health care system problems to which chiropractors offer partial solutions are provided in **Table 1-2**.

The Three Levels of Prevention

The best way to define the three levels of prevention in public health is to describe what is prevented in each. *Primary prevention* is the prevention of the *occurrence* or the *incidence* of illness or injury, prevented by risk reduction in susceptible populations; this is literally prevention of the initial onset of injury or illness. If primary prevention were perfect, society would need no other levels of intervention. But this is an imperfect world,

Table 1-2 Examples of Health Care System Problems to Which Chiropractors Offer Partial Solutions

Problem	Solution
Shortage of primary care providers	Designate doctors of chiropractic (DCs) as primary care providers, who after obtaining additional training can work in areas with plenary physician networks for backup.
Geographic maldistribution of primary care providers	DCs are more likely to respond to incentives to relocate to underserved areas.
High-tech but also often impersonal allopathic care	Chiropractic care and manual therapies are more personal, more hands-on, less mechanized.
Medical care that has become paternalistic and monopolistic, representing only one school of thought (i.e., “Western medicine”)	Chiropractic adds another dimension, and works well in partnership with other healing arts such as acupuncture and other Eastern traditions having similar philosophies or approaches.
Overreliance on and overutilization of drugs and surgical procedures	Nondrug, nonsurgical approach to health care.
Nonspecialist MDs are reported as undertrained for diagnosis and treatment of neuro-musculo-skeletal and low back conditions, and especially for nondrug, nonsurgical conservative care alternatives for them.	The training of DCs is geared toward neuro-musculo-skeletal and spinal conditions and focuses on conservative methods.

and primary prevention efforts can do only so much. For those cases too late or too severe by the time they are appropriately noticed, there is secondary prevention. *Secondary prevention* is prevention of disease or injury *progression* (prevention of *severity* or *prevalence* of disease or injury) by early detection and diagnosis and prompt intervention in exposed populations to reduce the extent of the burden on health. Likewise, secondary prevention efforts are imperfect, so a third level termed tertiary prevention is necessary. *Tertiary prevention* is prevention of *permanent disability* or *death* due to illness or injury, by ongoing care and rehabilitation for affected populations, treatment of complications, and restoration of functions. All three levels of prevention—primary, secondary, and tertiary—aim to prevent mortality and varying degrees of morbidity.

The public health care system includes all three levels of prevention but puts the most emphasis on primary prevention. Public health itself can be considered as the foundation or infrastructure base for primary, secondary, and tertiary care. Public health as an industry has had major accomplishments in prevention throughout history. The 20th-century accomplishments were particularly notable in the United States because organized public health initiatives were responsible for great reductions in morbidity and mortality rates and an estimated 25-year increase in life expectancy. **Table 1-3** lists, in random order, the 10 great achievements of the 20th century in American public health according to the CDC, and publicized in *Morbidity and Mortality Weekly Reports* throughout 1999.¹³ Selections were based on opportunities for prevention. Directly or indirectly, these achievements greatly benefited the health of every community during the last century and continue on into the new millennium.

Table 1-3 Ten Great Public Health Achievements in the United States, 1900–1999

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1. Identifying tobacco as a health hazard
 2. Declines in deaths from heart disease and stroke
 3. Family planning
 4. Fluoridation of drinking water
 5. Healthier mothers and babies
 6. Immunizations
 7. Motor-vehicle safety
 8. Control of infectious diseases
 9. Safer and healthier foods
 10. Workplace safety
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AGENCIES: HOW PUBLIC HEALTH SERVICES ARE ORGANIZED AND DELIVERED

A variety of types of agencies are involved in public health. The contributions of each are well-documented in the public health literature, and important for the reader to review. Their classifications are reiterated here and some important examples given, but the reader is referred to more comprehensive sources for more information about the literally hundreds of agencies involved in protecting the public and promoting its health. Remember that many entities that do not consider themselves to be health agencies and are not legally classified as such, nonetheless carry out some roles and functions that can be considered health agency tasks or as an extension or complement of them.

Agencies are how public health services are organized and delivered, an organizational resource. They are a major component of the health care system's infrastructure. The term *infrastructure* is commonly heard in public health discussions. The public health infrastructure is the underlying resources for public health, the support system. Like other public health terms, it is best defined by the components it includes:

- *People*: The human resources, key individuals and teams
- *Agencies*: The organizational resources and structures
- *Data*: The informational technology resources
- *Funding*: The financial resources and money to pay for what is needed

Public health agencies can be classified on a few different bases and characteristics: by levels of function, by sources of funding, by responsibilities, by organizational structure, and by defining characteristics. The major types of public health agencies are:

- Quasi-governmental (a hybrid category)
- Governmental, also known as public
- Nongovernmental, also known as private and abbreviated as NGO (nongovernmental organization)

Each of these will be discussed in the following sections. Although there are private agencies in existence, the term *agency* in the name of an organization most commonly indicates that it is a public sector government agency. On the other hand, the term *association* most frequently indicates a voluntary, private sector, nongovernmental organization.

Quasi-governmental

Although quasi-governmental agencies have some responsibilities assigned by government, they operate more like voluntary agencies. They are funded by combinations of grants, tax dollars, and private sources. They operate relatively independently of government supervision, but have been delegated, or contracted, or just assumed some functions by custom and default that over time became tradition. Perhaps the best example of a quasi-governmental agency at the international level is the International Red Cross, also called the Red Crescent or the Red Crystal in certain countries. It performs various services across borders during emergencies and war. Likewise, the American Red Cross performs duties ranging from war and disaster relief and services to armed forces, to safety-first campaigns, nursing services, blood drives, swimming classes, cardiopulmonary resuscitation (CPR) classes, and AIDS education while coordinating with both the civilian branches of government and the military structure.

Governmental

Government agencies are of course operated and managed by government officials, whether elected or appointed, and by salaried bureaucrats who are their employees. They are funded primarily by tax dollars or assessments and fees imposed on industries that are being inspected and regulated. They have authority for some geographic catchment area or jurisdiction. Whether fairly or not, like other government agencies, health agencies have been criticized as too bureaucratic, too political, poorly coordinated, wasteful, and duplicative.

One parameter on which to classify agencies is by the levels at which they function and the level of government that is responsible for their administration.

- International-level agencies function in two or more different sovereign nations, often in or across several.
- National/federal-level agencies function primarily within one country, although they may have satellite stations in other countries.
- State or multistate regional-level agencies function within one of the U.S. states or in a few adjacent states.
- Local-level agencies function within one city, county, district, or parish, or sometimes in combinations across a few adjacent jurisdictions.

At the international government level is the World Health Organization (WHO) with headquarters in Geneva,

Switzerland. The WHO is a branch of the United Nations and has carried out its work since 1948 in six designated regions throughout the world. It is the world's overall directing and coordinating authority on questions involving human health. Historically, the first real international public health agency was called the International Sanitary Bureau, which formed in 1851 to stop an epidemic of Asian cholera that was threatening to become a pandemic; as an ad hoc agency it disbanded after formulating its plan and recommendations. Another international agency is the Pan American Health Organization (PAHO), which is the international public health agency covering the region of the north and south Americas. Originally a free-standing agency, it existed before WHO, making it the oldest international public health agency in continuous existence; however, it now maintains some independence while operating as a branch of the larger WHO.

At the level of national government, all countries have a primary department, agency, bureau, or ministry responsible for the health of their citizens. It may be a cabinet-level agency and either part of some other agency or free-standing within government. The national-or federal-level health agency in the United States is the Department of Health and Human Services (DHHS). It includes the United States Public Health Service (USPHS), which is the principal federal agency concerned with public health in America, and the Centers for Disease Control and Prevention (CDC), which is the USPHS agency responsible for monitoring infectious disease in the United States and around the world in order to prevent disease and promote health. There are many other major and minor governmental agencies carrying out their tasks at the federal level under the overall organizational structure of the Department of Health and Human Services; their roles and functions are thoroughly described in other texts. A list of the various agencies included under the Department of Health and Human Services is maintained at its website, which can be accessed at <http://www.hhs.gov>.

At the state government-level in the United States, every state has a state health department or board of health that, similar to the national level, may be a free-standing agency or may be a branch or part of some broader agency. The state level in the United States is considered to be the level of sovereign power in health programs and is under the direction of a state health officer appointed by each state's governor. Each has the stated purpose to promote, protect, and maintain the health and welfare of their citizens.

State-level public health agencies are considered responsible for:

- Financing care for the poor and chronically disabled
- Regulating health care costs, including regulating health and other insurances
- Ensuring provider quality, including the licensing and regulation of health care facilities and professionals
- Providing training and setting standards for health professionals and for their training programs
- Authorizing local government health services as needed

Most counties and cities also have a health department or board of health, which is considered at the local level; like those at the state-wide level these may be a free-standing agency or a branch or part of some broader agency. (In Louisiana, the local level of designation is called a parish rather than a county.) Some areas have combined resources and have an agency spanning a wider region, which may consist of several smaller cities or even a few counties. The local level in the United States is the level at which regulation and provision of direct personal health services occurs. This is the “hands-on” level where many public health needs in the various communities are coordinated and regulated.

No matter what the level, each government health agency bears some responsibility for ensuring some aspect of the so-called three core functions of public health (enumerated earlier) to the people of their respective jurisdictions.

Nongovernmental

In addition to agencies operated by government entities, there are also voluntary organizations, also called nongovernmental organizations (NGOs), civil societies, or simply private sector agencies. By virtue of a formalized relationship and official designation, an NGO can be a part of or formally affiliated with a government agency and carry out specific government obligations, often as a condition of the status it holds. These NGOs may operate at any level: international, national, state, or local. They are of many types, including voluntary, professional, social, philanthropic, service, religious, and corporate. They have common defining characteristics, including:

- Created to meet a specific health need or even a single health issue, but can also cover an entire profession

- Usually categorical in purpose
- Have basic stated objectives such as research, education, services, or advocacy
- Funded or self-funded by donations, including from such sources as fundraising events and telethons
- Operated most commonly as nonprofit; occasionally as for profit
- Under their own jurisdiction rather than under direct government control
- Sometimes criticized for a lack of public health expertise and failure to coordinate with government agencies
- Often have high overhead and administrative costs
- Often able to energize a community response by an emotional appeal for their issue of interest rather than the more standard public health approach of starting with a survey of community needs and then prioritizing them for action steps
- Especially effective for start-up programs

Voluntary agencies usually cooperate with government agencies, but sometimes conflict when self-interests or special interests diverge from government plans. The standard public health approach of conducting community needs surveys and inventories; gathering and processing data; identifying trends, patterns, and clusters; ranking priorities; and balancing these against budget constraint realities is sometimes seen by private agencies as too bureaucratic, too much “red tape,” too slow moving, and too confining for their liking.

Examples of larger voluntary NGOs include the American Cancer Society, American Heart Association, American Lung Association, Braille Institute, Diabetes Association, and many other fine agencies. NGOs can have various subcategories or classifications as well. Service organizations and social clubs such as the Shriners with their string of children’s hospitals, the Elks, the Lions, Rotary International, and many others include health services among the other worthy and charitable causes they support.

Likewise, religious organizations and churches, sometimes referred to as the faith community, can fulfill health roles. Faith-based ministries, notably the Catholic, Protestant, and Jewish congregations, have often included a health care component within their congregations as well as extending into outreach programs. Pastoral care and chaplaincies in hospitals, missionary medicine, and relief programs have operated in both domestic and foreign sectors and incorporate a spiritual or holistic component in their approaches.

Corporate America also has created certain health care facilities that act somewhat as agencies for special target groups of workers. Workplace health and safety promotion; occupational medicine; provision of health insurance; on-site company doctors, nurses, or medical directors; Occupational Safety and Health Administration (OSHA) regulation compliance efforts; and even labor union–negotiated health benefits may qualify as an extension of public health endeavors, despite being carried out by the private sector.

Educational settings play a role in community health as well. The potential of coordinated school health programs for students, teachers, and employees to positively impact community health has been amply described in a text by McKenzie and colleagues.¹⁴ They refer to health education, on-site health services, a healthy school environment, school nutrition, and physical education as key elements that contribute to healthy students. At least in public schools supported by taxes, this appears to be a natural role opportunity. Other aspects of the educational system as part of healthy communities would include campus clinics, infirmaries, and university hospitals and medical centers.

Hospitals, even private hospitals, in a very real sense are a community resource and component of the health care system. In that sense, hospitals also can be considered health agencies, and hospitals work collaboratively with many other health agencies in their common communities. Many hospitals also reach people outside their walls through community outreach programs.

Some communities have a variety of smaller independent clinics or dispensaries, often with services to the surrounding neighborhood provided either free or on an ability-to-pay basis. “Free” clinics may be found in many inner-city areas throughout the United States. Some of these community clinics aim their services at specific target groups, such as women, ethnic minorities, or immigrants. Many have affiliations with full-service hospitals for referral and back-up purposes.

Philanthropic foundations are entities that are formed by wealthy individuals or their corporations to rechannel some of their profits back to community causes; examples include the Bill and Melinda Gates Foundation; Ted Turner’s United Nations Foundation; the Carnegie Foundation, which funded and commissioned the famous Flexner Report on early medical education in America; the W.K. Kellogg Foundation; the Ford Foundation; and the Rockefeller Foundation. The Rockefeller Foundation is historically considered the most important for public health in the United States and has been credited with resolving endemic hookworm

infestation in the southern states, as well as for funding the implementation of the recommendations of the Flexner Report.

Professional health organizations and associations exist principally to serve the needs of their collective members. They generally have a primary purpose of promoting high standards of professional practice for their specific profession, a concept similar to historical guilds or early trade unions. Most also express somewhere in their charters or mission statements a commitment to improving or safeguarding the people’s health. Examples of professional health organizations include the American Medical Association (AMA), the American Nurses Association (ANA), the American Hospital Association (AHA), the American Chiropractic Association (ACA), and the International Chiropractors Association (ICA). The special case of the American Public Health Association (APHA) is treated separately later in this chapter.

The World Federation of Chiropractic (WFC), founded in 1988, is an international federation headquartered in Toronto, Canada. The WFC is an association of national chiropractic associations, an umbrella organization over many independent associations, and has status with the WHO as a formally affiliated NGO. The World Federation of Public Health Associations (WFPHA) provided an official letter of support for the WFC’s original application for official relations to the WHO, partly in recognition for chiropractors working within the American Public Health Association for the previous several years. The WFC application was accepted by the WHO in January 1997. As part of its overall mission, the WFC fulfills a public health role by promoting international standardization of chiropractic education, research, practice, legalization, licensing, and codified scope of practice. This commitment to protect the public as well as to further its own profession has demonstrated that the leadership of the profession has concerns broader than their identity and role as the spinal health care experts in the health care system, even while specializing in that role.

Each May the WFC sends a delegation to join the other affiliated organizations and participate in the WHO World Health Assembly meetings in Geneva, Switzerland. After working cooperatively with the WFC over a few years, the WHO published its first *WHO Guidelines on Basic Training and Safety in Chiropractic* in November 2005. The WHO has had a chiropractic researcher from Life Chiropractic College on its staff, and in 2008 it had its first chiropractor serving as a WHO intern.

The WFC established an international Public Health Committee (formerly its “Health for All Committee,” so

named to mirror the former WHO objective) under chairman Dr. Rand Baird and charged it with coordinating chiropractic public health programs with WHO initiatives, cabinet-level programs, projects, and priorities. This committee, with its international membership from the seven world regions of the WFC, coordinates a no-smoking and no usage of tobacco products campaign called CAT (Chiropractors Against Tobacco) in support of the WHO Framework Convention on Tobacco Control (FCTC) and its Tobacco Free Initiative. The Public Health Committee carries out charges from the policy level of the WFC Council and Assembly, passing statements on international health issues down to the grassroots level of producing action steps including creating and distributing materials for individual DCs to use in their own offices. Given the importance of tobacco-related morbidity and mortality, and its ranking as the number one preventable health problem in the world, the chiropractic involvement is more than symbolic. The WFC Public Health Committee also promotes efforts in support of the WHO Global Strategy on Diet, Physical Activity, and Health (GSDPAH), with emphasis on reducing the worldwide pandemic of obesity, encouraging exercise, and using postural and movement routines such as the very successful Straighten Up and Move program pioneered by Dr. Ron Kirk of Life Chiropractic College, which has been featured during the annual World Spine Day in October. Because tobacco use, nutrition choices, and physical activity all involve behavior and lifestyle modification, and all can be addressed without the use of drugs or surgery, the natural methods of chiropractic and the position of the chiropractor as a role model, health counselor, and health expert authority figure are clear. Besides World Spine Day, other international public health designated days such as World Health Day, World Environment Day, and World No Tobacco Day each May 31 are observed and promoted through the WFC and other chiropractic organizations.

Besides their actual health endeavors, all of these civil societies and NGOs, public and private alike, publish useful information both for professional audiences and the lay public. The critical significance of all of these civil societies in contributing to the overall public health mission of preventing disease and promoting health is inestimable. Around the world, the importance of coordination, cooperation, partnerships, joint ventures, and combinations of efforts among agencies of all types works to the common benefit, and as a practical issue is the only way to move forward. In fact, partnerships, joint endeavors, alliances, and other cooperative combinations between the public and private sectors and

interagency multidisciplinary cooperation are the current and most exciting development in public health.

Chiropractic Within Public Health

Roles for the chiropractic profession and individual chiropractors' involvement in these agencies are an evolving and fairly recent development. In the past few decades, chiropractic has moved from a profession that traditionally practiced outside the mainstream and in relative isolation, to one that actively seeks integration and participation. A sentiment of "me-too-ism" has prevailed as integration increases. Doctors of chiropractic having extra interest, training, expertise, qualifications, dual credentials, and advanced degrees (MPH, DrPH, etc.) have led the way to recognition in various mainstream public health agencies and even in gaining greater visibility in the private sector in nontraditional roles for chiropractors, which in turn has led to greater acceptance in the public sector. Chiropractors have served well in decision making and advisory roles on councils, commissions, and committees, and for the Department of Veterans Affairs, Department of Defense, Department of Health and Human Services, and other health departments and agencies at the international, federal, state, and local government levels.¹⁵ Chiropractors have provided clinical services in projects at Veterans Administration hospitals, and been proposed for commissions in the U.S. Armed Forces and in the uniformed U.S. Public Health Service Corps.

A new cohort of chiropractors holding the combined DC, MPH degrees developed around the new millennium, and some crossovers changed careers or pursued dual careers in public health and chiropractic. Chiropractic had long had some tradition of being a change-of-career profession, and those with a foot in each were naturally positioned to bridge gaps between professions. Even holders of the MD, DC degree combination found that the professional credibility and respect earned in one profession would generalize and carry over to another; the minority phenomenon of chiropractors obtaining hospital privileges, medical staff appointments, and various other affiliations further helped this evolution. These often successful efforts started with volunteerism, and observed track records of performance brought more and higher levels of opportunity to participate in the public health arena.

It is easy to conceptualize and envision DCs serving in salaried posts, as consultants, as members of multidisciplinary teams, and as volunteers within practically all the agencies listed earlier in every category. More

important to the various communities served, there is a need for chiropractic participation and a void without it. Chiropractors bring a unique perspective and approach to complete the health care team. As agencies become more attuned to complementary and alternative medicine (CAM) and concepts of multidisciplinary, integrated care teams, roles for chiropractors will evolve further. Public health has always had a team-care approach, and positions have opened that were originally reserved for so-called “plenary” physicians (MDs and DOs) but eventually also were filled by dentists and veterinarians who developed interests in public health, obtained public health degrees, and assumed their rightful places in public health. So too should DCs move into various roles and positions throughout the public health industry. It is not difficult to project and imagine DCs as federal, state, and local health officers in the United States, and DCs as heads or staffers in international, national, regional, and local health agencies whether governmental, NGO, or quasi-governmental. And in thinking a bit futuristically and out of the proverbial box, it’s not out of the question to envision a DC as U.S. Surgeon General. Current developments are opening new opportunities, making for a most exciting future ahead for chiropractic roles and functions within public health.

THE SPECIAL CASE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The APHA can best be summarized by Article II of its Bylaws (April 2008):

The Object of this Association is to protect and promote personal and environmental health. It shall exercise leadership with health professionals and the general public in health policy development and action, with particular focus on the interrelationship between health and the quality of life, on developing a national policy for health care and services and on solving technical problems related to health.¹⁶

Detailed information about the organization, its many units, and its functions may be found at <http://www.apha.org>.

Founded in 1872, the APHA is the oldest, largest, most influential, and most diverse organization of public health professionals in the world. It aims to protect all Americans and their communities from preventable, serious health threats. It strives to ensure that community-based health promotion and disease prevention activities, and comprehensive, quality health services are universally

accessible in the United States. The APHA represents a broad array of health providers, educators, environmentalists, policy makers, and health officials at all levels working both within and outside governmental organizations and educational institutions. As the oldest (serving the public’s health since 1872), largest (55,000+ APHA and state public health association affiliate members), most influential (among the top 15 most effective lobbies on Capitol Hill every year), and most diverse (representing 25 sections of approximately 76 professions in various aspects of public health), there is no other organization comparable to the APHA.

The APHA’s multifaceted mission is to improve the public’s health, promote the scientific and professional foundation of public health practice and policy, advocate the conditions for a healthy society (particularly advocating in Congress and mobilizing its expertise for federal agencies), emphasize prevention, enhance the ability of its members to promote and protect environmental and community health, and support its affiliate state association members. The APHA paraphrases this mission as to prevent illness and injury, to promote good health practices, to keep the environment clean, healthy, and safe. An APHA slogan is, “APHA: Protect, Prevent, Live Well,” and some of its leaders have stated that the abbreviation APHA can also stand for “Advocates for a Public Health Agenda.”

Chiropractic participation in the APHA and other public health organizations is essential for true multidisciplinary representation, and is a professional responsibility as well. It affords the profession another opportunity to participate in and help shape the nation’s health care agenda. It provides visibility and creates an atmosphere for developing interprofessional collaborations. The APHA is a strong advocate for universal health care, and is thus an avenue for chiropractic to advocate for an “any qualified provider” clause in the U.S. health care insurance system. Many chiropractic colleges have clinics that serve indigent and other underserved populations. Participation in state public health associations and involvement with local health departments can raise awareness of our clinics and ensure that they are included in public health safety networks. The APHA is also an avenue for exploring opportunities by chiropractic for inclusion in integrative care clinics and provider networks.

Structure

The APHA is a complex organization that emphasizes inclusion and diversity. Broadly speaking, members represent two main constituencies: 25 professional sections, of which chiropractic health care is one, and 53 state affiliate

organizations. In addition, the APHA has special interest groups, forums, caucuses, and a student assembly. The APHA is governed by the Governing Council, its legislative branch, and the Executive Board, its executive branch. The organization is supported by a dedicated professional staff led by the executive director. There is a broad range of leadership and service opportunities in the organization. These include association-wide boards and standing committees, as well as task forces and working groups. Each section has its own officers, council, and committees. In addition, section and affiliate leaders have the opportunity to be elected/appointed to the Intersectional Council Steering Committee and to the Committee of Affiliates that represents the association's principal constituencies. The APHA has its own newspaper, *The Nation's Health*; the prestigious *Journal of the American Public Health Association*; and an extensive website that includes substantial public health information, as well as the Chiropractic Health Care section newsletters. The APHA holds an annual convention and is an active supporter of National Public Health Week every April.

The highlight of the year is the 5-day annual meeting and convention every fall attended by as many as 15,000 members and leaders in health and government. Here one can attend thousands of scientific and educational sessions, and national public health and political figures speak at the opening and closing sessions. The Governing Council, Executive Board, sections, boards, councils, and committees all have business meetings at this time. There are endless social events and the exhibit hall is as large as some city shopping malls. The venue provides a golden opportunity to meet public health leaders from numerous universities, all levels of government, and private institutions, all dedicated to improving the health of the public.

Governing Council

The Governing Council consists of about 200 voting representatives from the 25 sections, elected or appointed members from the affiliate state public health associations, and *ex officio* members from the Executive Board. The Governing Council debates and establishes organization policies and resolutions, elects officers, guides the Executive Board, and receives reports from the association leadership.

Executive Board

The Executive Board consists of the association officers, elected members, and *ex officio* members from APHA

boards and the Intersectional Council, Committee on Affiliates, and Student Assembly. The Executive Board carries out the policy of the Governing Council, hires the executive director, oversees the administration of the association, appoints committee and board memberships, and serves as trustee of the association's assets.

Sections

Currently there are 25 sections with diverse professional missions. These range from Chiropractic Health Care, Vision Care, and Podiatric Health to Medical Care, Oral Health, and Public Health Nursing, to Statistics and Epidemiology, to Health Administration, and a variety of others. Each section has a chair, chair-elect, immediate past chair, and secretary. Each elects a section council and at least two governing councilors. The section appoints an Action Board representative and representation to the Membership and Program committees. Section budgets are allocated based on membership. The three chairs sit on the Intersectional Council. As an example of the structure of one of the sections, the Chiropractic Health Care section has the following internal committees: Awards, Communications, Membership, Nominations, Program, Resolutions, and Section Manual. The section conducts a scientific program of paper sessions and has had an award-winning exhibit booth at the APHA annual meeting. It also has several business meetings at this time, as well as a midyear meeting held during the annual Association of Chiropractic Colleges conference.

State Affiliates

The 52 state public health associations and the Washington, DC, association fall under the category of state affiliates. These are independent incorporated organizations having a contractual relationship with the APHA. Each has a representative to the Governing Council, called the Affiliate Representative to the Governing Council (ARGC). The relationship between the states and the APHA is important because it allows a coordinated effort to be made on health policy issues of both national and local significance.

Intersectional Council and Committee on Affiliates

The Intersectional Council is composed of all section chairs, chairs-elect, immediate past chairs, and a steering committee. The Chiropractic Health Care section leadership thus has the opportunity to formally interact with the

leadership of all professional sections. The function of the Intersectional Council is to represent the common interests of the 25 sections. The Committee on Affiliates (CoA) is composed of an affiliate governing councilor from each of the 10 DHHS regions, officers, Action Board members, and Executive Board appointees. Its function is to help strengthen APHA/affiliate relationships and operations.

Boards and Committees

The APHA has an Action, Education, Science, Editorial, and Publications Board. Of particular importance, all sections have a representative on the Action Board and are thus involved in planning and organizing APHA policy implementation; this includes APHA's legislative program. Standing committees include Bylaws, Equal Health Opportunity, Membership, Women's Rights, and Policy. There is also a program committee that includes a member of each section.

APHA Staff

The APHA provides extensive services to its members and organizational units. Staff is also responsible for organizational operations and policy implementation. The executive director oversees the following departments: Convention Services, Government Relations and Affiliate Affairs, Membership Services, Publication Services, Media Relations, Scientific and Professional Affairs, Learning and Professional Development, and Section Affairs.

What is the purpose of DCs' public health involvement through APHA participation? Simply stated, it is the right thing to do! Chiropractic is a holistic health care discipline. As such, it has an obligation to address the patient's social and physical environments, both on the personal level and in the community domain. Community health is the domain and purview of public health and is hence a natural fit for chiropractic participation. The APHA is *the* public health organization for chiropractic participation.

History of Chiropractic in the APHA

Public health has a long and glorious history, probably dating from prerecorded times; its written history goes back thousands of years from perhaps before 2000 B.C., all the way forward to modern days. This history is important to study but well-documented in other texts, and need not be repeated here. However, the history of chiropractic in public health in the United States, and in

particular the history of chiropractic involvement in the APHA as part of its integration into mainstream public health activities, began in the late 1970s. Just as the chiropractic profession and individual chiropractors have had a history and roles in public health, so does chiropractic and chiropractors have an important history and roles within the APHA. The APHA has been and continues to be an important vehicle for integration into mainstream public health activities. Over the years both the ACA and ICA have passed various policies and resolutions dealing with public health, not the least of which is the public's right to choose chiropractic care as part of its quest for health. Professional involvement in public health has served the public interest by enhancing chiropractic communication and credibility. In 1983 the Governing Council of the APHA passed its Policy #8331, *The Appropriate Role of Chiropractic in Patient Care*, recognizing “. . . spinal manipulation by chiropractors [as] safe and effective [for] certain disorders of the neuro-musculo-skeletal system, particularly low back pain.”¹⁷

In 1995 the Chiropractic Health Care section was established within the APHA, giving chiropractic the equity and parity with all other health care professions that it had sought. The section's name was very deliberately chosen by its leadership in order to be the only one of APHA's many sections to have both the terms *Health* and *Care* in its official name. The formal section application document of the former Chiropractic Forum special interest group within the APHA was written by a team consisting of six of the most highly regarded and acknowledged experts in the area of chiropractic and public health. The application document showed a depth of knowledge and a commitment to public health.¹⁸

Chiropractor members of the APHA have served on various APHA committees and held various officer posts within the APHA. Articles by chiropractor authors and about chiropractic care have been published in the *American Journal of Public Health* and *The Nation's Health*. Every year the chiropractic national associations and chiropractic colleges fund paper presenters, researchers, teachers, and exhibits at APHA annual meetings. Chiropractic students are encouraged to join the APHA as student members during their public health classes. The world's largest chiropractic trade paper, *Dynamic Chiropractic*, has for many years carried a regular column titled “Chiropractic in the APHA,” edited by Dr. Rand Baird with contributions from various chiropractic authors.

The ACA and the Association of Chiropractic Colleges (ACC) maintain agency membership within the APHA.

Several chiropractic colleges have also done so for a number of years, and so did the Council on Chiropractic Education (CCE). The ICA did for over 20 years. The ACA and ICA have at one time or another passed official resolutions urging their own respective members, but also all chiropractors, to join the APHA and support public health. The ACA House of Delegates re-affirmed this position in 2008. The ACA has appointed a standing Committee on APHA for many years. National Public Health Week (NPHW) is an annual APHA activity in April and various chiropractic institutions have participated, with the ACA signing on as an official APHA partner, promoting the events in its publications and encouraging all its members to participate. ACA publications often feature public health topics and include a message that all chiropractors should be involved in public health and in the APHA. Notably the June 2002 issue of *JACA: Journal of the American Chiropractic Association* had a public health theme and a cover article titled “Public Health and Chiropractic—Meeting Somewhere in the Middle,” which extolled chiropractic involvement in public health and quoted several chiropractic leaders who were APHA members.¹⁹ An earlier article in the same publication explored the importance of chiropractic activism in the APHA to the chiropractic profession as a whole and to individual DCs, while detailing what chiropractic offered to the APHA, and ending with emphasis on gaining input to APHA policy making, which has far-reaching impact on health care decisions.²⁰

An interesting side note is that throughout chiropractic history some individual chiropractors and some chiropractic groups have expressed opposition to certain standard public health practices, such as vaccination, immunization, fluoridation of public drinking water supplies, and pasteurization of milk and dairy products, and entered the political arena to debate or oppose, often successfully, those measures in their communities. With a philosophy of preferring natural, nondrug interventions and freedom of individual choice, their opposition is perhaps understandable in that context, but it would be a myth to assume that such opposition is profession-wide or even very widespread. The necessity and utility of vaccination, immunization, fluoridation, and pasteurization are in most respects a non-issue for the leadership and the majority of chiropractors today. All of these topics are presented in chiropractic college classes, and chiropractic colleges have always had required, not merely elective, courses in public health in their curriculum, prompting advocates to point out that some DC programs have more required public health classes than found in some MD training programs.

Standard public health publications, including the *American Journal of Public Health* and *Morbidity and Mortality Weekly Report* (MMWR) from the CDC, are found in chiropractic college libraries. To varying degrees the chiropractic colleges also include teaching about the DHHS’s Healthy People National Health Objectives as a framework for identifying the most significant preventable threats to health and establishing national goals to reduce these threats.²¹

Chiropractors in the APHA and Public Health

Opportunities for leadership and participation abound within the APHA structure, and the expanded knowledge base, plus the contacts and collegiality of being in the APHA fraternity, also stimulate interest and open extramural opportunities in other mainstream public health sectors. Many chiropractors and other professionals working at chiropractic institutions have made contributions to the efforts of the Chiropractic Health Care section and its predecessor, the Chiropractic Forum. These are unfortunately too many to discuss in detail, but the entire profession appreciates all the chairs, secretaries, elected and appointed officers, governing councilors, Action Board representatives, program planners, and committee chairs, some of whom served multiple terms in these positions. Many have also made presentations at APHA scientific sessions.

Several members of note have served in leadership roles on APHA-wide boards and committees. Some have also served outside the APHA. Hopefully their accomplishments will serve as models and inspiration for future chiropractors. Dr. Rand Baird is credited with pioneering modern chiropractic involvement in public health, using the APHA as the vehicle for participation. His efforts in leading the battles for chiropractic recognition within the APHA, establishing a Chiropractic Forum special interest group within the APHA, and coauthoring and successfully championing a new APHA policy regarding chiropractic are thoroughly described in the two articles reprinted at the end of this chapter.

At the 1995 APHA annual meeting, Dr. Mitch Haas introduced a motion on the floor of the Governing Council to establish the Chiropractic Health Care section to replace the Chiropractic Forum. After the motion passed, Dr. Haas then became the first chair of the new section. The following year, Dr. Haas was elected by the Intersectional Council to its Steering Committee. He served two terms on the Steering Committee, was secretary of the Council in 1997, and became chair in 2000.

Because of a vote in the Governing Council that year giving a new position to the Intersectional Council Chair, the Chiropractic Health Care section had its first member on the APHA Executive Board within 5 years of its charter. Dr. Haas was appointed by two president-elects to serve on the Annual Meeting Planning Committee and the APHA Bylaws Committee. As a member of the Planning Committee he was able to organize a special session where he had the honor of introducing the Surgeon General, Dr. David Satcher, and APHA past-president Dr. Barry Levy. Dr. Haas also served on the ad hoc Development Task Force and the Work Group on Universal Health Care. Finally, he served on the Committee of Affiliates from 2005 to 2006 and received a citation from the chair for his contributions.

Other chiropractors who have been appointed to APHA-wide service include Dr. Lisa Killinger, who served on the Task Force for Aging; Dr. Andrew Isaac, the CHC's first African American section chair, who served on the Diversity Task Force; and Dr. Christine Choate, who served as the Action Board's Operations Subcommittee co-chair.

Chiropractors have made contributions to other organizations and public health institutions as well. Between 1999 and 2002, Dr. Cheryl Hawk was a member of the Iowa Board of Health, Iowa State Preventive Health Advisory Committee, and the Director's Council of Scientific and Health Advisors of the Iowa Department of Public Health. Dr. Michael Perillo is currently the Public Health Emergency Preparedness Representative IV for the New York State Department of Health. His primary focus is development and evaluation of emergency preparedness initiatives for health care facilities, including 145 hospitals, 325 long-term care facilities, and 25 community health centers. In 2006, Karen Konarski-Hart,

DC, was appointed to a multiyear term on the Arkansas State Board of Health by Governor Mike Huckabee and served a term as the organization's elected president. Dr. Konarski-Hart is believed to be the first chiropractor to serve as a president of a state board of health. Other chiropractic doctors have served as board members of their local health departments. Because of his experience with the APHA, Dr. Haas was elected Oregon's Affiliate Representative to the Governing Council. He was a member of the Oregon Public Health Association (OPHA) Executive Board and Executive Committee between 2002 and 2008, and served as OPHA president in 2007. Dr. Andrew Cohen became president-elect of the Hawaii Public Health Association before leaving the state to practice elsewhere. Other chiropractor members of the APHA have served in other capacities in various health agencies, public and private.

Two articles detailing the history of the chiropractic profession's involvement have been published in *Chiropractic History—The Archives and Journal of the Association for the History of Chiropractic*. Dr. Herbert Vear authored the first, which appeared in 1987. The second article, by Dr. Jonathon Egan with coauthors Dr. Rand Baird and Dr. Lisa Zaynab-Killinger, appeared in 2006 and was designated by the journal as its "best article of the year." Together these two articles provide an excellent chronology for the reader, but perhaps more importantly can serve to illustrate what can be accomplished with dedication and perseverance by chiropractors working together for public health. Much has been done and much more remains to be done by chiropractic in public health through the APHA. Role models, precedents, and examples for the future participation abound in these articles, and they are reprinted here with permission (tables and photos omitted).

THE ANATOMY OF A POLICY REVERSAL: THE A.P.H.A. AND CHIROPRACTIC, 1969 TO 1983

Herbert J. Vear, DC²²

Although all CCE accredited colleges provide core curriculum education in public health to meet state and provincial statute requirements, there is little historic evidence to suggest that the chiropractic profession has been active or supportive in matters of public health with the possible exception of that for orthostatic posture evaluation. There are several valid reasons for this isolation from mainstream public health, all of which parallel the explanations for the historic isolation of chiropractic practice and education from the scientific health community.

This paper traces the process of involving the profession with the American Public Health Association, and the 14-year campaign that turned around the policy of this organization toward chiropractic.

State and provincial chiropractic statutes in North America require examination of candidates for licensure in one or more of the following public health subjects: hygiene and sanitation, public health, toxicology and microbiology; however, there is little evidence to suggest that the chiropractic profession has been active

or supportive in matters of public health. The labeling of chiropractic as a “marginal profession” by Wardwell¹ in 1951 and later as “deviant” and “unorthodox” by others² did little within the chiropractic profession to encourage support of public health issues. Since its origins, survival of chiropractic as an independent health care profession was more important than support of medically dominated public health measures.³

Chartered in 1872 the American Public Health Association (APHA) is the largest, oldest and most prestigious, multidisciplinary public health organization in the world. In November 1969, the APHA passed a policy resolution, No. 6903: Chiropractors and Naturopathy,⁴ which was based almost entirely upon the biased Department of Health Education and Welfare (DHEW) *Independent Practitioners Under Medicare Report*, mandated by the U.S. Congress.⁴ The Congress, in planning the Social Security Amendments of 1967, PL 90-248, decided it needed more information about health care disciplines not included in Medicare legislation, before enacting amendments to Title 17 of the Social Security Act. The DHEW Report was refuted by a unified chiropractic profession response which encouraged the Congress to ignore DHEW recommendations. The APHA action in adopting a strong anti-chiropractic policy (No. 6903) appears to have gone unnoticed by the chiropractic profession in 1969.

The first record of any communication to the APHA information on the status of chiropractors is credited to Rand Baird, D.C., M.P.H., who wrote to John H. Romani, APHA president, on May 16, 1979. At that time, Baird was a student at the Cleveland College of Chiropractic in Los Angeles and also an instructor in Public Health. He asked the following questions:

1. Does the APHA have a policy statement regarding the role of Doctors of Chiropractic? 2. Does the APHA recognize chiropractors as primary physicians? 3. Are chiropractors eligible for APHA membership? 4. Have there been any articles in the *Journal*, either for or about Doctors of Chiropractic and their function in the health care delivery system?

Baird received a response on June 25, 1979 from Katherine S. McCarter, MHS, Director of Government Relations for the APHA:

Enclosed is a copy of a resolution, adopted by the Association, which states that APHA considers the practice of chiropractic and naturopathy hazardous to the health and safety of our citizens.

While chiropractors are not specifically excluded from membership, very few have joined (less than 10)

in light of our policy on the issue of chiropractic and naturopathy.⁸

Baird concluded that there was no occupational category for chiropractors because of Policy No. 6903. This resulted in an exchange of correspondence with the Director of Membership Services, Harold Cary, between July 1980 and October 1981.⁹ Baird made the following points in his letters: “I chose #14, ‘Drugless Practitioners,’ because I could not find a category for ‘chiropractor’ nor ‘chiropractic physician’ . . . this is a serious flaw, and as a concerned member, feel it may be discriminatory as well . . . you [should] remedy the situation by either establishing a new category for ‘chiropractor’ or ‘chiropractic physician’.”

Cary acknowledged that when the occupational categories were revised several years ago no one had ever expressed concern for the omission of a chiropractic category. Cary stated further, “yours is the third letter indicating a change should be made. This is good timing since we are planning to purchase a new computer soon which will necessitate the rewriting of every one of our membership programs.” The last letter in the exchange is dated October 13, 1961, and confirms that the new Codes Pamphlet lists “chiropractic physician” under Code 14. In the meantime Baird had recruited over 200 new chiropractic members, mostly students from Cleveland Chiropractic College of Los Angeles. The preceding events encouraged him to study the APHA Constitution, bylaws and policy making procedures with a goal of reversing the negative APHA chiropractic policy.

Baird contacted the American Chiropractic Association (ACA), the International Chiropractic Association (ICA) and the California Chiropractic Association for assistance. The ICA responded favorably by sending a representative to attend the APHA meeting in Los Angeles, November 1–4, 1981. The California Chiropractic Association agreed to sponsor a chiropractic exhibit booth. The booth was a first for chiropractic and was staffed by chiropractic physicians and students from Cleveland College.

Although the APHA has a procedure for introducing changes or amendments to existing policies, it is possible to submit a “late breaking” resolution to the Joint Policy Committee (JPC) for their consideration during the annual meeting. Baird prepared a chiropractic “late breaking” resolution for the annual meeting in Los Angeles. The JPC decided not to consider the resolution since the arguments in the resolution did not qualify it as a true “late breaker.” This meeting hardened the

determination of the chiropractic participants to change the APHA chiropractic policy at the next annual meeting in November 1982. There was an obvious need for an improved chiropractic identity within the APHA, which would be served best by forming a chiropractic special primary interest group (SPIG).

Following the 1981 Annual Meeting Baird made formal application to APHA to form a “Forum on Chiropractic Health Care.”¹² A response to this request was not forthcoming until April 21, 1982. The application “was disapproved by the Executive Board,” The letter went on to say that:

the Board felt that chiropractors should be welcome as individual members of APHA; however, in view of the current policy of the Association regarding chiropractors, the Board did not feel chiropractors should be a special group of the association at this time. The door was left open with this statement; The Board noted that this policy could be changed, but it is up to the group to change it.¹³

On June 4, 1982, Baird received his first formal encouragement from the APHA Joint Policy Committee (JPC) to pursue his objective in having 6903 repealed and replaced with a new policy.¹⁴ They had reviewed, thoroughly, the resolution “Chiropractic Health Care,” of November 1981 and also a revised version submitted early in 1982. The letter explained in some detail what was expected in order to supersede 6903. Baird rewrote his chiropractic resolution and the new version was submitted for publication in *The Nation's Health*, September 1982.¹⁵ News of this appeared in an ICA news release, along with a review of Baird's accomplishments in advancing the chiropractic cause with the APHA.¹⁶ This article prompted the author to write Baird and pledge the support of Western States Chiropractic College¹⁷ and to write to Ernest Napolitano, President of the Council on Chiropractic Education (CCE) requesting that he join the APHA on behalf of the CCE. The author was appointed as the official CCE spokesperson at the public meetings.

Baird's acknowledgement of WSCC support was accompanied by a request for letters of support to be written to the Co-Chairpersons of the JPC of APHA.¹⁸ WSCC, along with other chiropractic institutions and associations, responded to this request.^{19–22} Baird was now receiving strong support from the ACA and the ICA. G. M. Brassard, Executive Vice-President of the ACA, had joined the APHA as an individual member and planned to attend the hearings in Montreal on November 22, 1982. Arrangements were made for all

chiropractors attending the meeting to meet beforehand and plan a strategy for the public meeting.

Eight people met beforehand to plan a strategy for the public meeting. With a maximum of thirty minutes to present and defend the resolution, it was decided that Baird would present the position paper, “Testimony on a Chiropractic Policy Proposal.”²³ Fred Colley, Ph.D., a microbiologist at Western States College of Chiropractic, would speak to his experience as a public health teacher at both a medical and a chiropractic school. Walter Wardwell, Ph.D. from the University of Connecticut would present a sociological viewpoint of chiropractic. Gerald Brassard, D.C., the Executive Vice President of the ACA, would reinforce the gains made by the profession since 1969 and Herbert J. Vear, D.C., F.C.C.S., the President of Western States, would speak to the accreditation process in chiropractic education. Also present at that meeting were Karl Kranz, D.C., representing the ICA, James Watkins, D.C. of the Canadian Chiropractic Association and Robert Wakamatsu, a student at Cleveland Chiropractic College, Los Angeles.²⁴

The Resolution went uncontested at the public meeting. The absence of public opposition to the resolution from the Medical Section of APHA suggested that opposition would surface either at the JPC or Governing Council meetings. The Policy Committee-C decision was to present the chiropractic resolution to the JPC the next day as being uncontested. On November 23, the chiropractic contingent lobbied for support and planned strategies while the JPC met in closed session.

It was learned during the day that opposition to the resolution would occur the following day during the Governing Council meeting. As predicted, the Medical Care Section (MCS), the largest section within the APHA, spoke against the resolution and used a delaying tactic to avoid having it come to a vote. Their strategy was to have the chiropractic resolution studied by an unnamed committee.²⁵ Interestingly, the APHA Executive Board Minutes, November 12–18, 1982, “reported that a resolution was coming before the Governing Council which seeks an endorsement of chiropractic and which would supersede the 1969 resolution.”²⁶

On November 24, the chiropractic resolution surfaced for discussion by the Governing Council. The original resolution had been altered in content by the JPC but not beyond acceptance.²⁷ The main objective was to have the 1969 resolution rescinded even if a new resolution could not be passed. During the discussion, attempts were made to further alter the wording of the revised resolution, particularly changing

the phrase “primary care” to “limited care” and the phrase “licensed primary providers” to “licensed limited providers.” The Governing Council, after two amendments to the resolution, voted to table the resolution until a committee selected by the Board of the APHA could discuss the resolution. The chiropractic representatives were disappointed but realized, without a spokesperson on the Governing Council, the resolution had no other route to follow. The major concern was the attempt to use the word “limited” to replace the word “primary.” The chiropractic representatives met to examine the day’s events and plan. Two actions were agreed to; first, the contingent would continue as an Ad Hoc Committee to plan for 1983 and, second, to encourage membership in the APHA—Radiological Health Section, by chiropractic physicians and students. It was the committee’s opinion that the Radiological Health Section with only 250 members offered the best opportunity for the profession to have a chiropractic member of that section elected to the Governing Council to speak on behalf of chiropractic at Governing Council meetings.

Shortly after returning from the APHA meeting, Brassard contacted Wardwell and former ACA president S. Owens, both of Connecticut and close friends of the newly elected APHA President-Elect, Susan Addis. He asked for their help in having Baird either appointed to the special committee to study the chiropractic resolution or to be, at least, the senior chiropractic consultant to the committee.³⁰ On the same date, Brassard wrote to the APHA Executive Director and requested a chiropractic presence on the committee.³¹ These actions prompted the author to write to the APHA president on behalf of CCE and offer the CCE’s cooperation with the Executive Board.³² Brassard continued with his contacts “on the APHA chiropractic resolution,” and on December 1, 1982 recommended seven actions to Baird.³³

In the meantime, Baird was planning his response to the Governing Council’s action of November 24, 1982. He wrote a letter to the new APHA president, “to protest the actions of the Governing Council and Executive Board in allowing the MCS to defer voting on the ‘Chiropractic Health Care’ proposed resolution.”³⁴ As Baird noted, correctly, the “only specific issue raised by the MCS was on the current relevancy of the 1968 DHEW findings on chiropractic education and practices.” Baird enclosed and sent under separate

cover two important documents to support the findings of his letter of protest.^{35,36} He attached an introductory note which emphasized an important observation, “one additional salient issue is the fact that APHA based its policy #6903 on the DHEW study; there is no internal APHA committee study of chiropractic art and science.”

In anticipation of the January 13–14, 1983 meeting of the APHA Executive Board, Baird, Brassard and Kranz prepared a statement on the “Chiropractic Health Care proposal (1982).”³⁷ No chiropractic representative appeared at this meeting. The following are extracts from the minutes:

Dr. Robbins stated that the first order of business is to examine the scientific basis of chiropractic, and he urged that an individual be selected to review the state of the art and report back to the Board on the current status of chiropractic. He felt that the important thing here was to conduct the study, not establishing yet another committee.

Dr. Walker believed that the Governing Council had assigned the Board a fact-finding task, not a judgmental one, but the Executive Director commented that there were those on the Governing Council who felt that to consider this as purely a scientific issue would overlook such matters as choice of care, or inequities in holding chiropractors to a scientific standard that is not applied to, for instance, health administrators. Dr. Robbins, however, felt that it was important to separate these points from the scientific questions because otherwise they become blurred together. Dr. Johnson, agreeing with the approach suggested by Dr. Robbins moved, and it was seconded, that an individual be engaged to conduct a literature search and prepare a document for the Board’s review on the scientific basis of chiropractic. The motion passed but not unanimously.³⁸

The APHA commissioned Sylvia Simpson, M.D., M.P.H., to prepare a background paper on chiropractic as directed by the Executive Board. The paper, titled “Background Paper on Chiropractic”³⁹ was submitted to the APHA on April 6, 1983.⁴⁰ This 21 page paper with 34 references was generally favorable to chiropractic.

The weakness in the Simpson paper is its reliance on very dated chiropractic concepts, discredited early studies (e.g., DHEW, 1968) by adversaries, and no reference to legislative, educational and research achievements since 1968. The objective for the “Background Paper” was to examine the scientific support for chiropractic, it is unfortunate that a more serious effort was not made to accomplish that goal.^{41,42} However, the Baird response⁴³ was charitable with the following comment: “for a background study on

chiropractic, Dr. Simpson's paper was fairly accurate; however, it is only a brief and very general overview of the profession." The ACA response was less charitable with the following comment:

Unfortunately, it suffers from two major research flaws; hopelessly outdated statistics and data, and omission of information essential to the subject matter. The outcome is a report which leads its readers to numerous inaccurate impressions about chiropractic health care and its providers.⁴

Not one of Simpson's thirty-four references is dated after 1952. Only three chiropractic references are noted and two of these were cited in the DHEW report. There is no evidence that Simpson interviewed any chiropractic educators or requested current information from any chiropractic source. The importance of Council on Chiropractic Education publications, particularly "Educational Standards for Chiropractic Colleges Manual," were ignored. Equally ignored were college catalogs, which list all faculty educational qualifications.⁴⁴

Acknowledged to be out of context, the following are examples of statements made by Simpson: "Chiropractors do not recognize other causes of disease, such as micro-organisms."⁴⁵ Chiropractic places much less emphasis on diagnosis than does orthodox medicine.⁴⁶ Chiropractors reject surgery, drugs and immunizations as violating the sanctity of the human body.⁴⁷ Now most schools require two years of college. Now many schools require that their basic science faculty have graduate degrees.⁴⁸ Users tend to be older, report more chronic health problems, have used physicians relatively frequently, but report difficulty getting doctors (M.D.) appointments."⁴⁹

The two chiropractic responses not only corrected the above misconceptions, but went on to detail the higher education gains made by the profession since 1968. Both reports quoted from the Council on Chiropractic Education Standards⁵⁰ with emphasis on admission requirements, standard chiropractic degree program, diagnosis, scope of practice, cause of disease, academic educational standards required by all faculty, and practice standards.

The Baird response⁵¹ is noteworthy in response to the statement by Simpson, that "chiropractic sees itself as an integrated healing system, separate and distinct from orthodox medicine,":

In our view only part of the above statement is correct. Chiropractic is indeed a separate and distinct

healing art, philosophy, and science in contrast to traditional orthodox medicine. We hesitate to suggest however that it "is a complete integrated healing system." In the words of the New Zealand Royal Commission, "Chiropractors do not provide an alternative comprehensive system of health care, and should not hold themselves out as doing so." Chiropractic has been forced to practice isolated most of the time as a result of the ostracism it has been faced with. In any case, we generally see chiropractors as being practitioners of "limited primary health care." Chiropractors are primary care practitioners to a degree by virtue of the fact that patients may consult them directly and as such may gain entry to the general health care system. At the same time, chiropractors are "limited" in that they do not offer the comprehensive services often required in acute crisis care situation. In contrast, however, most medical physicians are "limited," type practitioners considering that they don't generally provide all the services necessary to completely serve their patients.

This reference to chiropractic as a "limited primary health care provider" is one of the first times that this description has been used by the profession to clarify the role of chiropractic in the health delivery system.

At the April 14–15, 1983 APHA Executive Board Meeting four actions were taken.⁵² *First*, the Executive Board designated itself as the referral group for further study of chiropractic policy issues and was to report its conclusions and recommendations to the Governing Council after considering the staff-commissioned background materials on chiropractic and a discussion with the chiropractic at its July meeting. *Second*, the question of a Chiropractic Special Interest Group was examined with the following action, "that the issue would be considered at the next meeting." *Third*, by motion the Board favored proposing a new resolution to replace 6903, based on the "Background Paper" and other materials. *Fourth*, application by chiropractic organizations to become agency members was deferred until the Board arrived at a final decision. Under the continuing leadership, of Baird, Brassard and Kranz, plans were made to attend the July 14–15, 1983 meeting. The American Chiropractic Association and the International Chiropractors Association actively encouraged their members to join the APHA to strengthen the chiropractic presence. Both ACA and ICA passed resolutions in support of participation in a national public health forum.

At the APHA Executive Board Meeting on July 14–15, 1983, lengthy discussion took place on the "complex" question of chiropractic policy issues.⁵³

The chiropractic profession was represented by Baird, Brassard, Kranz, and Wardwell. As spokesman for the chiropractors, Baird acknowledged that “they found the proposed substitute resolution almost completely acceptable, with a few revisions.” Board member Sheps raised his concern for the “scientific validity” of the larger group of practitioners called “mixers,” who supplement their spinal manipulations with “more questionable” therapies. He also expressed concern for the “sharp differences” in therapy used by the liberal and conservative practitioners. Baird provided an excellent answer in stating “the philosophical approaches to problems of health and disease are different for the two professions, but the bio-scientific basis for any health profession is grounded in two sciences, anatomy and physiology.” He defended the chiropractic use of, for example, ultrasonics, by explaining that chiropractors utilize such modalities in exactly the same way as physical therapists and medical doctors.

Following the chiropractors’ presentation, the Board met in private and “debated the chiropractic issues exhaustively.” Typical of these issues, as recorded in the minutes,⁵⁵ was that

many chiropractors do not limit themselves to those professional services which have been demonstrated to be safe and effective, and in fact some patients turn to them for complete care. The Board felt that there is a potential for harm and; they may treat conditions for which they are not properly trained, they may misdiagnose, and appropriate treatment may be delayed.

The Executive Board went on to approve a resolution for submission to the Governing Council in November, and approved formation of a Chiropractic Special Interest Group, however they denied agency membership until the fate of the resolution was decided.⁵⁶ The SPIG was established in September 1983, with Kranz as interim chairman. The APHA Executive Board announced its chiropractic decision in the association’s publication, *The Nation’s Health*.⁵⁷ On September 23, 1983, Baird was mailed a “draft” copy of the chiropractic resolution proposed by the Executive Board.⁵⁸

At the long-awaited meeting of the APHA Governing Council on November 11, 1983, the proposed compromise chiropractic resolution finally surfaced for discussion. Since Baird had been elected a Governing Council delegate for the Radiological Health Section in

1984, the council suspended its rules and allowed him to speak on behalf of the resolution. The text of Baird’s remarks are short, but of sufficient importance to be restated.

Thank you for suspending your rules and allowing me to speak. I have been asked to represent the chiropractic profession, and its organizations known as the American Chiropractic Association, the International Chiropractors Association, the Council on Chiropractic Education, and the Canadian Chiropractic Association, altogether totaling over 30,000 people, as well as several hundred chiropractor members of the APHA.

I am here now to represent our interests, and to answer your questions.

In response to the issue on the floor, the chiropractor members of the APHA do not agree with everything in the background paper by Dr. Simpson. But we are willing to accept it for what it is. It is an attempt to be objective, and to encompass many different viewpoints into a single summary document. Likewise, we do not fully agree with the alternative resolution proposed by your Executive Board. But as a compromise to which we had some input, we are willing to accept and support it.

A three year process, including a year long consideration by your Executive Board, led to this carefully worded compromise resolution. This is a free choice issue, this is a membership rights issue, this is a fair play issue.

APHA is a multi-disciplinary organization.

Following Baird’s presentation and the endorsement of the Governing Council, resolution #8331 passed.⁶⁰ On November 14, 1983 the Dental Section and the Medical Care Section attempted to have the chiropractic resolution overturned but they were overwhelmingly defeated by the Governing Council and Executive Board majority.

The Chiropractic Special Interest Group has sponsored in 1985 and 1986 the presentation of educational, technical and scientific papers on chiropractic which have been well attended and applauded by the multidisciplinary audiences. Regardless of the comfort the profession may take from adoption of a new policy on chiropractic by the APHA, there is still a great deal of concern within the hierarchy of the APHA for chiropractic patient care.⁶¹ It is this author’s opinion that the positive manner in which the prestigious APHA was encouraged to reverse its harsh policy on chiropractic health care should serve as a model for others seeking to change policy or opinion of like organizations.

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CHIROPRACTIC WITHIN THE AMERICAN PUBLIC HEALTH ASSOCIATION, 1984–2005: PARIAH, TO PARTICIPANT, TO PARITY

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Chiropractors were granted the right to form a group identity within the American Public Health Association (APHA) at the conclusion of 1983 after an official anti-chiropractic policy was reversed. Beginning in 1984, chiropractors began serving alongside other public health professionals within this prestigious association, the world's oldest and largest public health organization. Although permitted a group identity within the APHA, chiropractors still had to overcome many obstacles to full participation, including professional bias, misunderstanding, and struggle within the ranks. By 1995, chiropractic succeeded in achieving full APHA section status, or full equivalence to other health professions within the APHA. The year 2005 marked the tenth anniversary of this achievement. This article traces the history of chiropractic within the APHA from the early years of acceptance to the eventual celebration of a decade of full parity.

The year 2005 marked the tenth anniversary of the Chiropractic Health Care (CHC) Section within the American Public Health Association (APHA). In that year, two elected chiropractors and the section chair of the CHC section served on the Governing Council, the official policy making body of the APHA. There were 17 scientific and technical papers authored by 37 chiropractic co-authors presented in 4 sessions at the 133rd annual meeting of the APHA in Philadelphia, PA in December 2005.

In this and other recent years, chiropractors have been found at all levels of the APHA, having served on the Executive Board, published in the prestigious *American Journal of Public Health (AJPH)*, functioned in various leadership positions, and coordinated the activities of the CHC section. Chiropractors have received several significant honors within the APHA, including awards of distinguished service, the opportunity to personally introduce the United States Surgeon General at the Annual Meeting, and recognition for individually recruiting more members than any other member in the history of the association.

Chiropractic has full parity within the APHA, serving alongside over 50,000 other professionals who advocate for health promotion, disease prevention, and healthy individuals and communities. This parity has

made the APHA a powerful ally. Indeed, when the profession in the form of the World Federation of Chiropractic (WFC) sought official relations with the World Health Organization (WHO) in 1996, the World Federation of Public Health Associations (WFPHA) officially endorsed the application to WHO. This support came about specifically because of chiropractic involvement with the APHA, a significant member of the WFPHA.

This full parity as health professionals within the APHA did not always exist. As late as 1983, the APHA had an official policy against chiropractic. Chiropractors were considered a threat to the public health per APHA policy #6903. Through this policy, the APHA called on friends of public health throughout the United States to pursue the revocation of licensure of chiropractors in each state. That policy stood from 1969 to 1983—14 years!

In 1987, Herbert J. Vear, DC, outlined the overturning of that policy in "The Anatomy of a Policy Reversal: The A.P.H.A. and Chiropractic, 1969 to 1983" in *Chiropractic History*. In that paper, Vear described how chiropractic student Rand Baird, MPH approached the APHA in 1979 to determine their openness to chiropractic. It was then that the profession became aware of the anti-chiropractic policy. Vear described Baird's efforts to get chiropractic a "profession code" within the APHA, so chiropractors could join the APHA as chiropractors despite the anti-chiropractic policy. Vear outlined the efforts of chiropractors, chiropractic colleges and chiropractic associations to push for policy change from within the APHA after joining it. In 1983, chiropractors were permitted to form a Special Primary Interest Group (SPIG), called the Chiropractic Forum, though chiropractic organizations and colleges did not yet achieve status as APHA affiliated agencies. Late in 1983, policy #6903 was reversed with #8331, a compromise policy that supported chiropractic on a limited basis.

Some groups, such as the Dental Care Section, had opposed passage of policy #8331 and also tried to block agency membership for chiropractic organizations. They did so by noting what they described as the historic opposition of some chiropractors to well-established public health measures such as drinking water fluoridation. As that opposition was raised,

Rand Baird, DC, MPH said to the assembly, “We’ll toast the Dental Care Section by drinking a glass of Anaheim fluoridated drinking water right here.” Though Dr. Baird was ruled out of order, the wry humor succeeded and the new chiropractic agency members were allowed.

For full details on reversal of policy #6901 and the passage of policy #8331 see the Vear paper. Chiropractic involvement in the APHA since the reversal of that policy from 1984 forward will be further outlined here.

The Council on Chiropractic Education (CCE) formed a Panel on APHA in 1984. The first chair and members were Dr. Rand Baird and Drs. John Barfoot, Karl Kranz, and Herbert Vear. A significant first for chiropractic occurred this year, as Dr. Baird was elected to the Governing Council of the APHA by the Radiological Health (RH) section, the section most chiropractors joined to allow professional representation within APHA through aggregated numbers. The path was becoming clear for increased chiropractic participation, and shortly thereafter both the American Chiropractic Association (ACA) and the International Chiropractors Association (ICA) passed resolutions encouraging all their chiropractor members to join the APHA as a non-sectarian profession-wide venture.

Because chiropractors were now welcome as a profession within the APHA and had achieved a group status and identity, 1985 became a year of many more firsts for chiropractic. Chiropractors had previously operated booths in the exhibit hall at the annual meeting. 1985 was the first year that chiropractors presented scientific and technical papers within the APHA at the annual meeting. Those annual presentation sessions comprise the educational program, and have been a prestigious venue for researchers, educators, and clinicians to present their work to multidisciplinary audiences in the years since. Dr. Rand Baird became the first chiropractor to serve on any APHA committee, serving on the Election Tellers committee. (The appointment of Dr. Baird to this committee by Dr. Victor Sidell, MD, APHA President, was a real show of support. Dr. Sidell had already played a key role in helping chiropractic gain acceptance within APHA.)

Chiropractors were invited to participate in the Governing Council elections for unaffiliated members (from the chiropractic SPIG, as chiropractic still lacked its own official full section). They further continued service as members of the Governing Council from the RH section. Another significant first showed the power

of membership in a membership-driven professional organization: When contacted during the election process, each candidate for the President-elect and Executive Board within the APHA this year expressed support for the role of chiropractic within the APHA.

Despite these gains, a problem that would haunt chiropractors organizing within the APHA became evident, even at this early stage. Many chiropractors—and especially chiropractic students—were joining the APHA, yet few were renewing membership. In 1986, despite 101 new chiropractic members in the RH section, there was no net gain in membership because 176 chiropractic members failed to renew. Similarly, the Chiropractic Forum SPIG had 113 new members but 134 did not renew their membership. Though the Chiropractic Forum remained the largest SPIG within the APHA, it was observed that it would have been 25% larger if chiropractic members would renew their membership. As will become clear, chiropractic enfranchisement within the APHA would be threatened because of high non-renewal rates. However, chiropractic yet remained enfranchised, which continued to provide unique opportunities for chiropractors to engage their fellow health professionals.

In late 1985, another difficulty that would follow chiropractors within the APHA was the failure of elected members to fill their leadership roles. A true leadership crisis appeared this year, when the Vice-Chair and Secretary-Treasurer did not fulfill their duties, the Program chair/Unaffiliated Governing Councilor resigned, and the elected Chair resigned due to health problems. Dr. Karen Larson took the helm for 1986–1987 and did a remarkable job leading the SPIG through a leadership crisis. In 1986, Dr. Vear announced his intention to transfer from the RH section to the Chiropractic Forum to help provide leadership there.

In 1986, Dr. Baird questioned the candidates for the APHA Executive Board. He queried: “Although APHA has a SPIG Chiropractic Forum and several hundred chiropractic doctors, chiropractic educators, and chiropractic students, as well as four agency members, there still seems to be some controversy about chiropractic participation in APHA; what is your opinion of chiropractic participation in APHA?” He received uniformly favorable responses from all candidates.

At the 1987 annual meeting, all of the chiropractic presentation sessions were attended by Ruth E. Parry, M.A., M.A.S., a representative of the Veterans’ Administration (VA). She explained that she was attending to learn about the chiropractic profession, including

education and scope and standards of practice. She did not share her specific opinions of what she heard that day beyond being generally pleased with the presentations. However, chiropractic was clearly “on the radar” within the APHA. Organizations were taking notice and taking the opportunity to learn about the profession from chiropractors at their educational program paper presentations.

Relationships between APHA and chiropractic organizations were developed and strengthened throughout the decade. In 1987, the ACA established its Committee on the APHA. Dr. Vear served as the first chair of this committee, whose inaugural members included Drs. Baird and Lee Selby. (Dr. Baird had also served as the ICA representative to the APHA annual meeting each year from 1983–2003, and others occasionally served the ICA in this role.) The ACA panel in essence filled the role the CCE panel served for the prior 4 years, and so in 1988 the CCE panel was dissolved, though the CCE retained affiliated agency status with APHA. As chiropractors affiliated with the APHA continued to refine these professional relationships, it became clear that increased coordination was needed with other chiropractic groups interested in public health. In 1989, officers of the chiropractic SPIG, RH section, ACA APHA panel members, the ICA representative, and ACA executive board liaison enhanced inter-organizational communication and coordination in an attempt to eliminate the duplication of effort. Common purposes forged stronger relationships. Despite this, at year’s end there was no formal contact between chiropractors in the APHA and chiropractic college public health instructors, the Association of Chiropractic Colleges (ACC), and now the CCE.

By 1989, chiropractors represented a majority of the membership within the RH section for the first time (189 out of 341 members). As chiropractic representation grew, so did the number of chiropractors serving as officers within the section. In 1989, chiropractors served in every leadership position within the RH section except the Section Chair—a deliberate strategy to prevent alienating the non-chiropractic membership of that section. However, many chiropractors were again elected that did not or could not fulfill their responsibilities.

Despite the aforementioned difficulties in retention and in the failure of some elected to leadership to serve, the dedication of several determined individuals and the support of several professional organizations

and schools made the difference. Chiropractic survived and continues within the APHA due to the efforts of a core group of active members and leaders who diligently championed the role of chiropractic within public health. Many volunteered, some even taking unpaid leave from private practices to serve the greater good of the chiropractic profession. Colleges and associations sponsored many others. These individuals eventually helped achieve parity for chiropractic within this prestigious multidisciplinary association.

In 1990, a national health program appeared likely to succeed under the direction of the Clinton Administration. The Chiropractic Forum SPIG frequently pondered the role chiropractic might fill in such a system. Members of the group felt concerned that there did not appear to be a national chiropractic strategy at any level to help shape the national health care policy from chiropractic’s point of view. Members of the SPIG were concerned that it was unclear if mandated coverage would be determined at the state or national level and that chiropractors were not engaging this policy debate.

Another concern in 1990 was that the ICA had created new policies against immunization and drinking water fluoridation. Immunization and fluoridation are widely accepted public health practices and it was feared that these ICA policies would not be well received within APHA. Further, the ICA was an agency member of the APHA, and these policies appeared to contradict other verbal statements by the ICA made when it applied to be an APHA agency member. A related concern raised in 1990 was that chiropractors lacked interest in the overall public health effort because the public health education given chiropractic students may have overly focused on fluoridation and immunization. This strong focus on these “hot-button” issues appeared to be made at the expense of broader public health issues—and potentially at the expense of the role chiropractic could play in public health. To address this concern, Drs. Baird and William Meeker were asked to prepare a sample syllabus for a chiropractic public health course. At the same time, they were asked to consider and make recommendations for the apportionment of questions for national board exams in public health and microbiology that would reflect the enlightened curriculum.

Old problems persisted in 1990. Several elected members did not serve or show up for meetings and

retention remained unacceptably low, preventing the SPIG and the RH section from reaching their potential. Compounding the problem this year was that the call for abstracts for the annual meeting of the APHA was not appropriately published within the profession. A relatively poor response ensued. Further, though chiropractors had been formally admitted to the APHA for 5 years, no chiropractic-authored paper had yet appeared in the prestigious *AJPH*. Dr. Baird had two letters published in *The Nation's Health*, the periodical of the APHA, and two letters to the editor in *AJPH*, but no article authored by chiropractors had yet appeared in *AJPH*.

Chiropractors within the APHA attempted to address many of these problems in 1991. To address membership, *Dynamic Chiropractic* offered to donate advertising space, run a recruiting article, and include membership applications to the APHA. Leadership service improved, with only one member not attending the annual meeting this year, yet still submitting a report. To address the public health issues of immunization and fluoridation, chiropractic members of the APHA recommended that the ACA take an official stand in support of these public health measures. To improve attendance at chiropractic presentations at the annual meeting, the SPIG and the RH section determined to have copies of each other's programs within their booths. In spite of errors in the publication of the "Call for Abstracts" for the annual meeting educational program in many chiropractic venues that year, chiropractors were making progress within APHA.

Positive events in 1992 included Dr. Baird's appointment from the RH section to the APHA Committee on Membership, only the second time a chiropractor was appointed to a national committee within APHA. In 1992, a pro-chiropractic APHA president (Helen Rodriguez-Trias, MD) was elected who would begin service in 1993. Dr. Rodriguez-Trias would prove an important ally now and years later when official section status was sought. Also in 1992, Dr. Vear presented the proposed draft of a pro-vaccination policy for the ACA to consider endorsement. Fluoridation was discussed as well. Most Chiropractic Forum members present at the annual meeting voted to support these policies. They felt, as do almost all in the public health field, that immunization and fluoridation are proven public health tools. The group again recommended that the ACA adopt positive official stands on vaccination and immunization as an agency member, especially

in light of the ICA's perceived opposition to these measures.

Dynamic Chiropractic and other publications again helped publicize the need for chiropractors to join the APHA. This year, the "Call for Abstracts" received much better attention. At the 1992 annual meeting when the presentations were given, four medical epidemiologists from the Centers for Disease Control and Prevention attended the chiropractic session on immunization. These epidemiologists appeared genuinely interested in the presentations.

Despite gains in recruitment, 1992 was a critical year for membership. The chiropractic SPIG had the 4th best recruitment rate but the absolute worst retention rate of all APHA SPIGs. The RH section had the 8th best recruitment rate of all 24 sections within APHA, but ranked a dismal 23rd in retention. Because of this, there was another net loss in membership in both the SPIG and the RH section. Membership is critical for the retention of section status—and the voting seats on the Governing Council and APHA budget allocation that come with such status. As long as chiropractors were represented in an official section (in this case, the RH section) and had members on the Governing Council, they were able to help shape APHA policy. Otherwise, they effectively stood to lose representation and identity within the APHA. If chiropractic did not have 250 members in the RH section by September 1993, the section could be disbanded. All that had been accomplished over the last 13 years in the struggle for recognition of chiropractic within APHA would be lost.

Chiropractors worked hard at recruitment, and in 1993, chiropractors within the APHA reaped the rewards of their labors. Many chiropractic publications—especially *Dynamic Chiropractic* and those of the Foundation for Chiropractic Education and Research (FCER) and the ACA—had discussed the possible loss of enfranchisement and voting seats if more chiropractors did not join the APHA. Dr. Baird authored several articles within *Dynamic Chiropractic* about the September deadline. As a result, 1993 was a huge year for recruitment. The RH section reached 614 members, with the best recruitment rate of all sections and the largest membership in the 28-year history of the section. However, the renewal rate remained the worst. The Chiropractic Forum SPIG grew to 352 members, reflecting the best recruitment rate among SPIGs. It also had its highest membership ever; its size even exceeded that of 2 official sections. However, its renewal rate was the very worst of all sections and SPIGs.

This growth did not escape the attention of the APHA, where it was noted that this August was one of the best single recruiting months in APHA history, largely due to the chiropractic response.

Subsequent to this tremendous growth and the fact that over 500 of the members of the RH section were chiropractors, consideration was given to changing the name of the RH section to reflect chiropractic participation. Chiropractors were satisfied with their relationship to the section; they simply wanted the name to reflect the interests of the group. Several names were discussed, including “Chiropractic Care and Radiological Health Section” and “Chiropractic Care and Radiation Protection Section.” A committee was formed to prepare a 5-year plan for the section. The committee members were Bill Kirk, PhD, Dennis Murphy, PhD, Martin Meltz, PhD, and Rand Baird, DC. The plan would include the mission, vision, and goals for the section, which would help direct the naming process.

Because of the number of chiropractors now present in the APHA in both the Chiropractic Forum SPIG and the RH section, consideration was also given to having members of the SPIG transfer to the RH section if a name for the section was chosen that reflected professional identity. If this happened, the combined section would have strength exceeding 1,000 members, and would be the 11th largest section. Voting seats and budget would accompany size, and would afford great privileges to chiropractic within the APHA. As will be noted, the name change never happened, and events unfolded that would lead to chiropractic forming its own official section in the near future.

In recognition of service and recruitment, the RH section presented a Distinguished Service Award in 1992 to Dr. Rand Baird, the first time a chiropractor received such distinction in the history of the APHA. Dr. Baird also continued in his role on the APHA Committee on Membership, only the second time that a chiropractor served at the national committee level.

Several noteworthy events occurred at the 1993 annual meeting of APHA. First, Hillary Clinton spoke with APHA leaders about national health care reform. Second, Ian Coulter, PhD, gave a presentation at the chiropractic research sessions on how to think about health care policy issues. According to his abstract, “education as a health professional will not necessarily result in the ability to do policy analysis. Its purpose is to enable health professionals to become ‘literate’

about a broad range of health issues, many of which transcend their own discipline.” As the profession continued to integrate and enter the mainstream, it was felt that Dr. Coulter succinctly expressed the need for chiropractors to become “literate” about health care issues larger than themselves. A third significant event was that an educational session at the annual meeting called “Alternative Care—Fad or Medical Failure” was held that was not co-sponsored by chiropractors and had 6 speakers, none of which were chiropractors.

Networking with other healthcare professionals is critical, and this represented a missed opportunity, as did the fact that chiropractors mostly had been presenting research to other chiropractors at these annual meetings. One example of the power and importance of networking with other professionals became evident at the 1993 annual meeting. Just as Dr. Sidell and Dr. Rodriguez-Trias were powerful allies who had been and would yet be tremendously helpful to the profession achieving parity, others with increasing familiarity with chiropractic would become friendly and helpful. The new incoming President for 1994 (who began service at the 1993 annual meeting) was Eugene Feingold, PhD, JD. He had formerly vigorously opposed formal chiropractic participation within the APHA. However, he later took part in the reaccreditation process for Palmer College of Chiropractic and was now satisfied with chiropractic’s scientific base. He stated that he welcomed chiropractic within the APHA. Here, and in so many other occasions, familiarity with chiropractic brought new respect for the profession. Working in the APHA, which allowed chiropractors to work closely with thousands of similarly public health-minded practitioners, afforded many opportunities for building these new bridges of understanding.

1994 was another critical year. Echoing the failure of the Clinton health plan was a leadership crisis in the chiropractic SPIG. The elected chair of the SPIG, a non-DC, was removed from office after 11 months of failure to perform duties. Dr. Mitchell Haas took up the reins as acting chair after special election by the other SPIG leaders. This was a portentous time. There was a critical mass of chiropractors in the RH section and in the SPIG. The RH section had determined to change its name to “Radiological Health and Chiropractic Care Section,” but the request to change the name was denied by the Executive Board of the APHA in July 1994. The Board suggested that rather than change the

name of a section organized around an interest, that chiropractors seek their own independent section. Strong leadership was essential here.

Six chiropractors accepted the substantial responsibility to complete the application for Section status within the APHA. Drs. Mitchell Haas (serving as chair), Rand Baird, William Meeker, Robert Mootz, Michael Perillo, and Fred Colley, PhD, agreed to do the considerable work assembling the materials required by the APHA. It took several months, but the opportunity represented the culmination of sixteen years of effort within the APHA.

As part of the strategy to become a full section, Dr. Baird suggested that 200 chiropractic members of the RH section switch their membership to the chiropractic SPIG. When this was done, there were over 500 members in the SPIG. At this size, the chiropractic SPIG was larger than all the other SPIGs combined and larger than 7 sections. It was also the largest SPIG ever—which placed chiropractic in a great position to achieve full section status with voting privileges on the Governing Council and full parity. These authors had until April 1995 to prepare the APHA section application for the chiropractic profession.

Despite the excitement among chiropractic members about the potential opportunity to become a full-fledged section, chiropractic continued to be plagued by non-attendance at the year-end APHA annual meeting. Three of the sixteen papers scheduled for presentation during the chiropractic sessions were simply not presented, because their authors did not attend the conference. One of the chiropractors scheduled to preside over a session failed to attend without providing notice. Dr. Craig Nelson substituted at the last minute for this individual, but credibility was still affected every time someone failed to fill the responsibilities they had accepted.

Three exciting developments from 1994 deserve final mention. First, the APHA officially supported California's Health Security Proposition 186. Though the proposition ultimately did not pass, this was a watershed moment, as the APHA gave as one reason for its support the fact that this proposition had chiropractic coverage as one of its benefits. In this and later political battles, it was clear that participation in this highly regarded organization was important for chiropractic and for public health. The APHA was a perennial strong voice on Capitol Hill—and now included chiropractic interests in its agenda. Another development was that the RAND Corporation, a scientific “think-tank,”

published studies on chiropractic that helped to further the chiropractic cause. A last development of note from 1994 was that a new SPIG formed: “Alternative Medicine.” This SPIG had few members to start with, but had substantial interest. One of their sessions, “Alternative Methods of Medical Care,” had an audience of 250.

April 1995—the deadline for the chiropractic section application—arrived. This excerpt from the 1995 ACA Committee on American Public Health Association annual report summarizes the events leading to full section status for chiropractic in APHA [original grammar, spelling, and punctuation retained except as noted]:

The application and supporting documents were first submitted to APHA's Executive Board in March for the Board's April 17–18 meeting, deferred until May 9, 1985. After lengthy discussion and evaluation of the application according to the 1975 “APHA Criteria for Establishment of New Sections,” the Board returned the application to the authors requesting additional information and more specific answers to some of the questions that accompanied the criteria. These were addressed and the application revised again, and resubmitted to the Executive Board which then reviewed it July 18, and determined its completeness, and scheduled it on the subsequent agenda of the Governing Council. . . .

Throughout the Summer and Fall, the team members, especially Drs. Haas and Baird, continued correspondence and conversation with APHA leaders, Governing Councilors, and Executive Board members, answering questions and concerns and lobbying for the application. Varying degrees of support were elicited from Board Members. . . . Lively debate was encountered from [some].

The Governing Council began the discussion of the Chiropractic section application on Wednesday, November 1, 1995 shortly after 9:00 am. Dr. Mitchell Haas as a Governing Councilor from the SPIGs, and Dr. Rand Baird holding a proxy from the Radiological Health chairman, were seated.

When the Governing Council began the debate, several other well-known leaders in the scientific community spoke out for chiropractic! William Kirk, PhD, radiation physicist, spoke on chiropractors' expertise in radiation protection of the public. Victor W. Sidell, MD, a highly regarded former president of APHA and internationally acclaimed physician spoke about our dedication and our contributions. Letters of support were received by the Governing Council from Dennis Murphy, PhD, Chair of the Radiological Health Section, and from Helen Rodriguez-Trias, MD, another recent APHA past president. Professor Jon Lemke, PhD, from the Statistics Section, spoke about chiropractic research and praised Palmer College's research department.

Ted Miller, PhD, from the Injury Control & Emergency Health Services Section, eloquently described the high quality of chiropractic care for low back pain and other injuries, for valid data documenting our efficacy, quoted the [Agency for Health Care Policy and Research] guidelines and other studies, and praised chiropractic colleges and ACA and ICA for their track record in maintaining agency membership in APHA.

Minimal opposition was raised to the chiropractic section application, mostly in the form of concerns about chiropractic support of proven public health practices such as immunization and water fluoridation. Concern was also raised that a Chiropractic section should focus on rallying chiropractors' support for public health preventative programs; the need to monitor fringe practitioners and unscientific procedures was also mentioned. Opposition was voiced by John Muth, MD, MPH, from the Colorado affiliate, and from APHA President-elect E. Richard Brown, PhD. Mention was made frequently of an anti-vaccination letter filled with questionable references that had been published a few weeks prior in *The Nation's Health* by a self-billed "DC-MPH homeopathic physician-public health educator" (who fortunately was determined not to be a member of ACA or ICA or APHA!). Dr. Victor Sidell spoke again in our defense, as did Alan I. Trachtenburg, MD MPH, chairman of Alternative and Complementary Health Practices SPIG [the re-named "Alternative Medicine" SPIG], and acting director of the Office of Alternative Medicine at [the National Institutes of Health].

Dr. Haas expertly answered several concerns, and Dr. Baird ended the debate by calling for fair play, equal membership rights, and non-discrimination against a profession, pointing out to the Governing Council that the section application was in good order and that the chiropractic members were stronger in some areas than others but nevertheless in substantial compliance with the required criteria for being granted full section status.

The application was voted upon and by an overwhelming majority the CHIROPRACTIC HEALTH CARE SECTION was established, becoming the first new section in three years, joining APHA's 24 other sections as a full-fledged partner with equity and parity with all other disciplines. It was noted that in its Centennial year, the Chiropractic profession had joined the other professions for public health.

Indeed, in the year chiropractic celebrated its hundredth birthday, it achieved equality in this setting.

The section's name was chosen by Dr. Rand Baird, and was—and remains—the only section with both the words "health" and "care" in it. As noted previously, connections made in years past had proven fortuitous. Both Dr. Sidell and Dr. Rodriguez-Trias as former APHA presidents provided critical support at

the time of the application. Dr. Rodriguez-Trias voiced her support with these words:

Over the years that the Chiropractic Forum has been actively involved in APHA activities, I have met with many of its leading members. I have been struck by their understanding and commitment to APHA's mission and goals. The Chiropractic Forum would make an excellent addition to the community of APHA sections. I hope that the Executive Board will add its support to the Forum's application when it comes before the Governing Council.

Dr. Haas became the first chairman of the new Chiropractic Health Care (CHC) section. He immediately appointed the other five chiropractors that had helped complete the application for section status to a committee to prepare a mission statement for the new section. Drs. Rand Baird, William Meeker, Robert Mootz, Michael Perillo, and Fred Colley, PhD went to work.

Because the new section had been created, chiropractic members continued to shift from the RH section to the CHC section. It was assumed that some chiropractors with DACBR (Diplomate, American Chiropractic Board of Radiology) credentials would remain in the RH section, but most chiropractors transferred. This was a blessing to the new CHC section, but did harm the RH section. RH section members and officers—many of whom were not chiropractors—deserve thanks for their support of the chiropractic section application. The RH section faced downgrading to SPIG status before chiropractors began joining the section in the early 1980s, and now did again as the chiropractors left. Chiropractic membership had temporarily breathed new life into the RH section, but the radiation protection members never revitalized recruitment from their own primary profession. Many of the RH leadership roles had been expertly filled by Drs. Rand Baird, John Pammer, Jr., Sharon Jaeger, Michael Loader, and Robin Canterbury, but an unfilled gap was created when they eventually left to join the new CHC section. In 1998, three years after chiropractic achieved its own section, the RH section would finally revert back to a SPIG after 34 years as a section. The low renewal rate of chiropractic members continued to plague the new CHC section. It was clear that to retain section status, the CHC section should strive to have 500 members in September 1998 when the official membership tally was taken by APHA. If there were not 500 members, section status would be endangered.

At the moment, though, chiropractors in APHA celebrated the fact that many years of hard work had paid off.

The CHC section was excited to work with the Podiatric Health, Vision Care, and RH sections, as well as with the Alternative and Complementary Health Practices (ACHP) SPIG on collaborative projects as a full APHA partner at last. The ACHP SPIG was growing rapidly and was very public with their support of the chiropractic section. Last, another important contact came into a position to help the profession: Fernando Trevino, PhD, MPH, Executive Director of APHA was elected president of WFPHA. The WFC would make its application to WHO in the next year, and WFPHA would offer its support with these words:

The purpose of this letter is to offer the support of the World Federation of Public Health Associations (WFPHA) for the application of the World Federation of Chiropractic (WFC) for official relations with WHO. We are familiar with the WFC . . .

Members of the chiropractic profession have been increasingly active in national public health associations. In 1995, after approximately ten years [sic] of collaborative work, the American Public Health Association created a separate chapter for chiropractic in recognition of the contribution of members of the profession to the activities of APHA. WFPHA is of the view that the WFC can be a significant resource in assisting the goals and activities of WHO.

For these reasons, WFPHA gives its warm support to the present application.

Those “years of collaborative work” were beginning to bear fruit in 1995 and 1996 and the future seemed bright for chiropractic and public health. In 1996, chiropractors were serving in multiple roles at the national APHA level. The CHC section staffed its first booth at the APHA annual meeting under Dr. Michael Perillo’s coordinating efforts. The section produced its mission statement, section information sheet, and booth description under the direction of Drs. Haas and Baird. The CHC section co-sponsored presentation sessions with at least five other groups at the annual meeting. For the first time, the CHC section presented its own awards for Distinguished Service and Accomplishments. These were given to Drs. Rand Baird, Karl Kranz, and Herbert Year. The RH section gave awards of Distinguished Service to two chiropractors: Drs. Beverly Harger and Michael Loader. The new President-elect of APHA—Dr. Quentin Young, MPH—was an old hospital acquaintance of Dr. Baird and “pro-chiropractic.” Despite continued poor renewal resulting in only 362 members remaining in the CHC section, these positive events demonstrated that chiropractic was fully engaged in APHA.

In 1997, Dr. Cheryl Hawk of Palmer College of Chiropractic facilitated another first for chiropractic in the APHA. Dr. Hawk arranged for Continuing Education credit for the chiropractic-sponsored education sessions, generating positive visibility. Additionally, the CHC section continued to coordinate presentation sessions with other groups. The CHC section was involved in many APHA projects, including work on the Strategic Plan and various task forces and initiatives. APHA’s Executive Director, Dr. Mohammed Akhter, recognized Dr. Baird for his tremendous success in recruiting members to the APHA. Dr. Baird has recruited more members to the APHA than any other member in the history of the association. Chiropractic membership in the CHC section did mildly increase in 1997 to 430. However, by 1998, 500 total members were needed or the section could be threatened with dissolution.

In 1998, the section discussed several topics, including the ideal chiropractic public health curriculum that would be presented at the next ACC meeting and policy statements on immunization and fluoridation by APHA agency members ICA and ACA that seemed to contradict official APHA positions. The CHC section discussed submitting input to the “Healthy People 2010” goals, but found that FCER was already working on this. The group further noted a significant trend was emerging in that an increasing number of chiropractors were pursuing formal public health degrees. Section members hoped that this would help further unite chiropractic practitioners with public health practice. Despite the section’s efforts, membership dropped below 300 in August 1995. Though recruitment of new members was exceptional, low renewal rates continued to plague the section.

Several significant events occurred in 1998. First, Dr. Mitchell Haas was elected to serve the APHA Intersectional Council as Chair-elect (and would serve as Chair in 2000–2001). This remains the highest elected position any chiropractor has held in the APHA. Due to a rule change, he would also receive an automatic seat on the Executive Board in 2000, which became the highest position ever filled by a chiropractor within the APHA. Second, a chiropractic-authored paper appeared in *AJPH* for the first time. Eric Hurwitz, DC, PhD, Ian Coulter, PhD, Alan H. Adams, DC, Barbara Genovese, MA, and Paul Shekelle, MD, PhD published “Use of Chiropractic Services from 1985 through 1991 in the United States and Canada” in the May 1998 issue. Other chiropractors served on APHA-level committees.

Last, as noted, the RH section was downgraded to a SPIG in 1998. By then all chiropractors had transferred to the CHC section.

In 1999, the ideal public health curriculum for teaching public health in chiropractic colleges was continued, and even received some attention in *The Nation's Health*. For the first time, other health care disciplines offered continuing education credit to their members who attended chiropractic sessions, a practice that would continue. Despite these accomplishments, membership in the section continued to struggle and was about 300 that year.

Dr. Michael Perillo received a Health Resources and Services Administration (HRSA) grant in 2000 to further the development of the ideal chiropractic public health curriculum. In 2001, that progress would be noted in a full article in *The Nation's Health*. Unfortunately, CHC section membership slipped under 300 in 2000, continuing the difficulty persistently faced by chiropractic within this venerable institution.

In 2001, because of his service as the Chair of the Intersectional Council, Dr. Haas sat on the APHA Executive Board. As such, he had the opportunity to preside at a session featuring U.S. Surgeon General David Satcher. That year, Dr. Haas was also elected by the Oregon Public Health Association to its seat on the Governing Council and its Executive Board, a historic first. The APHA officially recognized Dr. Baird for "Commitment, Dedication, & Outstanding Leadership." Significantly, Dr. Lisa Killinger, at the request of the APHA Executive Director, presided at a special session called "Faith, Terror, Hope, and Public Health: Exploring the Common Ground" at this post 9/11 annual meeting. Dr. Monica Smith co-authored an article to appear in *AJPH* this year, only the second article with chiropractic authorship in that journal. The APHA also announced that it would produce a special issue of *AJPH* in October 2002 on "Complementary and Alternative Medicine." Chiropractic was making amazing gains in the APHA and within public health.

Furthering those gains, the ACA declared its intention to develop a wellness model and increase involvement with APHA. *Dynamic Chiropractic* began a regular feature called "Chiropractic in the American Public Health Association" edited by Dr. Rand Baird that would ultimately feature articles by Drs. Rand Baird, Joseph Brimhall, Cheryl Hawk, John Hyland, Lisa Killinger, John Pammer, Jr., Monica Smith, and many others. Ironically, at this time of great achievement, chiropractic membership dipped to an all-time

low of about 240. The CHC had now become the smallest section within APHA.

Membership fell to 215 in 2002. Somewhat shockingly, one member who had failed to perform duties on the Section Council for three years showed up at the annual meeting exhibit hall where he rented his own booth and promoted his own commercial venture! Several other members failed to attend or fulfill section duties. A rather biased article was published in the "Complementary and Alternative Medicine Issue (CAM)" of *AJPH* about chiropractic. In spite of these low moments, there were many bright spots for the CHC section in 2002. Dr. Michael Perillo presented the "Model Public Health Curriculum" for chiropractic colleges to the ACC Annual Meeting in New Orleans. Dr. Lisa Killinger successfully authored and obtained an APHA grant to sponsor activities promoting intersectional collaboration, including a multi-disciplinary health promotion booth at the annual meeting. This collaborative booth won second prize for exhibits at the annual APHA conference, the first time chiropractic received an award for APHA exhibition. Chiropractic members continued to serve on official APHA committees and Dr. Haas continued as a member of the Oregon Public Health Association's Executive Board. *AJPH* did publish two chiropractic-authored articles in the October CAM issue. A total of four chiropractic-authored articles had now appeared in that prestigious journal.

In 2003, several positive developments continued. The CHC section collaborated for the second time with the Vision Care, Podiatry, and Oral Health Sections to produce a mega-booth in the exhibit at the Annual Meeting, which was awarded a tie for first place for finest exhibit. Several thousand people saw the booth, including a U.S. Navy flight surgeon "seeking DCs in Hawaii to whom Navy patients could be referred." Dr. Haas continued in his positions on the Governing Council and on the Executive Board of the Oregon Public Health Association, and chiropractors continued to serve on committees of the APHA. Dr. Haas also was the co-author on an article published in *AJPH* in December, only the fifth chiropractic-authored article to appear in this prestigious journal. This year, because of changes within APHA regarding the declining value and status of Agency membership, most colleges let their agency status lapse and instead were supported under the Association of Chiropractic Colleges (ACC), which had established agency affiliation with the APHA. Dr. Baird and a delegation from

the WFC had an opportunity to attend the WHO World Health Assembly in Geneva, Switzerland. There he met with Drs. Georges Benjamin and Allen Jones, both of whom hold significant positions within both the APHA and WFPHA. Surprisingly, chiropractic membership in APHA remained small, despite these tremendous gains made by and on behalf of the profession through affiliation with this organization. The CHC section continued to be the smallest in APHA, with membership of about 270 in 2003.

In 2004, the ACA expressed interest in a public health column appearing in their new online publication scheduled to launch in 2005. This would significantly complement the ongoing efforts of *Dynamic Chiropractic*, which has provided column space for articles on any aspect of “Chiropractic in the American Public Health Association” since 2001. More chiropractors presented papers in multidisciplinary settings at the annual meeting, an encouraging trend. The CHC section cosponsored another mega-booth this year in the exhibit hall. Despite these opportunities to function as equals in a multidisciplinary setting, membership in the CHC section remained low, below 235 in 2004. The section membership chair had not been fulfilling duties, and a new one was appointed for 2005.

There were positive developments in this active section. The Public Health Committee of the WFC developed two anti-tobacco public health posters that were distributed to all chiropractors through the efforts of *Dynamic Chiropractic* and many chiropractic organization cosponsors. Dr. Cheryl Hawk worked with many of these sponsoring agencies to co-author a published field study on WFCs anti-tobacco campaign. It was noted that increased emphasis was being given to Healthy People 2010 and related current public health information by the CCE and on National Board exams. It was proposed that chiropractic colleges should consider subsidizing APHA membership dues at least for lead public health instructors on their faculty. The section also announced plans in 2005 to create a national registry of chiropractic public health instructors. The section honored Dr. Baird for 25 years of work (1979–2004) within the APHA and for promoting chiropractic and public health. The CHC section was moving actively into the future.

The year 2005 marked the tenth anniversary of the CHC section and over 20 years of chiropractic within the APHA. Achievements this year included cosponsoring

a session at the APHA annual meeting with the Vision Care Section and cosponsoring a mega-booth for the fourth time with Vision Care, Podiatry, and the Oral Health sections. The CHC section reviewed the “Straighten Up and Move” program presented by Dr. Ron Kirk of Life Chiropractic College. The ACA began publishing a public health article in its online publication. In 2005, the sixth chiropractic-authored article appeared in the *AJPH*, this one with Eric Hurwitz, DC, PhD as lead author. Dr. Paul Dougherty of New York Chiropractic College introduced Dr. Baird to public health and chiropractic student Jonathon Egan at the conclusion of the CHC section business meeting. There, Dr. Baird extended the invitation to Dr. Egan to commemorate the 10th anniversary of the CHC section by chronicling the history of chiropractic within the APHA over the last two decades—the inspiration for this article. Also at this annual meeting, the APHA Executive Director and Membership Committee recognized Dr. Baird for his efforts over many years. Further, CHC section chair Dr. John Hyland and Drs. Mitchell Haas and Rand Baird were honored at the APHA awards ceremony in recognition of chiropractic’s ten year anniversary as an official section.

Again, in spite of all these positive events, section membership remained an obstacle and concern. The CHC section was the second smallest section in the APHA in 2005, exhibiting no real growth over the past several years and retaining membership just above 200. A new membership chair in 2005 provided hope that the section would again grow. *Dynamic Chiropractic* again showed willingness to support chiropractic and public health by generously donating column space for a membership drive in 2006.

To help enhance membership and connections with chiropractic campuses, the CHC section sought to complete a registry of all public health instructors at chiropractic colleges. While this was not completed in 2005, the CHC section recommitted to its completion in 2006. It was again noted that chiropractic college Presidents should subsidize APHA membership dues for all lead public health instructors on chiropractic campuses.

Chiropractic efforts within APHA will continue. In 2006, several leaders of the CHC section met again at the Association of Chiropractic Colleges-Research Agenda Conference (ACC-RAC) in Washington, DC and will continue to explore ways to enhance the role of chiropractic in public health, including the promotion of

membership in APHA. Meanwhile, the accomplishments of the past two decades should be recognized and celebrated. Chiropractic went from pariah, to participant, to full parity over 25 years of contact and cooperation within APHA.

This example could serve as a model for chiropractic engagement within other political and professional organizations. By collaborating with other professionals and developing relationships of trust, chiropractic has become a respected partner on both the national and global stages. All chiropractors owe a debt of gratitude

to those self-sacrificing volunteers who demonstrated determination, perseverance, and persistence while striving for the greater good of their profession over many years, creating a role for chiropractic within the APHA. Their work opened the way for chiropractic in many venues, including state agencies and as affiliate members of WHO. The past has been bright. The present is full of potential. Chiropractors can now take an active role in the local, national, and global public health effort, fully embracing a future with chiropractic and public health together.

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