Dynamic Chiropractic

EDUCATION & SEMINARS

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"CMCC Does Not Subscribe to 'Named' Techniques"

Dear Editor,

In the article, "We Need to Bring Order to Our Techniques," by Reed Phillips,DC,PhD available in the (January 1, 2002 issue or at www.chiroweb.com/archives/20/01/15.html), the author raises some very important issues on teaching of technique in chiropractic colleges. His argument for a more defined standard of care and assurance of quality is compelling. Society does and should hold health care providers to a high standard of care; as health care professionals, we must strive to uphold and, if possible, exceed such standards.

I would, however, like to point out that with respect to the Canadian Memorial Chiropractic College (CMCC), the information provided in Table 2 is misleading. While one could say that we expose our students to techniques other than Diversified in our curriculum, we were very explicit in our response to the survey to which Dr. Phillips refers, that there is no psychomotor component (lab) for the techniques of Thompson, HIO, Gonstead and Activator. It would be incorrect for the reader of the article to infer that CMCC teaches techniques other than Diversified in our DC curriculum. Furthermore, we do not teach the full named technique curricula in our postgraduate programme, but rather have provided workshops that have discussed the evidence and rationale underlying the techniques alluded to in the article.

As with LACC, the CMCC does not subscribe to "named" techniques in the DC programme. The "named" techniques that are discussed are done so from an evidence-based approach. This supports the notion that chiropractors should be familiar with various manual procedures to aid in patient management, while performing standard and accepted procedures in the examination and diagnosis of the patient.

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The Interaction between Organic and Psychosocial Models

Dear Editor,

I don't often feel compelled to write a letter to the editor, but I just finished reading the recent article by Dr. Arthur Croft, "Late Whiplash: The Controversy of Organic vs. Biopsychosocial Model" (Jan. 14, 2001 issue, or at www.chiroweb.com/archives/20/02/04.html). It's a very interesting article. Since I have long been a student of the biopsychosocial model, I thought I'd provide my two cents. (By the way, I contributed to Chapter 11, "Factors Affecting Long-Term Outcome," in the recent third edition of the Foreman and Croft text, *Whiplash Injuries.* Guess what my contribution was? You guessed it: "Psychosocial Factors of Chronic Pain.")

I have the utmost respect for Dr. Croft. His work and his contributions provide great insight into the mechanisms and problems associated with whiplash injuries. At his invitation, I had the good fortune several years ago to attend the CRASH program that Dr. Croft sponsors each year in San Diego. I must admit it was one of the most impressive continuing education programs that I have attended. I would encourage anyone interested in the topic of whiplash injuries to attend. Having said that, I'd like to disagree with some of the comments he makes in his recent article.

First and foremost, I take issue with the idea that it is a contest between the organic and biopsychosocial model. Rather than taking sides, it behooves all of us to understand that biopsychosocial issues confound and complicate the organic ones. It's not that organic factors don't matter, but you can't discount the psychosocial issues. There's an interaction between them. When one speaks of psychosocial issues, too often many interpret this to mean the problem is not real, and it's all in the patient's head. Whatever the origin of patient complaints, and whatever the complicating factors, pain is pain and symptoms are symptoms.

Rather than disregarding the evidence that runs contrary to Dr. Croft's opinion, I suggest that the evidence be given some credence. If we consider neck and back pain to be fairly similar in kind, we can borrow from the back pain literature. The case is compelling that biopsychosocial issues do indeed complicate recovery from back pain. Since there is some evidence in the whiplash literature, albeit not as much, it is not unreasonable to suggest that patients with whiplash injuries, whether acute or chronic in nature, are also impacted by a variety of nonorganic variables. Some patients move along with life; while they may have some residual symptoms, they are not disabled by them. Others suffer tremendously from seemingly minor injuries; sometimes in spite of any significant organic findings supporting their injury. The biopsychosocial model helps us to understand, in part, these differences in response.

In conclusion, I'd like to quote from Foreman and Croft's text, page 517 (3rd edition): "Rather than being a choice between whether an injury is real or whether a patient is malingering, it should be sufficient to state that the degree of suffering experienced by two patients with similar injuries will vary."

Who could argue that this degree of suffering is not influenced by factors such as the degree of life and job satisfaction, the possibility of some form of secondary gain, or the labeling provided by the medicolegal system? Again quoting from the Foreman and Croft text, "The pain is rendered far less tolerable when the rest of our life is not in order (Hadler, 1997)."

Once again, it's not an issue of organic versus biopsychosocial models. It is, instead, an issue of the interaction between the two.

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"Advertising Hypocrisy"

Dear Editor,

I am writing in response to the "President's Forum" authored by Dr. Winterstein in the November 5, 2001 issue of *Dynamic Chiropractic* (available on line at www.chiroweb.com/archives/19/23/21.html).

Dr. Winterstein's message was effective in taking a different angle to the survey conducted by Dr. Eisenberg, et al.[1] Dr. Winterstein hit the nail on the head by pointing out how we should not focus our efforts on what we're doing right as chiropractors, but instead focus on what we're doing wrong. In stating three facts about the survey, Dr. Winterstein ended each statement with how many patients disagreed. The most telling statistic was not that 52 percent agreed the CAM provider spent more time with the patient, but that 48 percent disagreed.

As I was trying to piece together why these statistics were so shocking, I decided to rethumb through the issue of *Dynamic Chiropractic,* and that's where I found my answer.

While reading the many, many advertisements placed throughout the issue of your publication (enough to make my head spin), I focused on those emphasizing methods of increasing patient flow. One such advertisement had many DCs trumpeting the success of a certain program, with one doctor saying: "Thanks to you, we had our biggest day yesterday! We saw 117 patients!" This advertisement also promises you'll only work 10 hours per week. Another strategist emphasizing increasing patient flow claimed its program would enable you to "average over 1,800 office visits per month."

Does anyone see the problem here? One of chiropractic's biggest promotions is how the patient is treated, not the ailment. Spending more time with our patients than the allopaths is what makes chiropractic so unique and effective. But how much time could you possibly spend with each patient if your clinic is seeing 117 patients per day, 1,800 per month, yet working only 10 hours per week? How could you possibly cultivate a meaningful doctor/patient relationship with that kind of patient flow? In my view, it's just not possible, and unfortunately, one of the largest chiropractic newspapers around seems to be advertising hypocrisy.

Yes, chiropractors have bills to pay. Rarely do you find someone who has not experienced some sort of financial strain when running his or her practice. But we're not supposed to be in this profession for the money. While going through school, all chiropractors are made aware that insurance reimbursement for chiropractors is minimal at best. But did you really go to chiropractic school for the money? I'm sure there are a few who did, but I'll bet most of us desired chiropractic medicine because of the doctor/patient relationships we knew we could cultivate that allopathic medicine could not. In chiropractic, transference is almost encouraged. In allopathic medicine, it is strictly discouraged.

The last disturbing advertisement I found proposed a strategy that claims to enable you to retire by the time you're 33. What kind of a career is that? What kind of professional satisfaction can you get from being a chiropractor for seven to eight years (assuming you enter chiropractic school by the age 22 or 23 and graduate by the time you're 26 or 27)? Once again, I see hypocrisy here. This profession is supposed to be about putting patients first, yet we're trying to tell our colleagues how to get out of the profession before the age of 35! Hypocrisy, hypocrisy, hypocrisy!

Before we go around telling other medical disciplines how to treat patients like people and not ailments, we must get the message right and, more importantly, we must make sure we practice what we preach. What are we supposed to preach - that by becoming a chiropractor you made the commitment to put the patient first, that you treat your patients with the respect they deserve, and treat them like a member of your own family.

I read all the time how chiropractors love being "separate and distinct" from the other medical disciplines. Well, that gap is closing at an alarming rate. And for someone who is a second trimester student and has not even entered the field yet, I find this quite disconcerting.

Reference

1. Eisenberg D, Kessler R, et al. Perceptions about complementary therapies relative to conventional therapies among adults who use both: Results from a national survey. *Ann Intern Med* 2001;135:344-351.

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