Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

DUH! Teaching MDs Not All It Could Be

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When reading over the study conducted by Drs. Peter Curtis, Tim Carey, et al., most DCs will probably end up scratching their heads. Much of what the authors seemingly took for granted just screams for a deeper understanding. And yet, in the midst of the study by these well-respected researchers, there is an insight that could be the topic of an important and timely investigation.

(*Note*: If you haven't read "Training MDs to Adjust Offers 'Little Extra Benefit'" in this issue, now is the time to do so before I go on to discuss issues you probably won't follow.)

But first, let's look at the components of this study that I would put in the "Duh" column:

- "Standard Sequence of Maneuvers" - After observing some "manual therapists," the authors note: "Whatever the specific mechanical diagnosis, it is common practice to first use a standard sequence of muscle energy and high-velocity, low-amplitude maneuvers applied to more than one musculoskeletal region."

Expecting to apply a "standard sequence of maneuvers" to a patient "whatever the specific mechanical diagnosis" is lowering the adjustment to a mindless level. Unlike much of medicine, chiropractors are after the cause, not just the symptom. Diagnosis/analysis is much more sophisticated and the resultant adjustment(s) are extremely specific.
Identifying the specific subluxation(s), knowing where to adjust, and how to adjust is critical for any degree of positive results.

- 18 Hours of "Educational and Skill Workshops" - While this has to be somewhat insulting, it borders on comical. MDs with relatively little exposure to the musculoskeletal systems expect to learn in 18 hours what DCs learn in four years. Is it any wonder that "only 43% of the patients who underwent manual therapy actually received the complete planned sequence of maneuvers?" The authors correctly perceived a "lack of confidence" in the actions of their MDs. The same could probably be said for the poor patients.

- 35% Received Narcotic Analgesics and 68.5% Received Muscle Relaxants - Why is it that immediately after learning "manual maneuvers" the MDs have to add drugs to them? They had only known these standard maneuvers for three months and already felt confident to mix the therapy with various drugs! Wouldn't it seem logical to understand the effects of manipulation before adding drugs to the mix? (They might just find that the drugs aren't necessary.)

- No Philosophy - The MDs didn't really seem to know why they were doing what they were doing. The patients presented with low back pain and (depending on which group they were in) the MD provided them with "five muscle energy techniques and three high-velocity, low-amplitude thrusts" on each side. (A robot could do as much.) They know anatomy from an allopathic point of view, but not from a chiropractic viewpoint. Without a philosophical foundation, how can they ever expect superior results?

Again, please know that I have great respect for the authors.

The one striking discovery that they did make was found on the last page:

> Two years after training, most physicians in the study reported continued use of manual therapy, with approximately half using only muscle energy techniques at a frequency of two to three times weekly. They reported that they had changed their management by performing more complete examinations, more touching, less use of narcotics, reduced referrals to specialists, and increased referrals to chiropractors. The "take" rate of the training appeared to be approximately 50 percent. A majority of the physicians believed that they were improving patient outcomes, perhaps because of their impression of immediate improvement, now shown by the data, after the first treatment.

After two years, with virtually no philosophy, only 18 hours of training, only three adjustment techniques and mixing in drugs to boot, the MDs began to "get it." They learned better examination procedures, the power of touch and that narcotics are not necessarily the answer. But perhaps most importantly, they developed a new respect for doctors of chiropractic.

If you think the authors missed the point, perhaps we also have.

For so many years, many of us have seen the medial establishment as anti-chiropractic. And while it continues to be true that political medicine is no friend of chiropractic, the same is not true for individual medical doctors. If this study tells us anything, it is that many MDs are willing to learn and, that once they have been given enough information about the value of chiropractic, they are ready to refer.

This is not something you have to hire a PR agency (or an attorney) to convey. This is a doctor-to-doctor opportunity; you can take them to lunch and help them understand what you do, why you do it and how it serves your patients.

Don't be shy about it. Be proud. You help a lot of people each day. Invite an MD into your office some afternoon or evening. Let them sit by you as you examine your patients. Show them what you're doing and let the patient share what they feel after the adjustment. (Your patients won't mind, they will be excited that you are working with MDs and they are working with you.)

Drs. Curtis, Carey, et al. were right. Teaching MDs how to adjust "offers little extra benefit." But teaching MDs about the effectiveness of the adjustment and the value of chiropractic care (for more than low back pain) offers great benefit.

Should we become pro-active in our efforts to teach MDs? Duh!

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