Dynamic Chiropractic

PHILOSOPHY

We Get Letters & E-Mail

The Key Is Trust

Dear Editor:

You recently published an article by Rob Sherman, Esq addressing the need to establish working interdisciplinary relationships between Chiropractic and the rest of the health care and policy making communities. As a DC who has lived through this transition, I say "Rob, you are absolutely correct! The key issue is trust."

The suggestions Mr. Sherman offers are excellent, but leave out a major factor ... the appeal that will attract the interest of the MD. True or not, MDs pride themselves on being highly professional and scientific as well as having the patient's best interest at heart. We all can list examples where this is not the case, and some where it is. That isn't the issue. What we need is a "hook" to get their attention and then develop the trust. There is another suggestion that I might offer that has demonstrated success for a handful of DCs. Meet them on business (competition for patients) neutral turf and engage in dialogue that is patient focused. That is patient focus not chiropractic or medicine focused.

So, how do you do that? It isn't that hard. Most actually find it fun. It can lead to some nice CME related vacations. It works well and it takes a little time to mature.

There are several steps.

First, nearly every community or county has a hospital that conducts continuing medical education programs. Usually, a simple phone call will get you on the mailing list. When the monthly or quarterly notices arrive, select one that has a musculoskeletal related or public health topic. Do a little review on that topic in advance and attend the meeting. Ask relevant topic related (not chiropractic related) questions. Engage in the socializing and conversation before and after. Let them get to know you as an intelligent person who has something to contribute in their terms.

Inevitably, when I have done this, I am asked where I practice and what my specialty is. Then I am able proudly announce myself as a local chiropractor. Within several meetings, one is usually able to strike a relationship that can be useful.

The keys are: don't prostelitize. Don't push chiropractic as if it were a used car. Don't push philosophy and don't talk about treatments you know are likely to be controversial. Be professional. Be conscious of the topic and its social issues. Address the community in terms of its problems and solutions. Let the trust build. The appeal that interests the MD is finding out that there is a common interest in the patient's needs and that there is a deeper intellectual capacity of the DC than he has been lead to believe by the stories or some of the advertising that is done. The MD has also observed the new interest in chiropractic and may actually be wondering what it is about and how to find one he can trust.

Why do we want to develop this relationship with the medical community? Its really simple. Increased business, increased case mix and a higher quality of health care delivery through

collaboration and referral for both their patients...and yours. These are the people that are asked to the policy making table and help to make decisions that affect you life as a practicing DC. We must reduce the adversarial relationships with them if we expect to get our concerns addressed in a real sense.

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Chiropractic Education Is Not Substandard

Dear Editor:

I, for one, am fed up with Dr. Daniel A. Shaye-Pickell's arrogant and condescending attitude towards the chiropractic educational system (*Dynamic Chiropractic* 01/27/97). Having been a classmate of Dr. Shaye-Pickell's, I am fully aware of his dissatisfaction with chiropractic education and I recognize his right to voice that opinion. However, I get the distinct impression from his two letters to Dynamic Chiropractic that he believes that rote academic regurgitation should be the quintessential criterion used for determining the quality of a chiropractic physician.

Personally, I do not advocate a standardized admissions exam (MCAT or CCAT) as a basis for potential doctor selection. An admissions exam cannot possibly review candidates' qualifications in certain areas that are essential for the competent treatment of patients. Integration of knowledge, compassion, tact and communication are all critical skills in the development of a physician and may not all be present upon admission to chiropractic college. These skills must be nurtured by the chiropractic educational process. How can an institution measure future chiropractor potential at the outset when students have not had the opportunity to demonstrate their ability to grow and learn?

The last thing students need is another set of exams. If the CCAT were to be implemented, students would be forced to write an entrance exam, four parts of the national board exams, a physiological therapeutics exam, a state board exam and additional exams to enter clinic at the individual chiropractic colleges. This will only be viewed as another "hoop" for students to "jump through" and review courses will pop up (for vast sums of money) to prepare students for the hurdle. Let us stop compounding the problem and break the cycle of apathetic learning here!

Perhaps the entire educational outlook needs to change rather than building upon the current system. If students look upon course work and exams as obstacles to surmount before achieving their chiropractic degree, they will not respect or apply what they have learned. An ethical standard and learning environment cannot be legislated. It must be set by example! Rather than spoonfeeding students with knowledge to be memorized and tested upon, the system should be designed so that students will feel compelled to absorb the knowledge they are presented with. They need professional instructors, who are experienced and up-to-date with their knowledge, to teach them how to integrate academic knowledge and apply it to patient care.

In addition, I take personal offence to Dr. Shaye-Pickell's flawed observation that Canadian students flood American chiropractic colleges after being rejected by the CMCC. Being Canadian, I toured several colleges, including the CMCC, before making Logan College my first choice. Some of us prefer the different approach to chiropractic education that certain American schools offer. At

the time of my admission to Logan College, the CMCC was Canada's premier, and only, chiropractic college. Dr. Shaye-Pickell should get his facts straight before making such obnoxious arguments.

I would have to recommend to Dr. Shaye-Pickell that if he is dissatisfied with his abilities as a doctor, then perhaps he should look internally at what he did with his education rather than how Logan college presented the education. Students need to take some responsibility for their professional development and stop pointing fingers at college administrations if they feel unprepared for the challenges of the real world.

Chiropractic education is more than just academics, it is the clinical application of all the knowledge we learn about human health and physiology with the philosophical twist that distinguishes chiropractic as the most unique health care profession on the planet.

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Deja Vu ... Kirlian photography?

Dear Editor:

Re: Jan. 27, 1997 issue
"*Chiro & Kirlian Photography,*" *page 8.*

In 1973, while finishing my senior year at college, I jumped at the opportunity to take an elective course from a renown economics professor. The course, "The Future - year 2000," required analyzing current economic, political and scientific developments and forecasting their influence at the turn of the century. In addition, each student must find and make a presentation of some obscure discovery that might have future importance. So, I researched Kirlian Photography.

I'd already had read the literature from the Russian and Chinese parapsychologists who reveled in their "discoveries" in psychokinesis and other paranormal phenomena. After all, I was living in the 'Age of Aquarius' where my generation was then enamored with the paranormal. I made a appointment to meet with Thelma Moss, PhD, the primary researcher studying Kirlian photography in the US. It was an eye-opening day I spent with the gracious Dr. Moss, and her assistants.

Kirlian photography basically involves placing an organic object (such as a body extremity, a plant leaf, etc) against a piece of unexposed film and then exposing it to an high voltage field. The developed film will reveal a corona, alternately called an "aura" or "life-force," being emitted around the area where the object is contacting the film. At Dr. Moss' lab I had the opportunity to take numerous photos of my fingers. Each displayed a corona. It soon became apparent that the intensity and size of the corona could easily be manipulated by varying the level of pressure on the film. Further, if I grounded the high-voltage field by placing a leg or my arm against the metal table, the image of my fingertips then displayed very large "auras." So, a great variety of images are possible by simply varying the pressures on the film, or the amount of electrical isolation.

Variations of humidity, temperature, and dampness of the fingers can also influence the magnitude

of the image. In short order it became apparent that Kirlian photography would not have any ethical influence on the future. In my mind, it would forever remain a pseudo-science, a parlor trick, like other alleged paranormal marvels.

It's not uncommon for a scientist to believe that because they have been trained in the physical sciences or the healing arts, that they are capable of flawless judgement even in the investigation of alleged paranormal phenomena. The better trained the scientist the more easily they can be duped, especially when the human element is involved. Dr. Moss was a fine psychologist, but not trained in electrical engineering. The "paranormal feats" of Uri Geller's mental spoon-bending and Peter Hurkos psychic abilities dazzled many scientists. Later, a professional magician taught investigators how to examine their "tricks" and reveal them for the frauds they are. Of the Russian and Chinese claims of paranormal feats, in the 1960s and '70s, those that have been reviewed under a new light have all shown that the scientists were mislead. It should be noted that of the references cited in Dr. Courtney's article, none were in peer-reviewed media or more recent than the eighties; this is because all serious research was abandoned when the level of evidence could not support the hypothesis of the technique.

For those interested in objectivity in evaluating paranormal claims, a good starting point can be found in a publication called "The Skeptical Inquirer." This journal is produced by the Committee for the Scientific Investigation of the Paranormal (CSICOP). This 20-year old group of renown scientists, authors and scholars is devoted to examining "The New Irrationalism: Antiscience and Pseudoscience." Their research and the references they cite can help light way for seekers the truth in the sea of junk science.

Kirlian photography can make some pretty pictures, but it has no place in the realm of chiropractic. Chiropractic, with the support of science, can have the stars in its future, and that future is too important to be lost under the burden of practitioners who erroneously embrace pseudo-science. Further, Dynamic Chiropractor should be more selective in choosing articles to better represent our profession within its publication.

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Give Credit Where Credit Due

Dear Editors:

I would like to comment on the article, "The Chiropractic Treadmill Test" by Scott Rosenquist, DC, (Feb. 24, 1997).

I was a classmate of Dr. Rosenquist at CCCKC, and had the opportunity of working beside him for a short time several years after graduation. I know that he is a dedicated and intelligent chiropractor. I also had the distinct privilege of working side by side with Dr. Leahy for two and one-half years, during the time that the myofascial release technique was being refined. I have been primarily utilizing this technique in my practice for approximately five years now.

My main concern with Dr. Rosenquists' article is one of omission. Reading his article, one would assume that Dr. Leahy had developed this technique singlehandedly. Unfortunately this is the impression in several articles in which this technique is discussed. Authors fail to note the

significant contribution of Dr. Leahy's co author, Dr. Lewis Mock. Dr. Mock was instrumental in the development of the technique and the publication of the original articles which brought the technique to our profession.

Additionally, the myofascial release technique, as described by Leahy and Mock, was built upon a foundation of knowledge previously laid down by researchers: Rolf; Nimmo; Travell and Simmons; Lowe; Rockwell, etc. As valuable as this technique is, it did not just spontaneously appear. It was the synthesis and refinement of all that went before.

Dr. Leahy and Dr. Mock have both, separately, continued to work to improve this technique, and educate, albeit in different formats, our profession about their work. Let's give credit where credit is due.

Brad Bingham, DC
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Clarification

Dear Editor:

I would like to thank Donald Corenman, MD, DC, Steven Gould, DC, DACBR, and Robin Futorna, DC, FACO for their response to an article that I wrote, "Diagnostic Ultrasound: PLL & ALL Fibrosis." They had indicated a few errors in the article which I would like to clarify.

The article should have state the PLL is located approximately 4-6 cm deep into the tissue, located in the region anterior to the spinolaminar junction. The ALL is located approximately 7-8 cm deep. These are very general guidelines and the actual location of these structures are dependent on the patient's age, body size and spinal level being examined. Also, ALL fibrosis is rarely visualized on the sonographic exam.

I had incorrectly used the term "inflammation" when attempting to describe the hyperechoic lesion relating to soft tissue fibrosis. Fibrosis and inflammation are not the same clinical finding and do not have the same sonographic characteristics. Effusion and inflammation appear hypoechoic or dark sonographically.

Various attempts have been made to describe the hyperechoic lesion in the PLL area, including nerve root area and ventral echoes reflected from the disc space. These descriptions are based on the location of the lesion, identification of other known landmarks and anatomical correlation. Kadziolka, et al., and Kamei, et al. had confirmed that the ultrasound beam penetrates the interlaminar space and reaches the disc level. Identification of the lesion in the lumbar spine is aided by the use of a pillow under the abdomen to straighten the back (Kamei, et al.) and open up the posterior joints. Images should be performed in the transverse plane, and in the longitudinal plane (Porter, et al.). Both planes are useful for identifying anatomical landmarks, confirmation of findings in multiple planes, and the reduction of error from artifact.

Due to the anatomical location of this hyperechoic lesion, reproducibility in multiple planes and clinical correlation, I cannot accept the description of bone casting a shadow as the sole producer of this finding. I feel that the terms which are regularly identified by some as fibrotic, bulging or calcific PLL are more accurate for describing this finding. The fact that this finding will normally appear at every level of most every pediatric spine is consistent with elongation of the ligamentous structures associated with growth and should be considered normal for this age group. it is my

opinion that elongation tearing (not complete rupture) or sprain and the resultant fibrotic repair process produces a similar sonographic appearance in the adult spine. Also, the earlier repair phases of tissue healing will appear more echoic than a chronic condition or near resolved lesion. Staging of the healing process would not be noted in bone shadow artifacts.

Finally, I feel that spinal imaging of the adult spine is a useful imaging modality. I feel that there is a need for standardization in the areas of terminology, technique and interpretation. A recent preliminary study comparing DUS and MRI on low back pain patients has shown a high correlation of disc injuries on MRI with nerve root area findings on DUS. This study also suggested that while nerve root area findings do not indicate a definite bulging or herniated disc, its absence is a strong indication that there may not be a significant disc injury. This raises the possibility that the less expensive ultrasound may be used as a screening test prior to the more expensive MRI for low back pain. Further research will be valuable in the progression of this technology.

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Limbaugh Could Be a "Positive and Uplifting" Chiro. Spokesperson

Dear Editor:

I recently read the letter concerning Rush Limbaugh as a promoter of chiropractic by Dr. Russell Gibbons. I also read the original column by Dr. Wilk (I believe he was the author). I take issue with Dr. Gibbons. I am a very serious listener to the Rush Limbaugh program and have been for approximately five years. Listening to Rush Limbaugh is like getting a crisp, cool breath of fresh air after having been stuck in a small room filled with cigarette smoke. He is a thoughtful and thought provoking in addition to being a very insightful commentator. I believe Dr. Gibbons is mistaking Rush's talent for a general dislike of his conservative message. It is a sheer pleasure to hear a man with a powerful, positive message delivered in a clear concise way. This is in no way an embarrassment unless you are a liberal at heart (in which case you should be embarrassed for the abject failure of the liberal policies that have been destroying the very fabric of our country). I laughed in amazement at the idea that Rush Limbaugh has a goal of unfettered and unregulated corporate profit making at the expense of the public. This idea is literally out of "left field." Furthermore, I disagree that his program is a mindless rhetoric and ridicule of our mainstream institutions. I know because I have listened for five years. If you call liberalism a mainstream institution, then yes he has ridiculed it. Many people have been saying and thinking what Rush has been saying but now have an advocate. And I don't intend to waste my hard earned money on the book by Steve Rendall. I would much rather read a positive uplifting message authored by Rush (and I have). As for Dr. Wilk's idea, I say go for it. You have my vote of confidence!

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