Dynamic Chiropractic

PHILOSOPHY

We Get Letters & E-Mail

Carrying the Olympic Torch

Dr. Long with the Olympic torch.

Dear Editor:

I had the great privilege of running the Olympic torch on June 30 in Montgomery, AL. I was accepted by my community services.

I would like to know if there were any other chiropractors that had this opportunity, and would like to hear from them.

I graduated with the March 1970 class from Palmer College.

Thank you,

Hugh Long, DC
Atmore, Alabama

"We have effectively diluted the clinical education to the point of being almost worthless."

Dear Editor:

In the December 4th 1995 issue of DC, Dr. Peter Martin suggests that chiropractic colleges should pursue tougher educational standards. He makes a good argument why our standards should be brought to a higher level, and then takes a quantum leap into the abyss of cluelessness with his suggestion of how to accomplish this task. He, and apparently the other college presidents, want students to get more pre-graduate education, and eventually require a bachelor's degree as an entrance requirement.

Having instructed students at two chiropractic institutions, and instructed both chiropractic and medical residents, it is my honest belief that this requirement will have virtually no impact on the quality of chiropractors graduating, nor on the quality of chiropractic education. I offer the following reasons.

1. The average entering GPA of chiropractic students is approximately 2.8. Rumors abound that "C" students make better doctors, and "A" students do research and write books. I have found few educators whose experience agrees with this. Students with higher GPAs generally have those grades because they have worked for them. Working hard is a trait of maturity, "getting by" is not. A thousand bachelor degrees, with the same low GPA standards, leads to the same kind of students we have now, and does nothing to increase the quality of graduating chiropractors.

2. At least two schools that I know have virtually unlimited enrollment. When the incoming class reaches the maximum number, they raise the limits. As far as I know we are the only health profession with unlimited enrollment. Even our local dental hygiene school has about 3 applicants for each opening. Why would these other schools limit their enrollment when we don't see the need? The answer is not in the classroom, it is in the clinic. Clinical experience is the most important aspect of training for students in any health care profession. It is where the classroom learning must be correlated and integrated.

   Unfortunately our enthusiasm for the limitless potential our clinics has outgrown the reality. To fulfill CCE requirements our clinics have turned to clinically worthless number generating entities, offering little clinical experience or training. Students may have reached their 250 spinal adjustments, but many have still never seen anything acute, much less that they might actually diagnose something other than low back pain. The variation in the conditions seen per student is completely lacking. We have effectively diluted the clinical education to the point of being almost worthless.

3. We have the highest default rate of ANY health profession. ACA's statistics report a significant drop in income of the average DC. Ty Talcott of Shared Physicians Network has stated that based on his companies communications with chiropractors (ACA, and non ACA), income has dropped 40-60 percent in the past few years, directly due to managed care. Now the schools want to require MORE years of schooling; hence, MORE DEBT! Increase debt + decrease income + increase number of graduating chiropractors + growing managed care = (How would you like to be in school right now?)

4. OK, say we increase the number of credit hours that a person needs to matriculate at our quality institutions. Dr. Martin said that most students already meet the 90 hours, and a large number have bachelor's degrees. Yet our chiropractic education remains the same. The complaints that chiropractic physicians are not as well prepared as doctors of medicine has little to do with the pre-requisites, and little to do with the endless classes chiropractic students take. It is with the limited clinical training and experience. SO, if you must require more pre-chiropractic classes, why not make the basic science classes as pre-requisites, and open up more time for diagnostic and clinical training. If you are worried that would cause loss of control on quality of basic science courses, simply add an entrance test that would screen out those whose basic science training was inadequate. Basic science is not unique to our profession anyway. Rather than rushing through a diagnosis class to barely teach the basics, this would allow training the students more fully so that they may actually realize why the basic sciences were important.

5. One college president, in talking to a beginning student, stated that when he was in practice, he saw 50 patients a day. Well, at only three working days a week, that means that we require two weeks of practice experience to graduate as a "doctor" of chiropractic. Is it any wonder that medicine, with its 2-3 years of full-time residencies after graduation, might consider our training a little inadequate to be called "doctor?" I'm not saying that minimum standards are bad, on the contrary, they should be increased. Of course, not until we either cut the number of incoming students, so that less students will have the kind of quality needed, or drastically increase the number of "QUALITY" clinical experiences (not asymptomatic "maintenance" patients, and not rub-a-dub-dub at the local dog and pony show) available for those presently in clinic.

A bachelor's degree does nothing but fulfill some states requirements, and give us the same requirements as medical education. Making at least some of the basic science classes pre-requisites could make this a welcome addition. A bachelor's degree, or more pre-requisite hours, at the present time, does no more to "upgrade our educational standards" than sleeping on a thicker textbook does to pass a test.

Anonymous DC
Missouri

Check Out Chiropractic OnLine Today

Dear Editor:

On page 8 of your September 12 issue (Volume 14, Number 19) you ran a story on Chiro-Serve exiting the Internet. Within the story, you mentioned that there were only two "chiropractic services standing" in the wake of this exit.

Please note to your readers that there has been a free chiropractic Internet service on the World Wide Web since June of 1995 known as Chiropractic OnLine Today ([url=http://www.panix.com/-tonto1/dc.html]http://www.panix.com/-tonto1/dc.html[/url]). Chiropractic OnLine Today has provided readers with up-to-date information in chiropractic and related health fields, along with publishing content from some of the top names and educators in chiropractic today. A partial list of our contributors include Drs. Louis Sportelli, Donald Murphy, Jan Corwin, and David Lemberg. Further, noted legal author, Mr. Robert Sherman, is also a regular contributor to our pages.

In addition to news and featured articles, readers have the ability to interact with our contributors via e-mail and can interact directly with each other on our Chiropractic Discussion Page. Chiropractic OnLine Today has dedicated itself to presenting chiropractic's message to practitioners and laymen alike in the "global" forum of the World Wide Web of the Internet. David Cash, CIO New York, New York

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Hypocritical

Dear Editor:

I just cannot understand all the uproar the chiropractors are having about our colleagues on the other side of the fence learning the art of manipulation. Was it not that manipulation was first discovered by our osteopathic brethren? We should be overjoyed that attention is finally being focused on what we do instead of being paranoid. In addition to this, isn't it quite hypocritical that we are all upset that MDs are learning manipulation taught on weekends when we ourselves are parading around claiming to be chiropractic orthopedists, chiropractic neurologists, chiropractic radiologists, chiropractic family practice, chiropractic pediatricians, chiropractic internists, chiropractic acupuncturists, chiropractic sports physicians. I'm sure the list could go on. I don't believe that medics will drop their prescriptions pads to buy adjusting tables. What I do believe is that you may get referrals once they are exposed to it and note its effectiveness and safety.

Brian Anseeux, DC, MD

Louisville, Kentucky

Bad Decisions and Bottlenecks

Dear Editor:

It is time the chiropractic profession took a look at past decisions that have become the largest bottlenecks to its progress for the purpose of re-evaluating them in the light of new data and furthering our progress.

The first and largest bottleneck is what has become chiropractic's most oft stated credo on technique. That credo needing re-examination and re-evaluation is the statement that every technique works. With the variety of theories upon which different techniques are based and the physical movements of various techniques being exactly opposite in direction for the treatment of the exact same findings of bone misalignment, there is no way such a statement can be accurate.

The origin of that statement has been forgotten by most of those still available to remember it and never learned by most chiropractors in practice less than 15 to 20 years. Its origin was at Parker practice management seminars. The reason for its origin was that doctors at the seminars would argue about which technique was best. Some of the doctors in those arguments went so far as to literally start fist fights over which technique worked best. Jim Parker saw that someone needed to do something to stop the arguments and the fighting, be it verbal or physical, otherwise chiropractic would tear itself apart. Being a very smart and clever man, he realized he needed something that made no one wrong and kept everyone's dignity. He came up with exactly that type of "everyone is right" statement. The statement was, "Every technique works." It became the credo of anyone wanting to avoid conflict in the profession and a refuge for those times when chiropractic results were negative. Anyone wishing to avoid factual negative observations of chiropractic treatment or avoid a discussion or examination of technique effectiveness just said something like, "Every technique works."

No one involved in the disagreements truly believed it, but it was something behind which everyone could hide in the name of peace and professional unity. At the time, it was probably needed, but the effects have been all too far-reaching. Somehow that everyone is right statement was allowed into the schools in lieu of research on the effectiveness of techniques. Due to that horrible error we do have outcome studies on the effectiveness of chiropractic that are meaningful. Since the studies do not use a uniform means of diagnosing what is called chiropractic subluxation, which is itself not uniformly defined, and since the studies do not use a uniform means of treatment, the type of treatment being used is never really measured. All that can really be claimed as a result of this so-called research is that, taken as a whole, physical treatments are better than medical treatments for low back and/or neck pain.

A review of that literature shows that the statements is also true for many forms of physical treatment, including much more than chiropractic therapy. Even the previous statement is suspect because there is no agreed upon specific definition of chiropractic therapy. A survey of non-specialist medical physicians by this author shows that most have become willing to refer to chiropractors, but that most have noted mixed patient response both between chiropractic physicians and with the same chiropractic physician on different patients. The result is that they are confused and hesitate to refer their patients until the medical means they are familiar with have become exhausted and the patient requests a chiropractic referral.

It is obvious to all but those hiding behind the statement that every technique of chiropractic treatment does not work.

The next bottleneck is the strong position against pre-and-post treatment radiography by our political and educational leaders. It should be noted that these groups, political leaders and educational leaders, originally were comprised of the same people and continue to have strong ties. Generally that is not a negative, but in this case it has led to some very bad decisions.

To understand those poor decisions one must look at the origin and history of the ban on pre-and-posttreatment x-rays. That origin dates back to the period between the 1950s and late '70s when office based x-ray became relatively inexpensive and widely available. Anxious to prove the theory and widely held chiropractic belief that chiropractic treatments (adjustments) straightened the spine leading to less nerve pressure, relief of symptoms, and better general health, many chiropractic doctors started taking spinal x-rays before and after treatment.

Measuring the changes noted on these films, those doctors were very quickly confronted with two unexpected and seemingly invalidating outcomes. One often occurring outcome was no noticeable changes in the spine after a period of treatment ranging from minutes to days, to weeks, or even years. This was even in cases where the patient was most certainly better by every other measure, from objective physical testing to subjective patient self-evaluation. The other unexpected and frequently occurring outcome that seemed to invalidate chiropractic theory and belief was that there were changes in the spine, but the changes were larger scoliotic-type curves in the patient after treatment rather than a straighter spine on the AP view. Again, this was often the x-ray outcome, even though the patient was better by every other measure, including the patient's own evaluation of movement and relief from pain.

The average chiropractic doctor in the field was very inexperienced in the methodology of research and data analysis, and evaluated this data as invalidating rather than as an indication the data gathering or analysis was flawed. By the late 1970s, after enough of this data was presented, and with no visible means of countering what appeared to be negative data and no willingness to change the chiropractic theory which seemed to be getting so many patients well by other measures, political and educational leaders in chiropractic decided to discourage pre-and-posttreatment x-ray. The policy line was that x-rays were not accurate and did not give true data, since other measures indicated patients were getting well and the x-rays, according to accepted theory, did not. This amounted to a statement that they did not like the data, would not collect it anymore, and would discourage others from doing so.

These political and educational leaders failed to note that the data, while accurate, was incomplete and misleading. They missed the logical conclusion to measure more; that more data might possibly lead to validation of chiropractic theories; rather than the seeming invalidation of the limited data collected, and used their power to prevent others from collecting the additional radiographic data. As noted below, the need to gather more data happens to have been the necessity. This additional data answers most of the questions posed by chiropractic theory.

As it turns out, those unexpected outcomes measured on posttreatment x-ray were not negative or invalidating to chiropractic. The x-rays evaluated for "straightening of the spine" were usually AP view films, which of course only give a two dimensional view of a three dimensional object that moves in three dimensions. In research awaiting publication, three dimensional modeling of the spinal column pre-and-posttreatment shows that the spine winds and unwinds or coils and uncoils in three dimensions, rather than moving left-right or anterior-posterior. As a consequence of that discovery, the increased lateral curves seen on the AP films while patients are improving is easily explained. When the spine unwinds or uncoils from its pathological or injured biomechanical

pattern to a more efficient and healthier biomechanical pattern, it does so in three dimensions. As the patient improves, depending upon where you catch the spine in the process of uncoiling, the AP films may seem more severely curved while the lateral film shows a partial return to normal position.

Strangely enough the reverse situation may also be true. In other research awaiting publication it has been seen that if the chiropractic treatments are making a given patient mechanically and/or symptomatically worse, the spine will often tend to straighten on the AP film (which seems a positive finding) and the lateral view film (which is easily noted to be a negative finding).

There is another related and very important finding that is already available in the medical referred and indexed research literature (specifically neurosurgical and orthopedic literature) and soon to be reconfirmed in research awaiting publication. That very important finding is that the spinal column is a single synchronized working unit which cannot be successfully or accurately be evaluated for biomechanics using sectional radiography or radiography in any single position.

The undeniable conclusion is that chiropractic can both accomplish virtually all the positive outcomes claimed for it by staunch chiropractic believers and virtually all of the negative outcomes claimed by its detractors. The outcome depends upon the appropriateness of the treatment for the mechanical condition of the patient. While this seems obvious to many, what is new is that there is now a method of radiographic biomechanical analysis by which patients' conditions can specifically and accurately be evaluated in a way that points to an effective plan of treatment.

Start using full spine pre-and posttreatment full spine radiographic analysis to determine the effectiveness of your technique and thus improve chiropractic overall.

Jesse Jutkowitz, DC
Milford, Connecticut

A Response to Dr. Dishman: Surface EMG Does Have Value

Dear Editor:

I am responding to claims regarding Surface EMG made by Dr. Dishman in his article on diagnostic ultrasound (DC, September 1, 1996). He stated that "Surface EMG ... which is not an EMG and never will be because it is basically a biofeedback myometer costing about $300 to $500." These types of statements are exactly what the scientific community likes to use to deride chiropractors and reduce their credibility in the eye of the public. I've listed below the problems with Dr. Dishman's statements.

1. To examine his hypothesis, I did a literature search using MEDLINE which accesses only scientific publications (quality ones). If it is true that surface EMG does not exist, there will be no scientific publications. When searching the term "surface electromyography," 189 papers emerged, not including the psychophysiology abstracts, books, and nerve conduction velocity testing (which does use SEMG for the motor component).

2. If surface EMG did not exist, why then did the very conservative Mercy Guidelines categorize it in the first place, and furthermore find the flexion/relaxation protocol in particular "promising" (a procedure appropriate for insurance reimbursement)?

3. With regards to the statement about cost: What does cost have to do with whether a device exists or not? The truth that SEMGs vary in cost (including software and hardware) from a low of $200 to a high of around $1,200 to build. Using the standard markup of 10 times which is common in the medical industry (and many others), they currently are well below the medical average at $5,000 to $7,000.

4. If Dr. Dishman wants to be specific about the lack of value that static scanning SEMG has in comparison to the more robust attached electrode dynamic SEMG testing, I would welcome such statements indeed. Static scanning is a screening tool and should not be billed as more than that. Attached electrode dynamic, on the other hand, is an excellent tool for examining how one uses their muscles in movement. A considerable difference in value and capability. Most all research papers are published using the latter technique.

In an exhaustive review of the SEMG literature published in the 1994 medical textbook, Advances in Chiropractic (Mosby-Year Book) Dr. John Meyer writes with regard to the SEMG flexion/relaxation protocol:

"Although there are still many questions that remain to be answered regarding the lumbar flexion-relaxation phenomenon, it is well established as a reliable and valid measurement of low back pain."

What makes this statement even more definitive is that it comes not only from one of the leading experts on SEMG, but also one of the most vocal critics of its use.

If anyone has any questions regarding SEMG, they may call me directly at (415) 367-8904.

David Marcarian, MA
President of PBI/MyoVision 3000 SEMG

DCs and PTs -- Let's Support a Common Agenda

Dear Editor:

As a practicing physical therapist (18 years) and chiropractic physician (12 years), I have watched very closely the development and advances of both professions. Of particular interest to me has been the political, professional, and clinical directions pursued by each of the groups.

While chiropractors have made great strides as a profession in the past decade, the real winner in my opinion has been the specialty of manipulation. It is now finally being embraced as a treating procedure necessary for the management of biomechanical disorders of the spine. Journals herald the efficacy of favorable clinical responses to spinal manipulation. Bastions of allopathic medicine are now encouraging medical physicians to form alliances with chiropractors as related to the treatment of spinal disorders. Most authorities still attribute manipulation to be the domain of chiropractors. However, this has not gone unnoticed by a large segment of the physical therapy profession focused on rehabilitation and physical medicine.

This advancement has developed sometimes in spite of the chiropractic profession and the juvenile infighting over which technique is superior to the other. To my knowledge, no single named

technique has ever produced unchallenged documentation regarding clinical superiority. They all seem to work when based on sound principles. The chiropractic art produces incredible results, and is deserving of even greater recognition. Meanwhile, the physical therapy profession has steadily been reading, studying, learning the art of spinal manipulation. PT professional leaders, like Stanley Paris and Robin McKenzie, continue to teach biomechanical analysis and appropriate manipulative application to packed audiences.

As a physical therapist, I maintain continuing education on a yearly basis for license renewal. I follow closely the growing list of physical therapy postgraduate seminars being taught in mobilization/manipulation. My best estimate is that nearly half of all seminars being taught across the United States involve the teaching and understanding of spinal biomechanics and manual therapy techniques. These now are beginning to include high velocity adjustive procedures. Some of these are being taught to physical therapists by chiropractors. Add to the list of continuing education study in radiology, orthopedics, pre and postsurgical spinal management, sports injury, and pharmacology, and you can begin to grasp the well focused, concerted effort by the physical therapy profession to place themselves in much more direct competition for patients.

Another observation regarding the two professions centers around professional unity. For most discussion purposes, the physical therapy profession belongs to one national organization, the American Physical Therapy Association. Additionally, state association membership involves belonging to a state subchapter of the national chapter. Therefore, one large common voice and 50 smaller state voices each year continue to grow and echo one common message: "Expansion of scope, independent referral, acceptance, and professional parity in the conservative rehabilitation treatment of musculoskeletal disorders."

In an evaluation of the chiropractic profession regarding association membership we have two national level organizations. Each of the state associations are completely independent with most states also having two or three different associations. Each group struggles for individual political identity and works on behalf of its own membership. Can you imagine the immediate overnight impact of merging state association and national association forces into one common voice? This is a challenge that I believe must take place in the very near future to ensure our survival as a political and professional entity. I applaud a leadership summit to discuss cooperation within the profession and extend kudos to Dr. Sportelli and NCMIC for lighting the torch. I joined a national chiropractic association when I began my chiropractic career. It continues to represent, for the most part, my views, and is by far the largest association with a real presence in the nation's capitol. The fact that so many DCs do not belong to a national association which represents their profession in the hugely competitive marketplace of health care disappoints me and is very unsettling.

I am very proud to be both a physical therapist and a chiropractor. I hope that each profession will continue to march forward in search of clinical excellence via research, and academic study. Whichever profession embraces this concept with concerned and undivided enthusiasm will, in my opinion, take the lead in providing conservative health care to the consumer patient population. Until which time that the vast majority of chiropractors understand the significance of supporting a common agenda, the potential we have as a cohesive profession, free of restraints of personalities and egos, remains in question.

Glenn Manceaux, PT, DC
Houma, Louisiana