Dynamic Chiropractic

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A Response to Dr. Craig Nelson

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In his recently published article in the Journal of Manipulative and Physiological Therapeutics and Dynamic Chiropractic, Dr. Craig Nelson has provided the chiropractic profession with a valuable dose of reality, despite the fact that numerous flaws undermine many of the arguments. Nevertheless, I have found his report to be among the best starting points for undertaking discussions concerning the primary care issue; first, because of the amount of detail included in supporting what I found to be four strong arguments that were stated; second, because the incorrect assumptions are excellent starting points for launching discussions among critics concerned with the expansion of chiropractic intervention to problems beyond the lower back; and third, because the overall tome of the article is so highly constructive in its seeking to elicit from the profession a clear answer about its aspirations and competencies in treatment.

The arguments which I fully support and feel need to be emphasized are the following:

1. With a few exceptions, infectious disease and trauma are not recognized as belonging to the chiropractor's portfolio of conditions treated. The clinical preparation of virtually all doctors of chiropractic includes contact with a tiny fraction of the number of patients seen by allopathic physicians in training during their internships and residencies. The burden of proof in responding to these conditions lies with the chiropractor, not the allopath.

2. The allopathic physician views the chiropractor as much of a dilletante in treating somamatovisceral conditions as the chiropractor would regard the MD manipulating the spine after taking a short training course. I would suspect that the specific survey results would show that the chiropractor receives more basic course work in matters pertaining to somatovisceral conditions than the allopathic physician receives in musculoskeletal information pertaining to spinal manipulation. Even so, the issue may come down to patient contacts during internships and residencies, in which the inexperience of either profession in treating conditions usually associated with the other becomes glaringly apparent.

3. Allopathic medicine has indeed "discovered the back" as shown by its opening of several back clinics within the past 10 years, offering a substantial challenge to the practice of the chiropractic profession. Dr. Nelson is quite right in calling for chiropractors to demonstrate their unity and competence in musculoskeletal interventions beyond reproach. If the profession lacks focus and a clear public perception of its expertise, it stands to lose its identity and become either absorbed or overrun by the allopaths.

4. The chiropractic profession needs to honestly address the question, "What do other practitioners do better than chiropractic?" Although embarking upon the wellness paradigm has its obvious appeal in heading off the further complications and greater expenses associated with treating advanced diseases, chiropractors must realize that there is no alternative to medical interventions for many of the sick population. Wellness and disease from a continuum, the paramount challenge being the ability of the wellness and sickness

practitioners to form a seamless coaltion in managing the patient who is getting either sicker or better.

To me, the major challenge to the practice of chiropractic as it presently stands is to be able to demonstrate, in great depth as much as in breadth, its ability to diagnose. Until this is achieved, any assertion that the chiropractor might participate a gatekeeper or portal of entry in any health care system is unfounded. Dr. Nelson's argument that specialists rather than generalists may make a more accurate diagnosis is highly provocative and in great need of experimental data, as it currently can neither be supported nor refuted.

The argument in Dr. Nelson's article which can be refuted are the following:

1. Chiropractic should follow the dental model in defining its scope of practice. To begin, it is generally accepted that physicians never treated teeth, although they clearly compiled a history in treating the back and will continue to do so. Thus, there is more overlap (and resulting competition) between allopaths and chiropractors than there ever was between allopaths and dentists. Secondly, there is nothing in the dental profession that even shows the potential of addressing whole body issues; the research and clinical literature have clearly demonstrated that chiropractors, on the other hand, have been fully involved with whole body issues since the beginning of the profession. Thus, the dental analogy falls apart; secondly, by recommending that the profession limit itself to neuromusculoskeletal intervention, Nelson is actually contradicting himself by admitting the nervous system -- a whole body network -- into the recommended scope of practice for the chiropractor.

2. The number of somatovisceral patients currently seen by chiropractors must be very close to an irreducible minimum. Losing them in the chiropractor's practice (possibly numbers may appear, such an action would be to relinquish the commodity upon which the real answers to the scope of practice question -- OBJECTIVE RESEARCH -- is based. It is only with the patients (few as they may be) being treated for somatovisceral conditions that the chiropractor can expect to conduct any clinical research. This argument seems ominously reminiscent of a "slash and burn" operative, in which holdings (however meager) are deliberately destroyed because there is the potential to lose them to fate.

3. The health care establishment needs to be convinced that such elements as antibiotics, immunizations, and insulin are not really important parts of primary care. In some instances they may not be. Insulin, although it can be self-administered, is by dint of its association with diabetes a secondary health care issue. Antibiotics, traditionally a first line of defense against infection, must be utilized with caution as they have many undesirable side effects,1 and their widespread use has been shown to accelerate the spread of drug-resistant pathogens.2 Immunizations DO pertain to the body's first line of defense; however, they are rarely administered after the first 10 years of life therefore could be argued to be a non-routine (and non-primary care) intervention.

4. Without clinical research to demonstrate the effectiveness of care for specific conditions, neither MDs or DCs will be reimbursed for treating those condition. In the ideal world, this might be true; however, it is a well-known fact that reimbursements are offered for orthopedic procedures or the treatment of glaucoma in which virtually no research of any kind has been documented. In fact, only 15 percent of all medical procedures have been shown to have been documented by research,3 and only 1 percent have been suggested to be of sufficient scientific value.4

5. Beset by disunity and factionalism, the profession needs to present itself as a neuromusculoskeletal specialty in order to achieve the identity needed to become intelligible (and acceptable) to the outside world. Medical guidelines are no less uniform. Allopathic interventions for mental illness, for example, encompass everything from psychiatric treatment to the administration of drugs to (in extreme cases) electroshock therapy. I would submit that it is largely a matter of chance as to what regimen a patient might undergo in many allopathic treatments, which is why they invented the Second Opinion.

I would agree with Dr. Nelson by taking his last argument as an impetus to define a position in assessing the chiropractor's scope of practice. Rather than use neuromusculoeketal intervention as a ceiling or boundary in defining the practice, however, I would rather attempt to propose it as a foundation -- a universal starting point from which all therapists may define their competence. Additional elements should serve as superstructural features until they are sufficiently documented in the research literature to become universal standards of practice.

In this manner, we must attempt to define a niche in any future health care system into which chiropractic intervention may realistically expand within the next 5-10 years. Indeed, this is precisely how most health care standards (including the Mercy Guidelines) are usually conceived, allowing additions and updates to be made on a periodical basis in which research is clearly going to support or discredit elements of allopathic as well as chiropractic care with the passage of time. To deny this type of flexibility is to deny the patient of any benefits of any research which is conducted within any branch of health care.

References

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