Dynamic Chiropractic

PHILOSOPHY

We Get Letters & E-Mail

The Big Guys

Dear Editor:

I had the opportunity to read your editorial, "The Only Thing to Fear," (editor's note: Dr. Hofmann's article) in the April 8th edition of Dynamic Chiropractic. I would like to comment on your final sentence in this editorial.

You state, "Arnie is one of the few ACA Big Guys who opposes the use of drugs." As a member of the ACA Board of Governors and a second generation chiropractor, I have never advocated nor been a proponent of the use of drugs in a chiropractic practice. Nor am I aware of any of my board members who are actively seeking to expand the practice of chiropractic to include the use of medication.

In our search for truth as a political leader and spokesman for our profession, we must be careful in the use of words we choose. This is why I am responding to your editorial. I do admit that there are members of our profession, and yes they may be ACA members as well as members of other organizations, that do want to include medication in their chiropractic scope of practice, but they are in my opinion a significant minority, particularly among the "Big Guys" of the ACA.

Robert Lynch Jr., DC
Portland, Maine

Hands On

Thank you for publishing Dr. Hammer's "Adjustment by Hand Only" in the April 22 issue of Dynamic Chiropractic. I have been reading Dynamic Chiropractic for two years now and have been stunned over the silence of the chiropractic profession regarding the use of activator techniques. Finally Dr. Hammer broached the topic, stating: "I doubt that the use of activator instruments could stimulate the amount of mechanoreceptors that a good, old fashioned adjustment is capable of stimulating." Just how much of the chiropractic profession agrees with his article? I would very much like to see future debate in Dynamic Chiropractic over the efficacy of hands-on manual techniques vs. activator techniques. For I know both MDs and DOs who practice hands-on manual techniques and who speak of receiving patients that have left their chiropractor after not getting help from their activator techniques.

Brandon Goff
Student, Texas A&M

Suffix it to "really" say ... apples, oranges or grapefruit?

In solemn but due response to chiropractor Gregory Baker of Chatsworth, Georgia ("We Get Letters 4-8 issue), I suggest that perhaps he first consider picking out the words that do not correctly fit into his sample selection of professional designations (for DCs), i.e., osteopath, dentist. After he has progressed to that point, he may then consider the difference between apples and oranges before comments are submitted in this regard.

Personally, I am proud of being referred to as a chiropractic physician with diagnostic qualifications in subspecialties of specific academic fields of interest and being able to communicate with and understand the work of allied professions in the health sciences. It is high and appropriate time that the chiropractic profession stand up and be recognized as diagnosticians with specialized professional services and not technicians "who just move bone," lest our apple be technically confused with an orange and then mixed in with a government grapefruit health drink.

S. Alexander Paduchak, DC
Peabody, Massachusetts

"... confusion between primary care generalists and primary care specialists."

Dear Editor:

Re: Commentary on Dr. Craig Nelson's "Chiropractic Scope of Practice."

While I generally agree with much of the substance of the commentary, upon further scrutiny it becomes clear that its basic premise, that chiropractors are not primary care physicians, is totally incorrect. The problem with the commentary is that it is predicated on an obvious error, and tainted throughout by several misconceptions that Dr. Nelson labors under simultaneously.

While there are many definitions of primary care, Dr. Nelson chooses to use the definition which was developed by the National Academy of Sciences, as cited in a publication by the Foundation of Chiropractic Education and Research (FCER).[1] From this definition, Dr. Nelson points out that there are several conditions which must be met to be considered a primary caregiver. He states that all but one, "comprehensiveness of services," can be met by chiropractors "if we really wanted to." For example, he suggests that we might have difficulty with "accessibility of services" because chiropractors are not typically available 24 hours per day, seven days per week. Ask yourself this question, "What kind of medical doctor keeps those office hours?" Obviously the intent of the accessibility issue is to be available to patients in urgent situations. Someone should inform Dr. Nelson that practicing DCs already do this. It is both a part of our chiropractic oath, and the very first part of the code of ethics of the ACA.[2] I quote from part A(1) of the ACA Code of Ethics: "Doctors of chiropractic should hold themselves ready at all times to respond to the call of those needing their professional services..." In other words, it is unethical not to be available, or not to have your practice covered when you are away.

Dr. Nelson then argues that chiropractors cannot meet the "comprehensiveness of services" test in the definition. I quote from his commentary: "This is defined as the ability to manage without referral 90% of the problems arising in the served population. Thus, a primary care physician may limit his practice to a particular population -- like a gynecologist, pediatrician, or an internist -- but within that population the primary care (physician) is expected to manage without referral, 90% of those patients' problems. Explicitly mentioned is the management of infectious diseases, providing immunizations, and managing minor trauma (lacerations)."

Here lies his fatal error. Dr. Nelson believes that because we cannot manage without referral 90% of our patient population, and because we do not administer immunizations, we are not primary care physicians. If we apply this logic to those very medical specialties which Dr. Nelson mentions the error becomes obvious. Gynecologists, assumedly, limit their patient population to women. Is Craig implying that a gynecologist can and does manage without referral 90% of all womens' problems? Including headaches, backaches, liver problems, glaucoma, etc. Does he believe that the gynecologist provides immunizations and manages minor trauma? If he does, he is completely out of touch with reality. A gynecologist does not limit their practices to a patient population of women, but to women with problems involving the female genitourinary and reproductive systems.

Internist also limit their practices to a group of systems, the internal organs. Because patients recognize these system limitations, and appropriately self-refer, I have little doubt that these primary contact or portal of entry doctors can effectively manage 90% of their patient populations without referral.

While it is true that pediatricians limit their patient population to children, and not to a system or systems, I doubt that pediatricians could be expected to manage 90% of all childrens' problems, from womb to adulthood. Hence the specialties of neonatology, pediatric oncology, etc. If the pediatrician could manage 90% of all childrens' problems without referral, it would probably make them the only group that fits Dr. Nelson's interpretation of the primary care definition. When one considers the prevalence of cardiovascular and neurovascular conditions, cancer, major trauma, neurologic disease, etc., it is not at all reasonable to assume that general practitioners or family doctors manage 90% of their patients without referral. In fact, in medical circles, these generalists have become affectionately know as medical "traffic directors."

Using the internist and gynecologists as models, it becomes clear that primary care doctors who do not do immunizations or surgeries, and who care for less than 90% of their patients without referral, do indeed exist. In fact, either you limit your patient population, or you treat without referral less then 90% of your patients. To suggest that a primary care doctor must both have an unlimited patient population, and treat 909% without referral, anywhere but in the most rural of settings, is patently absurd.

Chiropractors, like the specialists noted above, choose to limit their practices. In so doing we are able to care for 90% of our patients without referral, and therefore meet the test of primary caregiver. Dr. Nelson accurately points out that patients already recognize chiropractors as neuromusculoskeletal experts, and appropriately self-refer. He uses studies showing that 90-98% of all chiropractic patients complaints are related to the neuromusculoskeletal system.[3]

This is not to say that most DCs do not believe that via treatment of the neuromusculoskeletal system, other systems and conditions may be positively effected. However very few DCs hold themselves out as expert diagnosticians of those conditions.

In summary, DCs are primary care physicians, by any definition. The references to this status by the ACA and most of the accredited chiropractic colleges is not poorly though out or ill-conceived. Dr. Nelson would be well served to read the report by Meredith Gonyea, PhD.4 Dr. Gonyea and her associates appropriately differentiate between primary care generalists and primary care specialists.

While Dr. Nelson's motives may not have been to discredit or hurt the chiropractic profession, his paper has done just that. His salient arguments for direct access to chiropractors ... is lost in his confusion between primary care generalists and primary care specialists.

In this time of health care reform, his poorly thought out commentary could not have been less appropriate. Dr. Nelson states: "No one would seriously suggest that if you have a toothache, or if you need your vision examined, or you need bunion surgery that you should first go through an MD gatekeeper before seeing the appropriate doctor." Wake up Craig, that is exactly what is happening right now.

References

1. An evaluation of federal funding policies and programs and their relationship to the chiropractic profession. FCER 1991:23-4.

2. 1992-3 ACA Membership Directory. Code of ethics. 1992:B-2.

3. Phillips R. Survey of chiropractic in Dade County, Florida. JMPT 1982;5:83-9.

4. Gonyea MA. The role of the doctor of chiropractic in the health care system in comparison with doctors of allopathic medicine and doctors of osteopathic medicine. FCER 1994.

Joseph Ferezy, DC
Des Moines, Iowa

Pre/Post MRI Disc Research Study

In my last column I discussed nonoperative management of cervical disc herniations as assessed by MRI scans. At the end of the article I wrote of an ongoing research project I had started on Long Island on chiropractic treatment of herniated discs with pre/ post MRI scan documentation. I asked for national participation and asked other DCs to contact me for our research protocols. There was a good response.

In these times of outcome effectiveness it is necessary for wide scale research like this to be done, to show and document the efficacy of chiropractic management for the disc herniation patient. The study will use MRI, clinical exams, functional assessment surveys, and electrodiagnosis for pre/post evaluations. In this month's issue of JMPT, I have a case study that will be published on this topic. It is my hope to have many doctors from across the USA participating in this study, and to have the data published in the journal Spine, and then sent to all the legislators in health care policy positions. It is my intent to show that our care is not only effective clinically but in cost as well.

Editor's note: Doctors with experience in treating cervical and lumbar disc herniations and who are interested in participating in a nationwide research study utilizing pre/post MRI scans please call David BenEliyahu, DC, CCSP, at 516-736-4414. The purpose of the study is to document the efficacy of chiropractic management of disc herniations with MRI, and to determine the percentage of resorption and/or the resolution of the disc herniation with follow-up MRI.

Calcium Intake Not the Problem

I read Dr. Alan Cook's recent article about calcium and the osteoporosis "hype." I could not agree

with him more. In my experience working with a local mineral analysis laboratory, we have concluded years ago that calcium intake is not the problem. Utilization of calcium is the problem. In fact, calcium supplementation may actually worsen osteoporosis. When a patient's oxidation/metabolism is deficient to the point of being unable to properly utilize calcium, bio-available calcium is robbed from any available source. Usually the bone mass is first.

Ingested supplemental calcium additionally is nonavailable, creating parathyroid demands that may increase the bone depletion. As is typical in allopathic medicine, a backwards approach is always tried first. No attention is paid to correcting the failing oxidation rate, just additional masses of calcium are prescribed. The same logic is applied to the cholesterol hype. Intake of fat is not the problem. Failure to digest and utilize fats remain the problem.

Research done by several scientists have determined that at no time is their sufficient calcium available in the bloodstream of a chicken to produce an egg. Not knowing that fact, the chicken produces a daily egg is spite of scientific numbers. Even calcium deficient diets fed to chickens, fail to hinder their egg production.

Recommended use of Tums for calcium supplementation is quackery at its best, but "science" is the ruling byword.

William Risley, DC
Scottsdale, Arizona

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