Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Scope Revisited, Aberrations?

Willard Bertrand, DC

Dr. Craig Nelson's Sept. 1993 JMPT commentary "Chiropractic Scope of Practice" (reprinted in "DC" in three parts: Jan. 28, Feb. 25, March 25, 1994), demonstrates the danger of clinical inexperience in an academic setting. His 10 page article covers too much topic to be supported by merely five references. After all he did boldly state that chiropractors were incapable of managing anything but neuromusculoskeletal problems. This statement was totally unsupported by even one reference. He even has the nerve to compare chiropractors to quacking ducks![1] Were the source a general circulation magazine it would be irritating enough, but to find it in a chiropractic peer reviewed scientific journal is appalling!

Dr. Nelson's commentary opens with what must be his main concern: to gain access to federal funding. He states that the demonstration of skill in all areas of practice would be required for reimbursement. He cites an FCER report concluding that the profession lacks a credible scope of practice. He then dons his academic robes and sets off to identify what parts of chiropractic practice are credible.

Federal funding, although important to both patient and doctor, should not be the central criterion for determining the scope of chiropractic practice. It is important that chiropractic practice should be based upon credible scientific information, which I believe it is -- while Dr. Nelson apparently does not. Nonetheless, the scope of chiropractic practice must be determined by clinical evidence, and never should chiropractic science be brought so low as to be controlled in any manner by financial gain or loss. The chiropractic oath puts the patient first.

Next, he suggests that the concept of primary care has largely been unexamined. Perhaps Dr. Nelson may be one of the last academics to have awakened to the idea of the chiropractor as a portal of entry primary care provider, as he attests to in his commentary, and I quote: "It (primary care) is found in the mission statements of National College, Northwestern College, Los Angeles College,... Palmer College, Life College, and Sherman College, .. the ACA and ICA." Dr. Nelson infers that all of these groups have made the assertion that chiropractors are primary care providers, "but that the concept has been largely unexamined." Dr. Nelson states: "The phrase 'chiropractors are primary care physicians' has been spoken almost as a mantra without exploring the meaning of it." His assertion is preposterous and suggests that the entirety of the chiropractic profession has no comprehension of the meaning of their own mission statements. We are then left with Dr. Nelson's efforts to single-handedly define the chiropractic scope of practice from his ivory tower as an academician with less than a decade of clinical experience.

Dr. Nelson defines a primary care physician as someone with the ability to "manage without referral 90% of the problems arising in the served population." He goes on to say that the primary care clinicians may limit their practice to a specialty but must be able to manage 90% of the problems within that specialty. He states that since chiropractors cannot treat pneumococcal pneumonia nor orbit the earth in a spacecraft, chiropractors cannot practice as either primary care physicians or as astronauts. This line of reasoning is faulty. There are dozens of primary care physicians who routinely refer every case of pneumonia out to an internist. Included in this group

would be orthopedists, otolaryngologists, psychiatrists, cardiologists, nurse practitioners, and yes, Dr. Nelson, chiropractors. Dr. Nelson overlooks the fact that pneumonia only occurs in from 3-10% of those patients who take care of the viral bronchitis, influenza and other minor respiratory illnesses[2] that are manageable in the chiropractor's office, so that the pneumonia state is usually avoided. Dr. Nelson might find a useful academic pursuit to identify how many patients enter a chiropractor's office complaining of generalized aches and pains while at the same time are presenting with a respiratory or other organic illness. Is there no coughing in you office Dr. Nelson?

He does not take time to itemize the 60 most common presenting conditions in a doctor's office, yet he makes a sweeping generalization that these conditions are treatable only with the proper armamentarium of antibiotics, vaccines, and insulin. Where are his references for this? I suggest he searches for the facts on benign hypertension,[3] type II diabetes,[4] and the other conditions upon which he himself admits he is no expert and finds an expert elsewhere to gain some insight into the real world of wide scope chiropractic practice. It is beyond the scope of this article to bring him up to date with the science that broadly supports nonpharmacological management of these and many other conditions; also the literature that describes the dangers of medication in the management of many of the diseases he apparently misunderstands to be immediately controlled by medication.[5,6] This is in addition to the rapidly expanding area of preventive health care services which includes gynecological, proctological exams in chiropractic practice.[7] Perhaps he has not read past the titles of the JMPT papers on dysmennorrhea, asthma, and colic, which comprise more that one in 10 of the article published therein. His self-induced lack of clinical experience in these areas has apparently made him academically blind to the literature in these subjects.

And appropriately, clinical experience is the next topic of his commentary. He has a valid point in the respect that chiropractors are not exposed routinely to several weeks of practical experience in several important fields of study for the primary care practitioner. At the same time he does agree that the academic training is adequate (3740 classroom hours for DCs compared to 1670 for MDs) to prepare the chiropractor for such clinical experience. One could argue that, given six weeks of patient contact in each of the areas of study, a chiropractor would be as capable as their medical counterparts in the areas of pediatrics, gynecology, or infectious disease. This may come as a surprise to Dr. Nelson but there are many of us chiropractic practitioners who did just that by serving as associates or understudies to chiropractors skilled in these areas. I myself have over 24,000 actual patient contact hours in wide scope chiropractic. Would that meet his criteria? Anyone in wide scope practice must spend several months in an apprenticeship to get necessary training to perform adequately. That chiropractors have to seek such contact outside of the chiropractic colleges points to a need for the chiropractic colleges to make this experience available in their curriculum. Certainly even a xenophobic would not take away from the profession the ability to extend its education a few weeks in several areas of study. I personally invite him to spend a few days in my office and see what a general chiropractic practice looks and feels like (after all, we both are NWCC alumni). I doubt that he has ever been in one, nor has he tried to seek one out.

There are many primary care providers who have no more, even less training than chiropractors: these include general practitioners, nurse practitioners, and physician assistants. It is not a lack of education that blocks chiropractors from enhancing their performance as primary care providers, it is a mental bias in favor of the medical profession that is based upon popular notions rather than scientific facts. Dr. Nelson himself says that the limitations of the chiropractic profession, as he knows it, are limitations of choice. The critical difference is that his choice was his own to make, fortunately, he is not in a position to make that choice for the profession as a whole.

In his commentary he lists several objections that might be raised to his stand against primary care status. The first suggests that primary care chiropractors in rural areas are aberrations, abnormalities. This is a rude and malicious statement that Dr. Nelson should retract. Chiropractors have delivered many babies in towns where they were the sole provider of care for miles, saving many lives. Chiropractors have stitched up many wounds and taken care of thousands of "old salts," rural folk who are homebound or fear the medical dilemma of excessive care with little more result than an expensive diagnosis without a treatment. The transformation of a chiropractor into a primary care practitioner does not and cannot happen simply because a town has no medical doctor. To learn to manage a wide scope practice takes a willingness to assert every bit of knowledge gleaned from chiropractic school, your colleagues, and the scientific literature. You do not take care of Aunt Mille's bronchitis and have her die of pneumonia and continue to practice next week in a small town. Again Dr. Nelson has no concept of what he is saying in this area and would be better served to gain some experience in this area before he take such a harsh stand.

His remaining objections are summed up in one observation: You cannot separate the spine from the body. Dr. Nelson wants chiropractors to be neuromusculoskeletal specialists without the challenge of caring for or about organic disorder. Should we ignore that organic disorders affect the very spine Dr. Nelson wants to treat? Should we ignore that the same sympathetic system that increases blood pressure in the rest of the body also does so in the spine and affects the neural metabolism within and throughout the spinal column? Should we ignore that the spine of a diabetic presents with important and unique characteristics? Should we ignore that the physically abused patient has learned a spinal tension pattern that often leads to chronic pain? Should we ignore the effects of chronic hypoxia of COPD on the central neural system? Should we wait for medical science to identify these links for us so that the MDs will refer each of them to DCs to treat their spines? And a specialist to assist them with their nutrition, and another specialist to assist them with lifestyle changes, and another to help them learn to relax, and yet another to teach them prevention strategies? In the real world, patients with diabetes are shown the basics by their medical physician, and left to their own devices to do the best they can, often sadly not enough to prevent retinopathy, neuropathy, nephronpathy, hpercholesterolemia, and stroke. The same can be found with the patients with hypertension, pregnancy, and back pain. The chiropractor who takes the time to put aside the politics and the insurance can tell you that their patients enjoy something special. A patient is often helped by dietary advice and encouragement when their blood sugar is a challenge, a cognitive therapeutic discussion during a spinal adjustment, when they are anxious, or a word of advice as to which specialist to see. These things are not often found elsewhere.

Why? Because chiropractors work on the patient's body with their hands, while an MD checks patients for disease. A physical therapist stretches the joint, but a chiropractor knows the influence of the body around the joint. A dietician recommends a diet, but a chiropractor can explain the physiology behind the diet. A psychologist can teach a patient mental relaxation, while a chiropractor can physically feel when a patient is stressed. Chiropractors are uniquely trained to find and correct the causes of illness, the etiology of subluxation. This may not be as dramatic to Dr. Nelson as an insulin syringe, but it is far more valuable.

If you learned anything in those years studying embryology, physiology, cardiology, obstetrics, and the rest, you must have learned that you cannot understand the parts of the body without studying the body as a whole. It should be no great leap of the mind to also realize that one cannot treat the spine without paying attention to the whole body. Those who ignore the body must feel uncertain why their treatment is getting results and become dependent upon techniques and academic professorships rather than knowledge.

Dr. Nelson states that chiropractors are basically insecure and recommends a dose of tunnel vision

limited to the neuromusculoskeletal system as a remedy. I tell you that the reason any chiropractor is insecure is that they have already taken a large dose of this medicine. The only way to successfully treat the spine is through the body's own innate mechanisms that include diet, exercise, and relaxation. Chiropractors have spent many years studying the effects of the nervous system on each organ and on metabolism. They have studied the effects of diet and exercise and the mind on the function of the body. To assess and effectively manage chronic pain chiropractors must never give up their hard earned status as primary care providers.

Dr. Nelson says that if you look like a duck to him, if he thinks you walk like a duck, and if he believes you quack like a duck, he will call you a duck. To compare chiropractors with ducks, and to use quacking analogies in a peer reviewed journal -- from which he will be quoted widely -- is a foolish mistake. Chiropractors do not quack like ducks Dr. Nelson, and a primary care chiropractor is not an aberration!

JMPT should never have printed his unsubstantiated opinions at such length when a few paragraphs in the letters section would have been more appropriate.

References

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Willard Bertrand, DC
Union, Oregon