Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

We Get Letters

Umbrella Model of Subluxation

Dear Editor,

This is in response to the article by John Raymond Baker ("The 50 Treatment Lumbar Strain," in the Nov. 4 issue). Essentially, I agree with the observations of Dr. Baker. He rightly criticizes canned treatment plans and suggests the need to direct future research toward establishing uniformity in our treatment protocols. He even alludes to the inadequacy of the Mercy Guidelines in this regard.

I would like to clarify what I think the basic problem is. There is a lot of talk about practice guidelines, protocols, and visit limits these days. What everyone seems to be avoiding -- either because it is political suicide or because it may ruffle feathers, or it may set back "professional unity" -- is that we really can't talk about practice parameters, protocols, or research in this area until we can agree on what the lesion is that we are treating.

I'm not suggesting that we force one version of the subluxation on the profession, just that we agree to a short list of clinically recognizable phenomena and agree that the presence of these phenomena in various degrees and proportions is what we define as a subluxation. My preference is to use the five component model consisting of spinal kinesiopathology, neuropathophysiology, myopathology, histopathology, and pathophysiology. I'm not aware of a technique that has a model that won't fit under this umbrella model of subluxation.

To use an analogy, no one can put their finger on a lesion called Reiter's syndrome, yet it has been agreed that when the clinical presence of urethritis, conjunctivitis, and arthritis can be verified, it is Reiter's syndrome. I believe that we can get further in our discussions and research if we agree that the presence of one or more of the five components is indicative of the subluxation syndrome. I use that terminology only as an illustration, not to recommend it.

If we can agree as a profession to do as I have suggested, then we can begin to research the five components, how to clinically identify and monitor them the best, and begin the politically unpopular task of comparing the effectiveness of one technique to another to see which ones are most effective at reducing those components.

Joseph Siragusa, DC
2204 Commerce Drive
Monroe, North Carolina 28110

Praise for the Stillwagon's Plan

Dear Editor,

Thank you, thank you, thank you!

It's just what we need, at a time we desperately need it. The future of chiropractic is at the end of a 100 year long runway ... this is the craft that will launch it instead of the looming crash and burn.

Please provide us with more information on this plan. I have yet to hear anyone else come up with anything even close to this futuristic idea. We need everyone in the profession to get behind this. Medicine is already claiming to be the owners and experts of everything chiropractors or anyone else provides. Let's not let them steal the basis for our existence.

We can beat them to the punch with this one ... don't keep it a secret!

Richard Story, DC
South Sterling, Pennsylvania

Software Snafu

Dear Editor,

I am in total agreement with Shaun Callahan who wrote the letter about the need for technology in the chiropractic profession (Oct.7, 1994 issue of "DC"). Currently, I am a CA who spends hours upon hours on the computer and I feel strongly that if these questions would have been considered by software companies I would have more time to do other productive tasks around the office instead of spending too much time working with the system that does not really cater to my daily office needs. I hope more software companies will consider these questions when they are designing their packages for customers. Not only would this help me tremendously, but I'm sure other CAs would also be grateful.

Shannon Ferguson, CA
St. Petersburg, Florida

Better Alternative

Dear Editor,

I read the article by Stanley Greenfield, RHU, in the Financial Forum section of Dynamic Chiropractic, 11/4/94, and would like to offer another side of the concept Mr. Greenfield presented.

The concept is a disability income insurance with a return of premium rider. This is provision offered by a number of insurers which, assuming you never need your policy and go on claim, returns your premiums plus interest. Neat concept.

The other side of the story, however, is rarely presented. What is often omitted from the presentation is should you actually need your policy (statistics indicate most people will before retirement), the first dollars paid to the insured is their own money. Additionally, this rider usually adds 30 to 50 percent to the policy's premium. So the policy ends up costing much more and the likelihood of the insured receiving their money at interest, given the overwhelming statistics, is small.

If your readers like the concept of protecting their income and getting their premium back should they never need their policy, there is a better alternative to the return of premium rider. Everyone

should have their own disability policy and pay that premium to protect their income. Calculate the premium differential (base policy versus base plus rider). Invest the cost of the rider in a tax deferred product (fixed annuities offer the strongest guarantees). This way, the insured has protected his income against a probability, and still provides himself and his family with supplemental retirement income.

I wholeheartedly agree with Mr. Greenfield in the need for disability income protection. I suggest, however, the return of premium rider should be carefully examined. Thank you.

Tim McCafferty, CLU, ChFC
Acacia Financial Center
Orlando, Florida

Pharmaceuticals: Not the Answer

Dear Dr. Name Witheld,

You are right when you say that having an outside job to eke out a living does not make one a "bad" chiropractor. I find it annoying when a well meaning patient patient says, "I told my friend to find a good chiropractor." Any chiropractor who has a license to practice is a "good" chiropractor. Yet there are those who are academically brilliant and clinically excellent who can hardly make it in private practice, while those who just squeaked through college and the boards are very successful. There are those who do nothing but adjust subluxations whose offices are filled, and those who do all kinds of modalities and hardly adjust at all who are as busy as can be.

To paraphrase Mr. Shakespeare, the problem, dear Dr. Name Witheld, is not in chiropractic, but in ourselves. Being a successful chiropractor is more than giving the best adjustment you can deliver to that patient on the table, it's being a good employer, businessman, administrator, counselor, and communicator. If a patient perceives that they have been mistreated in any way, in any of the many steps from the phone call to the adjustment, the best adjustment in the world may not be enough to keep them coming back.

No, Dr. NW, adding pharmaceuticals to your practice will not insure your success. There are medical doctors who are failures in private practice, and they may be competent in what they do. However, they can make a handsome living working in a hospital or clinic.

Drugs in chiropractic will serve to confuse the public and move chiropractic closer to medical domination. Since they can't eliminate us, they will try to absorb us into extinction.

The road to success starts with willingness to change ourselves, not chiropractic and there are many successful practitioners who are willing to help.

Arthur Krieger, DC
Greenport, New York