Dynamic Chiropractic

PHILOSOPHY

We Get Letters

Dear Editor:

"For years now I have been receiving *Dynamic Chiropractic* and have found something of interest in every issue. As a 1927 graduate of the PSC I found the reminiscences of Dr. Quigley especially interesting.

The year 1927 taken from 1989 gives you 62 years in which I have been practicing chiropractic. I am 84-years-old and licensed up to September 1, 1990. If my health holds up I may extend that into 1991.

In the August 15, 1989 issue of *Dynamic Chiropractic*, I found the letters in defense of Dr. Kale to be of great interest. From the time I was 11 until I was 22, I suffered pain in both hips and both knees. Chiropractors of that day adjusting my lower back gave me no relief. Then, a student chiropractor of the Palmer School adjusted my atlas and I have had no trouble in my hips or knees since.

In my early practice I put two cases, paralyzed in both legs, back on their feet, and two cases paralyzed in one leg back on their feet. I did this with upper cervical adjusting only.

Nothing convinces a chiropractor of the validity of his profession like getting personal results from an adjustment by another chiropractor. For years I experienced discomfort in the tissues on the right side of T3. I asked a visiting chiropractor to adjust it. He gave me a recoil adjustment with the contact on the right transverse of T3. In the three years since then I have had no more trouble at T3. Last summer I demonstrated my current (Nimmo) technique to a recent graduate. Then I asked him to look at my axis which limited the amount I could turn my head when doing my isometric exercises. In the sitting position he gave me what we used to call a TM (thumb movement) adjustment and I have had no neck trouble since then.

This autumn I spent three hours bending forward as I picked wild raspberries. Next day I suffered arthritic pain in my left knee and back pain to the left of L5. I reasoned that if bending forward caused the pain, then bending backward should cure it. I laid flat on my back with a bolster pillow under my lumbars for an hour. Two sessions like this and all the pain was gone. Bending forward had compressed the lumbar disks; bending backward had decompressed them.

Chiropractors have always wanted to prove by so-called "scientific methods" that their profession has validity. They have hired Ph.Ds -- Dr. Suh in Colorado, and Dr. Joe Keating now of Palmer-West -- to research chiropractic. These scholars have found this task frustrating. The methods that the medical profession use in research are not applicable to chiropractic. A drug can be tested against placebo. What placebo can you use to test a chiropractic adjustment?

My friend, Dr. C.O. Watkins, was gung-ho on clinical research. Yet, I was never able to pin him down on how this was to be accomplished. If it were to be done by chiropractors in their individual offices, they would have to take the word of each patient that they had been made to feel better. In other words, it would be based on testimonials and the Ph.Ds have declared that testimonials can not be used in research. They say we must use only measurable symptoms and the words of the

patient do not count. When my patient says, as he frequently does, "I feel better already," that is proof to me of the validity of what I have been doing to him. But this is not considered "scientific."

Testimonials got a bad name when they were used to sell everything from snake oil to hair restorer. Now, as long as we must depend upon the word of our patient to determine the results from our adjustments, maybe we can upgrade testimonials and make them more acceptable. Each practicing chiropractor could be supplied with a number of "research" cards. At the top would be the patient's name and number, next the chiropractor's name. Then the diagnostic code and the procedure code. Then the patient's assessment of results. This, signed by both the patient and the doctor could be passed on to the director of research of his national organization. Passed through a computer, this information could tell us how we were doing.

When he reads this, Joseph Keating, Ph.D. will be horrified that any chiropractor could come up with such a crazy idea. Yet some refinement of this procedure is about the only way clinical research on chiropractic can be done. The methods that work for medicine will not work for chiropractic. The only thing we have in common is a desire to help sick people."

Harlin R. Larson, D.C.
Havre, Montana

Dear Editor:

Have you ever read an article in a chiropractic publication and had evil thoughts about either the author or their subject matter? Such seems to be the case more often these days as we are bombarded with a variety of controversial subjects that all have direct bearing on how and why we practice our profession. There are many articles available that tell us how to practice, and our professional organizations would very much like to tell us why to practice.

It is interesting to note that for years the big professional management firms told us that the third-party pay practice was our future and that we wouldn't survive without seeing hundreds of new patients every month. We were told that to be successful we would need to perform expensive tests on expensive pieces of equipment and charge the costs to an insurance company. Then we were told that health care costs were rising to the point that only people belonging to some pre-paid health plan would be able to utilize our services. We were encouraged to seek hospital staff privileges so that we could run even more tests under the guise of medical authenticity, and no doubt to add to our professional status. Our state and federal organizations told us to support inclusion in Medicare and other government programs so that we wouldn't be left out of the government health care dollars. We were encouraged to support many political candidates with our dollars so that we would get a fair hearing for our proposed legislative ventures. Does all of this sound familiar?

So what has happened in the last 10-15 years?

The practice management firms are asking for more money and telling us that a cash practice is the way to go and for another fee they will show us how to run one. We are being told to advertise for new patients -- billboards, television, testimonials, and national publications. We are fighting with ourselves over which professional organization is the best. We are fighting with the courts over hospital privileges.

We are fighting with insurance companies over standards of care and utilization of services, and we are being totally confused by Medicare and other bureaucratic programs. Our state and federal

organizations still waste as much money as they ever did on legislators and lobbyists who have no idea what it is that the chiropractic profession wants -- or needs.

Have we advanced or have we just progressed by luck and the efforts of the unpretentious and unpublicized few?

Meanwhile, I wonder how many of us there are that have always run a cash practice? That have over a thousand active families in our offices as regular patients each year? That see only four to five new patients every week, but keep them for years? How many offices don't belong to any state or national chiropractic organization, do not participate in Medicare or state programs, and only file insurance claims as a service for patients who have already paid for their care in our office? Many of us don't donate dollars to PACs because we talk with our legislator while they are lying on our treatment tables. We submit realistic insurance claims that never get reviewed or reduced because we practice chiropractic and not pseudomedicine. Perhaps we even refer to our local and area medical colleagues because we feel that by referring we don't lose a patient, but instead, instill in our patient even more faith in our judgment and professionalism. And we manage to do this without advertising, except by the type that money can't buy -- word of mouth and reputation.

You would think that after making all of these mistakes that there would be none of us left. We run our offices without fanfare, without window dressing, and we provide honest chiropractic care. We get along with insurance companies, with hospitals, with area medical colleagues, with major employers and obviously with patients because our growth is steady.

We are successful because chiropractic is successful -- and we practice chiropractic.

So where does that leave us? I really don't know. But its worth thinking about the next time you read your mail and see some ad for a practice management course. Or the next time Joe Salesman tells you how to pay for that miracle machine by running all those new tests and billing the insurance company for them. Or when your friendly state or national organization asks you for more dollars for its political action cause-of-the-month club.

Steven J. Parkin, D.C.
Le Mars, Iowa

Dear Editor:

We recently read your article "Sabel Wins New Jersey Standards Case" published in *Dynamic Chiropractic*, January 3, 1990, concerning the settlement of the case -- in the matter of the suspension or revocation of the license of Larry Sabel, D.C. It was not clear from the article whether you ever actually read either the amended complaint or the final consent order. Please accept the following corrections of some erroneous statements in the article.

1. No charges were dropped by the state. Rather, a settlement was reached after a year of litigation. The terms of the settlement specify many standards of conduct which Dr. Sabel has agreed to abide by, and if you read the complaint you will see why those requirements were placed in the order.

2. Dr. Sabel was not charged with failure to refer musculoskeletal cases to medical doctors. He was charged with failure to terminate his treatment or refer a patient to even a different chiropractor when, after months or years of often intensive adjustment, the condition the patient sought relief from wasn't relieved or was no longer improving. He was also charged with using threatening, harassing, intimidating or obscene language and tactics in talking

with patients who wanted to end treatment or weren't sure that they wanted to start.

3. It was never alleged that chiropractic can't benefit a scoliosis condition at the appropriate age. The primary issue on the advertising concerned whether chiropractic adjustment of infants and toddlers could prevent rashes, scoliosis and crib death, and whether these conditions are caused by twists and tumbles by infants and toddlers, which are not followed by a chiropractic adjustment.

4. Dr. Sabel agreed to pay $20,000 in costs for the use of the State.

5. Dr. David Singer was not a witness, affiant, or party to the proceedings.

6. New Jersey chiropractors had been working hard for years to attain a law creating a board of chiropractic examiners. They were successful in August 1989.

Linda S. Ershow-Levenberg
Deputy Attorney General
Newark, New Jersey

Editor's Note: It would appear that the information Dr. Sabel provided *DC* for the January 3 issue was not factually complete.

Dear Editor:

American Chiropractic College of Radiology Position on Videofluoroscopy

I would like to make the following comments regarding the recently published Academy of Chiropractic Radiology position on Videofluoroscopy (VF).

1. "Item #1a. Symptomatic patients who have a supportive soft tissue lesion"

Discussion: Symptomatic patients with a supportive soft tissue lesion could include 100% of all chiropractic patients. With what criteria are soft tissue lesions identified? Which specific lesions should be analyzed by videofluoroscopy? What affect does videofluoroscopy's analysis have on the therapy a patient receives?

2. Item #1d. Recurrent nerve root or cord symptoms.

Discussion: Recurrent nerve root and/or cord lesions are best visualized on magnetic resonance imaging and computed tomography. The nerve roots, spinal cord and surrounding soft tissues cannot be visualized on videofluoroscopy. How can videofluoroscopy rival MRI or CT in this area?

3. Item #7. "Chiropractors performing videofluoroscopy studies should have training in fluoroscopic techniques and interpretation at the undergraduate and postgraduate level."

Discussion: Discussion is two-fold. First basic questions have not been answered in regard to VF that all other imaging modalities have been measured by. Secondly, if these questions can be answered, what constitutes adequate training in technique and interpretation?

The questions that mold or formulate the protocols for the utilization of videofluoroscopy as an imaging modality are:

1. What constitutes an abnormal finding?

2. Is there research available to demonstrate the correlation between abnormal motion on VF and the patient's symptoms?

3. Is there research available that demonstrates significant abnormalities on VF that cannot also be demonstrated with static flexion/extension x-rays?

4. What does aberrant motion mean?

5. Are there findings on VF present in both symptomatic and asymptomatic patients?

6. What affect does the visualization of an abnormality on VF have to the overall treatment of the patient?

When the above questions are answered, only then can videofluoroscopy be used at its full potential.

In conclusion, imaging technologies such as plain x-ray, CT and MRI are being continually examined through research in order to define protocols for the utilization of these procedures. To accomplish this, a number of questions must be answered.

The plain x-ray is the primary imaging modality to visualize congenital anomalies, fractures and arthritis. CT scans aid us in the visualization of small fractures in the posterior elements of the spinal column. MRI is proving very sensitive in intervertebral disc lesion, spinal tumors and bone marrow abnormalities. These uses have developed from research comparing one imaging modality to another. Abnormal findings have been correlated with patient symptoms and therapeutic results.

Videofluoroscopy has not been researched in this way. Until basic questions are answered through research, videofluoroscopy cannot be considered anything but investigational.

I thank you for providing a forum for this discussion.

Bryan Gatterman, D.C., D.A.C.B.R.
President, American Chiropractic College of Radiology
San Leandro, California

Dear Editor:

I have two questions in response to the Price Club's change in chiropractic care benefits, in January 3, 1990 issue of *Dynamic Chiropractic*, page 20. One, why do we always believe the insurance company and start blaming our own? Second, why must we apologize for 5.8% of the health costs?

In regards to my second question, 5.8% does not mean that all the chiropractors were overcharging; it more than likely means that more people chose chiropractic care over medical care. I am not denying nor defending that some doctors overcharge, including MDs, but I am questioning that it is the real reason for the cut. First by inference of the article, the Price Club had unlimited or very high limits on chiropractic care which is very rare, and when they say they compared their costs for chiropractic care with "other plans," I guarantee that those "other plans" had much lower limits on chiropractic care if they covered it at all. My assertion is if the Price Club used the excuse that chiropractors were overcharging to cut health care benefits period, I would suggest to the employees that they ask for the breakdown of the cost per patient and compare it with the MDs. I would also like to point out that these people for a job, stand and lift a good deal of

the day, which predisposes them to musculoskeletal injuries, possibly more than the average person or people on the "other plans." Maybe a local chiropractor could work with the Price Club to ergonomically evaluate and redesign certain mechanically disadvantaged jobs?

This brings me to comment on my first question. We as chiropractors need to be confident in what we do and not apologize or allow the insurance companies to dictate to us how and for how long to treat. Yes, there are DCs out there that are overcharging, but they are not the majority. Let the insurance companies handle them -- they know who they are -- rather than have the rest of us being paranoid and suspicious of each other.

In closing, I want to answer my own questions. First, insurance companies know they can get away with cutting chiropractic care so they do, so we need to push them to prove what they are saying, not automatically believe it; read between the lines. Chiropractic care has been proven cost-effective time and time again, and we are still fighting the insurance companies, which makes one wonder about their motives. Second, we should not apologize for 5.8%; we should shoot for 10%, then 15% and up. That would mean that more and more people are being helped by chiropractic, not just being overcharged!

Suzan Kudick, D.C.
Olympia, Washington

Dear Editor:

I would like to respond to Dr. Krib's article, "None Are So Blind," in the December 15, 1989 issue of *Dynamic Chiropractic*. First I agree with the concern that in the future, possibly (near) future, the medical profession may indeed try to send us into extinction by "accepting" manipulation as a health tool, and then proceed to crowd us out of the health care market. However, Dr. Krib's perspective of the issue and several points discussed in the article bothered me greatly.

1. The theoretical article insinuates that training and subsequent adjustments given by personnel trained within the framework of a medical college and hospital would insure superior training and a higher degree of safety and success than could be given by a chiropractor. First, with all the other training, diagnosis, and treatment plans required of a medical physician, added to the low priority a manipulation would be given in treatment plans, I doubt that the training and success rate would be near the quality of that obtained by a chiropractor whose primary mission is to seek out and correct subluxations.

As far as safety is concerned, a recent article by I.H. Heller, D.C., of Guthrie, OK., states that over the past 44 years and several million adjustments given in the time-frame, only 22 cases of dangerous side effects of manipulation have been reported. I would venture to say that the number of patients who would obtain serious side effects in the form of infections obtained while visiting the germ-filled atmosphere of a hospital to receive an adjustment while in a vulnerable subluxated state, would be much higher than 22 per hundred million. Let's also not forget the side effects brought on by a segment adjusted in the improper line of correction, which I believe would take place much more often in a group not so concerned with the subluxation. Along this same line of thought, I would have to believe these people would only learn the most gross and easily performed general manipulations. Would they really be seeking out subluxations? Would they really seek the proper line of correction? I think not.

I will agree that the hospital could make the adjustments safer in one aspect by giving every patient with even the slightest hint of a disc-related problem, an MRI or CT to rule out disc

herniation. I'm sure at $350 to $1500 dollars a pop they would be glad to do so and convince the patient and/or the insurance company of the necessity in the process. I feel that a chiropractor using good diagnostic procedures and good judgment is helping the public save a great sum of money annually in this area.

2. Dr. Krib states, "the public does not want another demeaning, self-serving, copy-cat impersonation such as osteopathy." Yet one paragraph later he discusses expanding our scope of practice to include obstetrics, "if midwives can do it I think we can," and several other areas blessed by current scientific thought. Doesn't this seem a bit "self-serving" and "copy-cat like?" It appears to me to do so would lead us right down the path the osteopaths chose years ago.

3. You want to put more pressure on the schools to expand their educational scope. What would you sacrifice to teach biofeedback, obstetrics, etc.? Maybe a philosophy class, which in most colleges have already been cut to the bare bone. Or maybe whatever business management classes we get (at my school one three-hour class for one quarter). Then we could all attend practice management seminars. No matter what your opinion of said seminars, wouldn't it be nice if the schools (which I believe have a little more interest in patient care than profit per patient) could better prepare the young chiropractor for the business side of the profession?

Even if schools could expand their curriculum, wouldn't you rather have them expose the students to more chiropractic techniques of diagnosis and treatment of the subluxation? Wouldn't it be nice if the schools had more time to expose their students to Gonstead, Thompson, SOT, Gostric, Toftness, Logan, Pettibon, Motion Palpation, etc., prior to graduation? This would give the young chiropractor more weapons in his arsenal and help all of us understand more about what a fellow chiropractor with a different technique is doing, creating a better understanding among ourselves. It would likely cut down the egotistical back-stabbing within the profession. If doctors care to attend other types of schools or seminars to obtain skills such as biofeedback or acupressure, more power to them. But I'm afraid adding such items to the already overcrowded chiropractic curriculum is far down the priority list.

4. Lastly, but maybe most important, I did not see the word subluxation once in your article. Even if the MDs thought that manipulation could help, "conditions classified as neuromusculoskeletal in nature," (paragraph 6), it will be decades before they admit the subluxation may cause organ dysfunctions such as hypertension, ulcers, asthma, diabetes, etc. Therefore, they will always treat pharmaceutically first, with the adjustment as a secondary procedure. They will never give the subluxation the credit it deserves. I get the feeling that you, Dr. Krib, have lost your confidence in the subluxation and the healing power that correcting it can provide. I urge you to rediscover it.

I wish I had all the solutions but I don't. I do feel there are better ones available than presented in Dr. Krib's article. Here are mine:

1. Get back to educating your patients on the subluxation and its affects. Make them understand that you are doing more than treating pain. Help them understand that chiropractic and the subluxation is the answer to many problems they never associated with our profession. Let them know subluxation is our priority!

2. Promote legislation to limit manipulation by other professions. Not because we should be worried about being overrun, but because other professions will downplay the importance of the subluxation and push the term (not the condition) into extinction. They will be treating a condition they do not understand. I consider that dangerous, as I do any physician treating, rather than referring a condition they do not understand.

3. Believe in what you do. Stand tall. Support each other. Join and give input and criticism to

your local and national organizations. They are the loudest voice we have at this point. Dr. Krib, thank you for getting me off of my "hind-end."

Scott B. Wood, D.C.
Kirkman, Iowa

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