Victims again? Who is the problem? (Commentary) JCCA 2002; 46(4):221–223.

To the Editor:

I enjoyed Dr. Carter's comments in the Dec. '02 issue of JCCA. Having worked with Dr. Carter on the CCA Board of Governors, I am familiar with his ability to explain highly evolved concepts with his own brand of "down home" philosophy. That, and his patented animal jokes made for some enjoyable Board meetings. He raises a few points in his Commentary which I think deserve further development.

I commend Dr. Carter for his observations. He quite rightly points out that currently there are a number of good reasons chiropractors could easily buy into the victim mentality. The value in his argument is an understanding that becoming a victim is not limited to chiropractors, but is an element of human nature. As victims, we don't have to work to solve a problem. We can blame others, thereby avoiding the confrontation and conflict which are an essential part of growth and development. If we can turn this concept to our practices as chiropractors, it becomes clear that many of our patients also are struggling with this issue.

Like the chiropractors in Manitoba who have dealt with the on-off-on funding for the treatment of children, or those who must deal with the stiff and restrictive guidelines for coverage put in place by Aetna, our patients face many barriers to achieving and maintaining good health. Whether it is funding for chiropractic care, negative comments from other health care providers, harsh conditions at work or stress at home, most chiropractic patients have a least one foot firmly planted in victim territory. If we, as healers and teachers, are to help guide out patients to good health, we should first stop claiming victim status for ourselves.

Dr. Carter postulates that a new set of guidelines will help remove the lack of definition of our scope of practice from the menu list of good reasons for being victims. This may be true, but if we can't stop being victims without a new, revised, current, updated set of guidelines, the point has been lost on us.

Regarding our professional turf, Dr. Carter suggests that we will gain position through proficiency and research. I would like to point out that while being proficient hasn't hurt us, neither has it done much to move us ahead during the past 100 years. Rather, it seems the key to our success in the future is research. We have seen more doors opened to chiropractic by science than by discourse about what we do, at least on a national level. Unfortunately, it seems every forward step fueled by a strong positive study is matched by a backward step forced from within by proponents of our century old roots.

I won't cry that unfounded claims made by adherents to 100 year old dogma are jeopardizing the future of chiropractic. That would be avoiding conflict as a victim rather than contributing to the evolution of this profession by looking to the future. That would do no good for my patients or my profession.

Thank you for your listening to my thoughts on this issue.

Dr. D.J. Leprich, DC
Ontario

To the Editor in reply:

Thank you for your comments. We did share some history together. I would elaborate on two good points you made which do require further clarification. New Guidelines will have a positive outcome for our profession only if they are developed correctly, understood by everyone involved in chiropractic care and, the guidelines must be followed by our membership. It is then we will appreciate the returns. You questioned if our proficiency in the past really did much for us. I believe it did. Today we have over 60,000 chiropractors in North America and hundreds of thousands of patients despite the opposition of medicine and government regulations. There are over 70 countries which provide chiropractic care. This is because of our proficiency. Our proficiency has also lead to other disciplines practicing the art of adjusting/manipulation. Each year the percentage of these manipulations given by chiropractors are reducing. The profession at large should discuss these points you bring to attention.

A very quick animal story may illustrate this point. The story is told of a sensitivity workshop where individuals came for understanding and personal growth. A chief of one of the First Nations Band was attending the workshop. Part way into the workshop some asked the chief how he

felt. He said, " inside of me, it feels like there are two dogs, a good dog and a bad dog. The bad dog keeps trying to fight the good dog." Someone asks: Which dog wins? The chief replies; "Generally the one I feed." So it is with us individual and collectively as a group.

Dr. Ron Carter, DC
Alberta

Chiropractic Name Techniques in Canada: a continued look at demographic trends and their impact on issues of jurisprudence. JCCA 2002; 46(4):241–256.

To the Editor:

In a recent article,[1] Dr. Gleberzon supports the incorporation of name techniques into the CMCC curriculum and advocates their inclusion by regulatory bodies. Unfortunately, the bulk of his argument rests on a logical fallacy: argument based on popularity (argumentum ad populum). He argues that, because techniques are popular with students and popular in some sectors of practice, they should be embraced by CMCC and regulatory agencies. This flawed reasoning was a major impetus for the introduction of evidence based practices in medicine: techniques that were popular and widely used were not supported by the evidence.

On the question of evidence, I would restate one of Dr. Gleberzon's comments as diversified technique is the most studied AND has the best evidence to support it. Most of the citations in his opening paragraph, in fact, cite literature based on studies that utilized diversified technique. Dr. Gleberzon is quite correct to point out the logical fallacy *no evidence means the proposition is false* (argumentum ad ignorantiam). However, the corollary of this argument is equally true: *no evidence means the proposition is true*. Dr. Gleberzon cites his previous review[2] to state that *there is abundant evidence suggesting that patients experience significant therapeutic outcomes.* The usefulness of this review in supporting such a claim is severely limited by the lack of systematic and explicit methods to identify, select and critically appraise the studies it included.

While an interesting opinion paper, Dr. Gleberzon presents some fundamentally flawed arguments and so does not provide a methodologically sound basis for decisions by either educators or regulatory bodies. Issues around technique, scope of practice, definitions of controlled acts and interpretations of the rubric of *chiropractic practice* are important ones. This issue is certainly worthy of further investigation and discussion.

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Cameron McDermaid, DC FCCS(C)
CMCC

To The Editor In Reply:

Thank you for the opportunity to respond to the letter by Dr. McDermaid. While his letter is articulate, it is fundamentally inaccurate and based on a rather narrow professional perceptive. Quite uncharacteristically, Dr. McDermaid makes many factual errors in his arguments that ultimately undermine the foundation upon which his premise is based.

Error #1: Confusing Diversified Technique with Spinal Manipulative Therapy (SMT)

Dr. McDermaid makes a cardinal error when he confuses Diversified Technique (DT) with spinal manipulative therapy (SMT). The former is an eclectic system technique, whereas the later is a mode of therapy. The studies which I cite in my article[1] have monitored the effects of SMT on many clinical conditions such as low back pain or headache. The conclusions drawn from those studies on SMT cannot be limited to DT, and several cited articles repeatedly emphasized this important fact (see for example 2). The mechanical properties of SMT (high velocity, low amplitude) are equally applicable to other technique systems that use similar thrust patterns, such as Thompson Terminal Point, Gonstead Technique and Cox-Flexion Distraction Techniques.

Error #1a: Assuming Diversified Technique is taught consistently throughout the profession.
It may come as a surprise to Dr. McDermaid to learn that, while all chiropractic colleges teach DT, each college teaches it within their own ideological model. Thus, a subluxation-based college emphasizes the intent of Diversified Technique is the identification and correction of subluxation to remove nerve interference and augment the natural recuperative abilities of the patient or to thwart disease. This is very different from the DT model taught at CMCC. Moreover, a list of the diagnostic methods used by different diversified practitioners displays the same variability found within the profession itself, a list that includes static and motion palpation, leg checks, thermography, x-ray line marking and so on. Thus, when Dr. McDermaid discusses diversified technique we cannot know under what conceptual model it was performed.

Error #2: Students and field doctors
Perhaps this is nothing more than a difference in operational definitions, but I think that a number between 30% and 60% of field practitioners in Canada and the United States reporting to use different Technique systems constitutes a group larger than 'some', and their opinions matter (see below). Additionally, I think that the students at CMCC would be distressed to learn that Dr. McDermaid dismisses out of hand their interest in being taught different approaches to patient care.

Error #3: Minimizing the importance of consensus
Here I think is Dr. McDermaid's weakest argument. He suggests that consensus opinion should not be taken into account with respect to decision-making processes of curriculum programming or the development of standards of care or guidelines by regulatory bodies. This is antithetical to the Clinical Practice Guideline (CPG) development process. At its core, the CPG process hinges on gathering expert opinions from all points of the chiropractic ideological compass. Gatterman *et al* is quite clear on this point; for CPGs to be accepted, they must be inclusive and reflect, as much as possible, the diversity of diagnostic and therapeutic approaches found within the profession.[3]

Error #4: What constitutes evidence
Regrettably, I am left to conclude that when referring to 'best evidence' Dr. McDermaid is limiting his inclusion criteria to randomized clinical trials or meta-anaylses of these trials. I am sure Dr. McDermaid is aware of the limitations of these studies (see 4), and is also aware of the importance of drawing upon clinically-based outcomes research, expert opinion and practitioner experience in forming an evidence-based medical (EBM) or evidence-based care (EBC) model.[5] During a recent presentation at CMCC, Dr. Cheryl Hawk emphasized the important place of clinical-based practice in health care. Dr. David Sackett has emphasized, both in print[6] and during this testimony at the Coroner's Inquest in Ontario,[7] the importance of including different levels of evidence in EBM. He has stated that were medicine to rely solely on those procedures that have withstood the rigors of RCTs, the health care delivery system would grind to a screeching halt.[7] The use by chiropractors of the principles of EBM is fundamentally no different than the manner in which medical physicians use it. In other words, all these different strands of evidence must be woven into a tapestry suitable for clinical application and patient care planning.

As educators, it is our responsibility to have students learn more about different Technique Systems and their growing impact on the professional practice activities of Canadian chiropractors. I would agree with Dr. McDermaid that we are obliged to create an evidence-based framework within which these investigations are conducted. I have endeavored to create such a framework in the course offered to students in Name Techniques at CMCC. After the thoughtful application of an evidence-based approach, students have expressed considerable interest in receiving further instruction in some of these Techniques. Thus, consensus opinion is derived from careful investigations by students, and not the other way around. Perhaps, not surprisingly, the opinions expressed by students mirror trends of professional practice activities emerging from the field. Clearly, as Dr. McDermaid points out, popularity should not be the *sole* criteria upon which curricular decisions are based, or regulations developed. However, since there is some evidence of their therapeutic efficacy, Technique Systems should not be rejected out of hand. This apodictic attitude, that assumes only those procedures supported by RCT finding are appropriate for clinical use, is the antithesis of an evidence-based approach.

With all due respect to Dr. McDermaid, this may come down to nothing more than the difference between research-driven ideology and clinical-based practice. Dr.

Robert Cooperstein (Palmer West) and I have just now completed a textbook entitled *Technique Systems in Chiropractic*.[8] In it, we describe the different Name Techniques found within the profession and explore several issues germane to them. In particular, we discuss the frustrations found at the research-clinical interface and suggest:

This state of affairs mandates to the colleges the task of teaching their students how to function comfortably within a realm of clinical uncertainty, how to do without the outmoded pseudo-confidence and pseudo-science of technique charlatans. They must proudly tell the students that we now know enough about our craft to safely cast off some of the tethers of system techniques, that their rules and methodologies are too narrow and constraining. This does not mean rejecting system techniques, but more carefully nurturing their concept of systematic thinking, without which efficient patient care cannot begin. Students and field doctors alike deserve the freedom to practice chiropractic technique in a more creative, eclectic way, always consistent with the dictates of normal science. Hopefully, they will experience the thrill of participating in the most liberal period of chiropractic technique practice since its very inception, one in which the learning of system techniques can be organized and enriched by the success of chiropractic research.

Dr. Brian J. Gleberzon, DC
CMCC

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The academic legitimization of chiropractic: the case of CMCC and York University. JCCA 2002; 46(4):265–279.

Letter to the Editor:

I wish to congratulate Dr. Grayson on his very interesting chronicle of the events leading to the unsuccessful affiliation between CMCC and York University.[1] The purpose of this letter is to bring to the reader's attention a rather ironic circumstance: Namely, that three of five articles in the December 2002 issue of the JCCA actually overlap with respect to this unfortunate chapter in CMCC's history.

Through an odd twist of fate, I found myself in possession of the document package Dr. Grayson referred to in his article, and I think the readership will find a brief description of its contents illuminating. This document package, while undated, was assembled by De Robertis and the so-called 'Gang of Four' (to quote Dr. Grayson) who vehemently opposed affiliation. Sometime around February, 2001 this package of information was distributed to all York Faculty at Atkinson College, just prior to the vote on motions that were to be held in Atkinson Council on March 28, 2001 (see 1). In general, information in this package attacked CMCC on four fronts. These were: (i) subluxation, (ii) vaccination, (iii) chiropractic care for children and (iv) Name Techniques.

The Gang of Four insisted that CMCC taught subluxation theory as if it drove or underpinned its curriculum. The Gang of Four criticized the faculty of the Chiropractic Principles department in particular for discussing the concept of subluxation, despite the fact that is it entirely appropriate for it to do so.

Subluxation-theory has been an integral component of chiropractic history, back to the time of the Palmers. There is a plethora of different subluxation-equivalents[2] anchoring different chiropractic philosophies to Name Techniques, and it continues to hold currency with some members of the chiropractic community (see 3). It would be more accurate to state that CMCC, as an academic institution, explores the concept of subluxation from many different perspectives.

The Gang of Four also cited as evidence that CMCC exclusively embraces subluxation-theory the fact that its Library and Bookstore house literature on the subject: That is, both sites have articles, books and journals that embrace subluxation-theory. Of course, the Gang of Four neglected to mention that the book-shelves in the same Library and Bookstore literally groan beneath the weight of journals, articles and books that vehemently reject subluxation theory as well.

The attack by the Gang of Four towards CMCC in the areas of subluxation-based care, chiropractic pediatric care and the use of certain Name Techniques was principally driven by citing an article in the non-peer-reviewed journal *Canadian Chiropractic*.[4] In the article cited, an author details her clinical experience of successfully managing a child with respiratory difficulties (including asthma) using Torque Release Technique.[4] Not only is Torque Release not taught at CMCC (apart from a description of the Technique itself), and apart from the fact that the use of Torque Release would not be permitted in the clinics at CMCC, this article was simply what it held itself to be: A case study. The Gang of Four appear to have been purposely obtuse in citing this article, emphasizing that, because its author was a CMCC graduate, it somehow reflects the normal curricular content taught in the undergraduate or clinical education programs of CMCC. Since this article also questioned the usefulness of vaccination, the Gang of Four also concluded that CMCC has an anti-vaccination stance. Again, had they taken the time to investigate this issue in a comprehensive and systematic manner, even a cursory examination of the courses taught in Microbiology and Pathology would reveal that CMCC has accepted the evidence of vaccination efficacy, and emphasizes its important place in public health care.

An article by Dr. E. Ernst in the *British Medical Journal* was also cited as proof that chiropractic does not work.[5] Of course, what the Gang of Four chose not to mention was that Ernst's article was an editorial, in which he often attempts to substantiate his opinions by citing his own other, unsubstantiated editorials. This would not be problematic except for the inescapable fact that De Roberts and his colleagues sought to disseminate Dr. Ernst's editorial comments as if they were facts. Conversely, the Gang of Four only grudgingly referred to the articles written by 'S Haldeman', referring to him as a chiropractor but choosing to omit the fact he is also a medical doctor and neurologist. I leave the reader to draw his or her own conclusions as to the motivations behind these omissions.

The Gang of Four rallied around an article by Dr. S. Homola,[6] who challenged the frame-work upon which subluxation theory is based. It should be noted that Dr. Homola often cites articles on subluxation from the 1950s. Moreover, Dr. Homola also included as evidence of chiropractic's questionable safety profile the findings reported by Dr. John Norris from the Canadian Stroke Consortium (SPONTADS). This despite the fact that Dr. Norris has recently stated that any conclusions drawn from his study were 'speculative' and 'conjecture'.

Lastly, Dr. Homola discusses the controversies surrounding many Name Techniques, notably Applied Kinesiology, Upper Cervical Techniques and Activator. It is noteworthy that Dr. Homola did not discuss the body of evidence indicating that these techniques have been reported to achieve clinically important outcomes for patients in case studies, case series, clinical trials and randomized clinical trials (see 7). Again, the Gang of Four chose not to discuss this article's limitations, nor did they choose to draw their target audience's attention to the fact that these Techniques are not taught in the undergraduate curricular program at CMCC, beyond a detailed discussion of their approach to health care (see 7 and 8). That is to say, courses in the Applied Chiropractic, Clinical Sciences and Clinical Education departments of CMCC do not instruct students in these Techniques for the purpose of achieving a level of clinical competency.

Dr. Stephen Barrett[9] in a closing article in this package of information given to York Faculty, reiterated these criticisms on pediatric care and subluxation, drawing most heavily on the article in *Canadian Chiropractor* previously described above. In addition, under the heading of 'Dubious Practices', Barrettt described some Name Techniques, again making no mention that these Techniques are discussed at CMCC for academic purposes only.

So what conclusions can be drawn? Either consciously or unconsciously, the Gang of Four seemed to take great effort in misrepresenting chiropractic as a profession, and CMCC as an academic institution. Nowhere do we find a balanced description of the accrual of the evidence base demonstrating the efficacy and safety of spinal manipulative therapy for spinal pain and headaches, as reviewed in detail by Meeker and Haldeman.[10] When looked at in its entirety, the package disseminated by the Gang of Four is an unbalanced document painted with the veneer of scientific objectivity. At a minimum, the Package represents a glaring example of the misuse of the literature. At the extreme, this package of information represents a document unworthy of scholarly and purportedly scientifically minded individuals, as alluded to by Grayson (1:272). This would not be so tragic a circumstance were it not for the fact that according to Dr. Grayson many faculty at York University apparently relied solely on this information during their personal deliberations deciding as to whether or not to vote for or against affiliation (see 1).

Perhaps, in retrospect, we should not be all that surprised by some of the events of the failed York-CMCC affiliation process. It would appear that much of the deliberations about CMCC were not restricted to a fair assessment of its academic merits or curricular content, but rather the deliberations degenerated into a biased critic of chiropractic in general, and the perceptions and practice activities of a minority of practitioners in particular. Unfortunately, this process is repeated far too often.

Dr. Brian J.Gleberzon, DC
Associate Professor, CMCC

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