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

To the Editor:

I have read with interest Dr. B.J. Gleberzon's article regarding chiropractic techniques in Canada. Although this study provides some interesting information, I take exception with the inappropriate manner in which it is employed by Dr. Gleberzon as well as much of his commentary.

Dr. Gleberzon contends that information gathered at various times from second and fourth year students at CMCC, concerning their preferences for including certain chiropractic name technique systems in the curriculum of CMCC, may be used to inform curriculum development at CMCC. As questionable as the foregoing premise is, he goes further to suggest that these curriculum preferences may also be instructive in the development of professional practice guidelines and standards of care. Dr. Gleberzon goes even further to suggest that the utility of these curriculum preferences could be used to help regulatory bodies determine what they should include in their scopes of practice. In particular he feels that they could help the Chiropractors' Association of Saskatchewan (CAS) conclude that its present prohibition against the use of mechanical adjusting devices, specifically the activator adjusting instrument, may not be evidence-based. In the latter instance, Dr. Gleberzon helpfully references prior research of his own.

One could surmise from such an ambitious application of this information that it, and the manner of its collection, meets the highest scientific standards. Unfortunately, this is not the case. What Dr. Gleberzon has collected, by means of student projects, is nothing more than opinion. While these opinions are interesting it is doubtful that they have much utility, even in terms of informing curriculum development at CMCC. As Dr. Gleberzon states in the rather modest limitations section of his paper: *"... because students are not in clinical practice, they may lack the practical knowledge base needed to make appropriate decisions with respect to curricular content*." To which I would add, "no kidding."

To further suggest that these opinions have a role to play in establishing professional quality assurance standards and guidelines or, to be in any way instructive to regulatory bodies, is ridiculous. While Dr. Gleberzon's commentary on these issues and others (ie. evidence-based practices) is replete with his opinions and biased observations, the fact remains that he has offered not a shred of credible evidence that the information he has collected has any relevance for the grandiose purposes for which he suggests it be used.

By what peculiar intellectual alchemy Dr. Gleberzon transforms the "lead" of opinion (students' and his own) into the "gold" standard of objective proof worthy of broad application in the chiropractic profession is incomprehensible. I can only hope that the standard of scholarship that Dr. Gleberzon employs in this paper is not pervasive at CMCC.

The ability of the chiropractic profession to self-regulate is a privilege not a right. It is also a serious business since it involves the protection of the public. The ability to self-regulate is delegated to the chiropractic profession, by the elected representatives of the public, because they are confident that chiropractic has attained a level of professionalism consistent with putting the public interest ahead of its own.

Provincial statutes give the chiropractic profession the legal authority to establish standards of practice to ensure, to the extent humanly possible, that its practitioners are competent to provide the public with safe and effective care. I can assure Dr. Gleberzon that while professional regulatory boards set standards for public protection based on information from many competent sources, they are certainly not predicated on student projects or material of similar quality.

It is inaccurate and inappropriate for Dr. Gleberzon to suggest that the Chiropractors' Association of Saskatchewan is not aware of contemporary data with regard to the activator adjusting device. It may interest Dr. Gleberzon to know that the CAS convened a committee, the Mechanical Adjusting Device Committee, to review the literature on mechanical adjusting devices and provide a comprehensive report. The committee employed a stringent standard to choose and analyze peer reviewed material in the areas of usage, efficacy, safety and educational standards. All of this material pertained to the activator adjusting device.

The report of the Mechanical Adjusting Device Committee was recently presented to the CAS membership and is being prepared for publication. The report will speak for itself and readers can draw their own conclusions.

Dr. Gleberzon's article is a wonderful example of how to attempt to take what is essentially very modest material and use it for purposes for which it is entirely unsuited.

Dr. J.R. Corrigan
President, Chiropractors' Association of Saskatchewan

To the Editor in reply:

Thank you for the opportunity to reply to the letter from Dr. J.R. Corrigan, President of the Chiropractors' Association of Saskatchewan (CAS). Although I was somewhat taken aback by the degree of personal attack evident in his letter (itself speaking volumes about the level of respect Dr. Corrigan accords members of the profession who have opinions other than his own), I was more surprised by what his letter said or, more accurately, what it did not say. Nowhere in Dr. Corrigan's rather condescending communication do I find a scholarly defense of the prohibition against the use of instrumented adjusting in Saskatchewan (see 1).

My chief concerns regarding the indefensibility of this regulation can be summarized under the following headings:

1 Transparency

Certain buzzwords become conceptual anchors over time. A concept very much currently in vogue is the requirement of all health care stakeholders to be transparent in terms of policies, procedures and regulations. For example, as a practicing chiropractor, I have the privilege to practice chiropractic, but not the right to do so in an opaque environment. It is therefore incumbent upon me to have a transparent practice that is open to inspection by other interested parties, including third party provincial payers, Revenue Canada and the regulatory body of the jurisdiction in which I practice.

In much the same way, regulatory bodies are not, nor should they be, immune from careful inspection by their constituent members, government agencies and the research community, all of whom have an important role to play with respect to ensuring that all policies, decisions and regulations are rational and responsible. No doubt Dr. Corrigan would agree that regulatory bodies such as the CAS are not above such scrutiny. As Dr. Corrigan wrote, regulating the profession is a privilege, not a right and it is a serious business. So serious, in fact, that all decisions, policies and regulations must be able to withstand the intense scrutiny of scholarly investigation and debate. Metaphorically speaking, decisions, policies and regulations must be able to endure the harsh light generated by the lamp of knowledge that may be shone in their direction. Authors such as myself must be permitted to explore these types of issues unhobbled by personal vilifications or demonizing accusations.

2 Evidence

If Dr. Corrigan's contention that the CAS is aware of the contemporary data regarding the Activator is credible, this necessarily prompts questions with respect to how the existing evidence was evaluated. As Dr. Corrigan must know, when it comes to the application of evidence-based medicine, or 'Best Practice' in the broader sense, one does not have the luxury of selectively editing the literature. As many experts in this field have consistently reiterated, EBM is the integration of all types of evidence, ranging from randomized clinical trials (bearing in mind their limitations), practice-based outcomes research, case studies, case series, practitioner experience, experimental studies, patient preference and consensus and expert opinions.[2–5] In the matter at hand, there are existing studies that investigate the Activator relative to all of these types of evidence. As with all types of health care research, these studies display a degree of heterogeneity with respect to their quality and each study possesses some flaws and weaknesses. However, despite these limitations, taken as a whole, the literature is robust enough to support the assertion that instrumented adjusting is efficacious, safe and useful for a broad range of clinical exigencies. Moreover, I would draw to Dr. Corrigan's attention the conclusions reached by the Clinical Guidelines for Chiropractic Practice in Canada (Glenerin) report, itself a consensus-driven document, that reads:

> 4. Mechanical force, manually assisted procedures;
>
> 10.8 The application of manually assisted mechanical force can be be utilized in chiropractic practice. This involves the use of mechanical adjusting devices.
>
> (a) Rating: Promising for neuromusculoskeletal disorders

Evidence Class II and III
Consensus Level: 2

For the Glenerin document, Class II referred to 'studies in referred journals' and level 2 consensus refers to '70–85%'.[6] It is noteworthy that the members of the Glenerin Committee were able to develop this statement in the early 1990s, a point in time when the literature pertaining to instrumented adjusting was much more sparse than it is today.

When, in my article, I turned my attention to the issue of the defensibility of the CAS' prohibition against instrumented adjusting I did not suggest that student opinion be used as a gold standard of proof. It is for that reason I 'do not offer a shred of credible evidence' in support of 'grandiose purposes'. Instead, my argument focused on the following issues: evidence of efficacy, safety, concerns about quality assurance and lack of physical touch. I also alluded to the Activator's broad clinical applicability. Nowhere in Dr. Corrigan's letter do I find an adequate response to these issues. I am therefore left to conclude that either Dr. Corrigan did not read the article in its entirety or was otherwise content to make inaccurate assumptions about its content. Since I never suggested that the opinions of students be applied to the deliberations concerning the ban on instrumented adjusting, all the other erroneous assertions of Dr. Corrigan that branch from this inaccurately rooted assumption are fruits of a poisoned tree; they are spurious and irrelevant.

What I *did* report in the first part of my article is the following. Over the past six years, students have consistently expressed an interest in learning different Technique Systems in addition to Diversified Technique, among them either using an Activator or learning Activator Methods Chiropractic Technique: after Diversified technique, the Activator is among the most commonly used adjustive method in the chiropractic field and; there is an ongoing influx of American-trained chiropractors returning to Canada, many of whom have obtained a level of competency in various Technique Systems other than Diversified Technique. I would remind Dr. Corrigan that I am not the first person to suggest that demographic data be considered in policy development: Witness the impact of the Baby Boomer cohort group in economic and health care decisions ranging from social security funding, long term care, housing and prescription drug reimbursement schedules.[7]

The demographic data I tracked with respect to Name Technique use by Canadian chiropractors will present serious challenges to current regulations. Of course, Dr. Corrigan is certainly able to ignore these demographic changes but doing so does not lessen their predictable impact on the chiropractic landscape in Canada in general, or Saskatchewan in particular.

3 Fairness

Here at last is the core issue: Is the selective ban of the Activator, to the exclusion of all the other 200 or so Name Techniques used in the chiropractic field, fair? Unfortunately, a policy that singles out and bans any device or Technique, without justification, gives the appearance of being arbitrarily constructed. One of the most common questions I am asked when discussing this topic with students or with my colleagues in the field, at CMCC or from other chiropractic colleges is: Why is the Activator banned in Saskatchewan and not Technique X, despite the fact that Technique X is not taught at any accredited chiropractic colleges and may have far less evidence underpinning it? For example, why has the CAS not banned pelvic blocking (used by SOT practitioners), or drop table use (used by Thompson Terminal Point Technique practitioners) or distraction techniques (used by Cox Flexion-Distraction Technique practitioners) for spinal adjusting, each using mechanical devices that may be considered as a form of non-manual adjustive care? Where, one must also ask, is the commissioned Report exploring Upper Cervical Techniques, Logan Basic, Applied Kinesiology, Gonstead, Chiropractic BioPhysics and so on? For that matter, the precedent now set by the CAS leads to a still more undesirable slippery slope with respect to choosing which procedures are permitted for clinical use, and which are not. Since there are some gaps in our knowledge base with respect to spinal manipulative therapy, one must now ask where is the Commission on Manual Therapy?

As an instructor in the Technique department at CMCC, I am often confronted by students who seek a rational explanation to support some of the theoretical models and clinical approaches taught to them in class that currently lacks a firm evidentiary base. In order to quell their anxiety, many of my colleagues and I respond by using the same principles that are employed in other health care disciplines. When incontravertible evidence to the contrary

does not exist, it is an accepted principle in health care decision-making processes to reasonably suggest that a practitioner (or student) rely on the evidence that does exist (imperfect though it may be), consensus opinions and his or her clinical experience to fill the gaps in the current knowledge base.[2,3] If and when new evidence is brought forward, it must then be interwoven into existing clinical practice, modifying clinical activities accordingly; ultimately, regulations must change in a commensurate manner. However, I would be unable to follow this principle were I to follow the precedent now set by the CAS. Instead, I would be compelled to limit students to using SMT to manage patients with low back pain, possibly neck pain and some types of headaches, thereby potentially depriving many patients of important health care benefits.

4 Outside implication

Unique among all jurisdictions in North America, the Activator is prohibited from use only in Saskatchewan. Unfortunately, the critics of the profession seize upon this issue, further dividing the profession and causing confusion among the public. Some anti-chiropractic authors have now labeled the activator as a 'dubious practice' activity because it is banned in Saskatchewan and point accusatory fingers towards those practitioners who may choose to use it outside of that province.[8] Thus, the prohibition against the Activator has a damaging rippling effect to the profession at large that travels far beyond Saskatchewan.

Summary

In conclusion, I must reiterate and emphasize that I did not suggest that the CAS does not keep abreast of the contemporary literature as stated by both Drs. Corrigan and Kitchen (see letter to the editor below). Rather, what I did suggest is that keeping abreast of contemporary data is an arduous task and articles such as mine may aid regulatory bodies in ensuring their standards of practice are defensible as new evidence emerges. It is unfortunate that an outside observer might perceive the response by Dr. Corrigan and some other members of the CAS to my comments and questions to be more emotive than scientific; that they chose to react with daggers drawn rather than with thoughtful introspection. It illustrates an unfortunate example of a profession unnecessarily divided and an opportunity regretfully lost.

References

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2 Hayes B. Clinical expertise in the era of evidence-based medicine and patient choice. ACP Journal Club 2002; Mar–Apr;136–A11.
3 Sackett DL. Evidence-based medicine (Editorial). Spine 1999; 23(10):1085–1086.
4 Bolton JE. The evidence of evidence-based practice: What counts and what doesn't count? J Manipulative Ther Physiol 2001; 24(5):362–366.
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8 Barrett S. Evidence of unscientific teachings at Canadian Memorial Chiropractic College. Addendum to Oral Testimony at the Conference on Chiropractic Degree Studies York University. Oct 29, 1999. Undated (c2000?).

Dr. Brian J. Gleberzon, DC
Associate Professor,
Canadian Memorial Chiropractic College

To the Editor

I am writing in response to the article; "Chiropractic Name techniques in Canada; a continued look at demographic trends and their impact on issues of jurisprudence" (JCCA 46(4). 2002), in particular to correct a point concerning regulatory issues in Saskatchewan. Had Dr. Gleberzon contacted the regulatory body before writing this article he could have avoided creating misinformation on this matter.

Understanding the regulatory process should be the first step when attempting to relate issues of opinion with those of regulation. This would entail reading the Acts of each provincial jurisdiction and their bylaws. Unfortunately, I do not see these as being referenced and would assume this was not done.

This paper was a comparison of student reports/

thoughts/wishes/ on the topic of technique from a didactic education program to those of students in a problem based program. To comment on the lack of strength of the methodology, analysis of data and the research bias is not the intent of this letter. I will leave that to others to discuss. The ability to extrapolate these to regulatory issues is befuddling.

The Acts give the power to the profession to establish regulations and thus self regulate. It allows for making regulations to determine qualifications, standards, tests of competency, etc, in the registration of Chiropractic professionals. It also allows for the setting of standards regarding the manner and method of practise and ensuring that proper instruction was done; and the validation of that instruction. There are many methods to ensure this is done and all regulatory bodies utilize the most appropriate means possible to ensure the public's safety. The profession has input into the process of regulation through its research, educational programs and clinical knowledge. It is given by the elected representatives to the professional Boards and Regulatory bodies. Guidance from Boards, Councils of Education, Associations, professional standards/guidelines aid in the determination of these regulations. Ultimately, the regulatory bodies answer to the Government which gives the profession its authority through the Act. These regulations are in place to allow for the protection of the public and to ensure the rules and regulations are followed. Without borders to the profession , mayhem can occur and it behooves the self regulatory professions to regulate on behalf of the public.

Concerns about what should or should not be regulated are common to all self-regulating professions. Guidelines are not based upon wants. They must have justification and reasoning that is acceptable. Based on research, they must be accountable to the final decision makers, Governments, who provide the Acts on behalf of the public.

Dr. Gleberzon is not factual on the issue of mechanical adjusting devices, in particular how it relates to the regulatory process in Saskatchewan. Had the author taken the time to write/phone/discuss the concerns with the regulatory body in Saskatchewan, some anguish could have been avoided.

The Chiropractic Act, 1994 of Saskatchewan states 2(e):

> ... "chiropractic means";
>
> (i) the science and art of treatment, by methods of adjustment, by hand, of one or more of the several articulations of the human body; ... (Underlining mine)

Regulatory Bylaw 19(1)(c) states:

> "no member shall use a machine or mechanical device as a substitute method of adjustment by hand of any one or more of the several articulations of the human body;"...

The Act and its bylaws must be taken together. Regulatory Bylaw 19 deals with professional standards, and while 19(1)(d) dealing with modalities has been amended 19(1)(c) has not. The article quoting "v. Guiding professional practice standards of care" reference #65, is incorrect. Professional Standards 19(1)(c) was not amended October 2001. Furthermore Regulatory bylaw 19(1)(c) was approved by government in 1994 and was part of "The Chiropractic Act" which was the Act established in 1978, as well as the prior legislation.

Suggesting that the profession in Saskatchewan does not keep abreast of contemporary data is inappropriate. It would have been to the author's benefit if he had contacted the appropriate bodies in Saskatchewan, where he would have realized the profession had commissioned a study into mechanical adjusting devices in the fall of 2001. This study does not rely on the work of others (students who are writing to achieve a passing grade in the hopes of reflecting the wishes of a marker) to review the existing research.

The committee employed a stringent standard to choose and analyze published material as to the efficacy, usage, educational standards and safety of mechanical adjusting devices. This report was recently presented to the CAS membership and is being prepared for publication. While the report will speak for itself, it is interesting to note that the authors unanimously agreed that the available literature on the topic was generally flawed and weak. Dr. Gleberzon would serve himself and his students well to read this paper when it is published to see how credible research is carried out.

I further believe the author undermined the authority of the College of Chiropractors of Ontario by indicating they were word-smithing their standards of practice. This appears to imply they changed these standards to simply allow for practitioners to bill third party payers. I would think they spent a significant amount of time reviewing their Act and bylaws before making any changes.

Teaching students about the value of research and the

ability to critically think and analyze is one issue of a chiropractic curriculum. Teaching them about the need and necessity of the regulatory process is another that is valuable. I like to believe CMCC imparts this to their student body. Professors should avoid trying to extrapolate the wishes of students, to the needs of and expectations of the public, without first doing the appropriate investigations.

R.G. Kitchen, BSc(Hons)DC, FCCSC
Registrar, Chiropractors' Association of Saskatchewan

To the Editor in reply

Thank you for the opportunity to respond to the letter by Dr. R.G. Kitchen, Registrar of the Chiropractor's Association of Saskatchewan (CAS). It may surprise Dr. Kitchen to learn that, contrary to his erroneous assumption, I did in fact contact the CAS in March 2002 and specifically asked for a copy of the current regulations governing the use of mechanical assisted adjusting devices in Saskatchewan. I was subsequently faxed a copy of the Regulation Bylaw 19 (1) 'professional standards' which clearly displayed the printed parenthetical notation "amended Oct, 2001" (available from Editor). If Dr. Kitchen is correct and only section 1(d) of Bylaw 19 was in fact amended at that time, the notation of amendment as it appears in the document should clearly reflect this to avoid misleading the reader. However, Dr. Kitchen's rambling rodomontade fails to obscure the fact that Bylaw 19(1) (c) is accurately quoted in my article and that this Bylaw prohibits the use of the activator and other such devices in Saskatchewan, which is obviously the relevant issue.

Furthermore, as was the case with Dr. Corrigan, Dr. Kitchen has also erroneously stated that I suggested that student recommendations be consulted during the deliberations regarding the defensibility of the continued prohibition against instrumented adjusting in Saskatchewan, inaccurately linking the two arms of my article. In the manuscript of my article, I did not make such a proposal. Instead, I questioned the defensibility of the CAS' regulation in terms of evidence of efficacy, relative safety, quality patient care and lack of physical touch; questions that Dr. Kitchen apparently feels do not warrant a reply. When I focused on the prohibition in Saskatchewan of the Activator, I also alluded to the activator's broad clinical utility and 'popularity among both practitioners and patients', making no mention of its popularity among students

Dr. Kitchen's attempt to denigrate the student investigative research projects described in my article is gratuitous and reprehensible. I take the strongest possible exception to his statement that the students were writing their reports "to achieve a passing grade in the hopes of reflecting the wishes of the marker". This statement impugns the academic integrity of CMCC's students, faculty and curriculum. For Dr. Kitchen's information, student grades were based on factors such as thoroughness of literature review and the use of an evidence-based approach to support their position, irrespective of whether or not it advocated inclusion or exclusion from the curriculum.

I believe that Dr. Kitchen is purposefully obtuse with respect to the degree of deference that must be accorded to the provincial government in Saskatchewan, and the purported inclusive nature of the regulation development process there. It is noteworthy that a group of chiropractors were successful in having the ban against the use of the Activator in Saskatchewan lifted in 2000. However, the CAS decided to appeal this decision and it was successful in having the ban reinstated 14 months later. Thus, it is inaccurate for Dr. Kitchen to suggest that the CAS is simply *following* the Chiropractic Act of 1994. Rather, it would appear that the CAS has been much more proactive in continuing the ban against instrumented adjusting then the letter from Dr. Kitchen would imply.

I would also ask Dr. Kitchen to explain if, by only permitting adjustments by hand, the CAS interprets the Chiropractic Act of 1994 as a prohibition against pelvic blocking, drop table and distraction table use (see letter to Dr. Corrigan above)? If not, then the Act and Bylaw may reasonably be judged by outside observers to be inequitably, and at the extreme, capriciously interpreted. If so, why pelvic blocking and not B.E.S.T. Technique or Toftness Technique or Spinal Stressology (each a form of manual chiropractic care but controversial nonetheless)? No matter how the issue is approached, the Act and Bylaw in their current forms promote inconsistency and confusion in the profession particularly when viewed from a broader North American perspective. Moreover, the CAS sets a dangerous precedent in this matter. An outside observer may now demand all health care decisions made by chiropractors in Saskatchewan meet impossibly high evidentiary stand-

ards, questioning those practice activities that are already accepted by a majority of practitioners in the field, their clinical practice guidelines and their professional regulatory body.

Dr. Kitchen's comments regarding the process by which the standard of care in Ontario pertaining to the Name Techniques permitted for use in clinical practice was developed requires clarification. The word-smithing I alluded to had nothing to do with ensuring eligibility of third party payer compensation (apart from refraining to refer to Technique Systems as 'experimental'), but had everything to do with ensuring that the standard was comprehensive, defendable and accurately reflected its regulatory intent. That is, the standard seeks to take reasonable steps to ensure that, if a practitioner is using a particular Technique in his or her private practice, the Technique must be taught in such a way as to ensure clinical competency. I believe that the CCO demonstrated considerable wisdom in this matter by removing the assurance of clinical competency from the hands of Technique seminar entrepreneurs and placing it in the hands of accredited chiropractic colleges, while avoiding singling out any one Technique to the exclusion of others. The CAS would do well to consider drafting a similarly constructed standard.

I have recently obtained and read with great interest a draft of the 137-page report titled 'A review of the literature pertaining to the efficacy, safety, educational requirements, uses and usage of mechanical adjusting devices' commissioned by the CAS. I found it to be a scholarly document with defensible conclusions based on a thorough and trenchant appraisal of the literature. Although the report is currently being prepared for official publication, its conclusions are well known and are in the public domain. I will briefly outline four of the more pertinent findings. The review committee concluded that there is sufficient evidence to support the statement that MAD (mechanically assisted device) procedures using the Activator are as effective as manual high velocity, low amplitude (HVLA) adjustments in producing clinical benefits and biological change (majority opinion 4 to 2). The committee also concluded (consensus 5 to 1) that the Activator is now being widely used by chiropractors for both spinal and extremity disorders, and has broad applications. Of greatest importance, the committee came to consensus (4 to 2) that the Activator is safe and has no more relative risk than HVLA procedures. The committee further stated that in all three of the above areas the literature was flawed to varying degrees and generally weak and that additional research is needed. That said, the committee members clearly stated that the literature was sufficiently robust to reach the consensus opinions outlined above. The committee could not come to consensus with respect to educational requirements. It should also be stated that after these findings were presented to the CAS in October 2002, a vote was held. As a result of this vote, despite the committee's conclusions, the Activator continues to be prohibited for clinical use in Saskatchewan.

I encourage all chiropractors to review the committee's report when it is published. I believe that it will stimulate more meaningful and informed discussion and debate about this issue that in turn will lead to a more rational and evidence-based (or evidence-informed) approach to the regulation of our profession.

Dr. Brian J. Gleberzon, DC
Associate Professor,
Canadian Memorial Chiropractic College

To the Editor:

Dr. Gleberzon made some excellent points about comparing diagnostic tests and procedures on an even and fair basis. Currently in Saskatchewan, the chiropractors have the problem of the provincial association (CAS) holding the activator technique to some higher or ideal standard when compared to other techniques and procedures. The CAS recently spent approximately $50,000 to fund a six-person committee to review the literature on the activator efficacy and safety. The report revealed a committee consensus (4 to 2) that … "the evidence in the literature support the statement that MAD procedures using activator are as effective as manual HVLA in producing clinical benefit and biological change." It is of interest to note that two members of your editorial board members were on the committee. (Dr. Mierau voted against recommending activator while Dr. Triano voted in favor).

Dr. Gleberzon's article points out "… guidelines must allow for flexibility for individual differences, in terms of ideological principles, diagnostic and therapeutic preferences, and individual preferences, whereas standards of care are authoritative statements that establish minimum

levels of acceptable performance." He also states that "… guidelines should be inclusive, patient centered and based on a variety of evidence and clinical experience." Note the references to "individual patient preferences" and "patient centered." In Saskatchewan, it appears that the CAS board refuses to consider patients' choice and/or preference.

Dr. Gleberzon specifically comments that he finds the situation in Saskatchewan "… particularly puzzling" and that "… the continued prohibition against the use of the activator by the CAS may not be defensible at this time in terms of an evidence-based approach."

It is time that more chiropractors speak up about this prohibition regarding activator. The public in Saskatchewan request and deserve the right to choose between a variety of treatment options. Despite thousands of letters being sent to the CAS office in the past, the board continues to ignore the public's request for increased treatment options. Even at the last provincial meeting the majority of chiropractors in Saskatchewan voted to change the bylaw that can be interpreted to prohibit the activator. However there was not the two-thirds majority required changing the bylaw, (61 yes – 34 no).

There have been harsh penalties imposed by the CAS board for practitioners implementing the activator treatment. Personally, I was fined $10,000 and had my license suspended for one week in 2002 for using the activator during a patient treatment. A number of other doctors have also been fined and/or suspended. I believe these are outrageous penalties for a procedure, which is widely used and allowed in every other jurisdiction in North America. What patients and many chiropractors in Saskatchewan want is a system that is egalitarian, rather than authoritarian.

Robert A. Simpson, DC
Saskatoon

To the Editor in reply:

I would like to thank Dr. Simpson for his letter to the editor, especially under what must be very difficult circumstances for him. I would echo his suggestion that chiropractors with an opinion or position on this matter should 'speak up' by way of submitting a letter to the editor of the JCCA. The intent of a 'letters to the editor' section of a journal is to promote a forum for the congenial exchange of ideas and, at times, the forceful expression of divergent points of view, albeit in a respectful manner. It is my opinion that an issue such as the prohibition against instrumented adjusting in Saskatchewan should prompt chiropractors to enter a scholarly dialogue in this section of the JCCA.

Dr. Brian J. Gleberzon, DC
Associate Professor,
Canadian Memorial Chiropractic College

To the Editor:

I would like to thank Dr. Gleberzon for his efforts in writing this article. I suspect that many of his comments will spark much-needed debate within the profession.

I would like clarification regarding an article that I co-wrote with Dr. Mierau several years ago, that is mentioned by Dr. Gleberzon.[1] In this article, we describe a case of a patient who had thoracic and scapular pain, allegedly due to the use of MAD. We wrote this article directly from court transcripts. In those documents there was no mention of any co-morbidities, yet Dr. Gleberzon describes the "eventual discovery of a rare tumor of the scapula which failed to respond to different surgeries". As Dr. Gleberzon fails to provide a reference for this information, and as it was not included in the original documentation of the case, I wonder if he might be kind enough to clarify his information, and references, for JCCA readers?

Reference

1 Nykoliation J, Meirau D. Adverse effects potentially associated with the use of mechanical adjusting devices: a report of three cases. J Can Chiropr Assoc 1999; 43(3): 161–167.

Jim Nykoliation, BSc, DC, FCCS(C)
Saskatoon

To the editor in reply:

Thank you for the opportunity to respond to the letter by Dr. Nykoliation. By way of clarification, the information he seeks comes from his own article in the JCCA,[1] as well as from the article by Drs. Carey and Townsend (standard of care example #4).[2]

References

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Dr. Brian J. Gleberzon, DC
Associate Professor,
Canadian Memorial Chiropractic College

To the Editor:

In response to the discussion of diversified adjusting and named techniques I would like to suggest that diversified is itself a named technique. If diversified truly were a diversified technique, then by definition, it would incorporate various aspects of other techniques in its attempt to offer a diversified approach. When we are asked to fill out association surveys we are asked what technique(s) we use and find "diversified" being listed amongst others such as Gonstead, Activator, upper cervical etc. Therefore, rather than viewing diversified as distinct from the so called "named techniques" it should be viewed as one of a number of techniques available to today's practitioner.

By limiting CMCC's students exposure to techniques other than diversified, I believe we are hurting our profession in several ways. First of all, if students' knowledge of chiropractic adjusting techniques is limited to just one technique then our graduating students are severely limited in their means by which to treat the varied range of conditions seen in practice (one of the major reasons we see so many practitioners studying other techniques after graduating).

Secondly, if the college deals only with one technique then chiropractic research aimed at determining better and more efficient ways of adjusting our patients and improving their health becomes very limited. Maybe instead of seeing research on turf toe or depression amongst students etc., we could see more research that is aimed at helping the field practitioner in dealing with patient cases. Wouldn't it be exciting to see research dealing with various techniques as to their scientific basis and support. For example, how about the neurological rational for upper cervical adjustments helping low back pain or the neurological basis of Logan Basic helping headaches, etc., etc. The possibilities are limitless.

Thirdly, I believe that taking a stance which only supports diversified technique, the college is in danger of affecting its future financial support from the field doctor. As the number of practitioners incorporating techniques other than diversified into their practice continues to grow there can be friction between what they do and what the college supports. This third point is true in my case. I have used several techniques other than diversified in my office during my 23 years of active practice, some of which are core curriculum courses in other accredited chiropractic colleges and which have a good research base and yet members of the college have "badmouthed" these techniques to my patients (this has happened on more than one occasion). Up until this time I had continued to support the college since graduation but have since severed such support. Why should I support, or send students to a college that by its philosophy and actions denigrates???????? the work I do in helping my patients.

Your coworker in serving the sick and suffering,

David M.B. Wilson, BA, BTh, DC

To the Editor in reply:

In many ways, a response from me to Dr. Wilson's letter is not necessary. I believe his letter makes several important points and Dr. Wilson may be speaking for a substantial segment of our profession. I agree that D/diversified technique can be considered as a Name Technique, although an argument can also be made that it is a generic approach to health care comprised on an eclectic assortment of diagnostic and therapeutic skills (see, for example 1). I would only add that some of the research articles he cites in his letter on topics such as turf toe or depression among students are also important to the enhancement of our profession. That said, I would echo his call for more studies exploring many of the issues he describes (neurological basis of Logan Basic Technique, neurological rationale for upper cervical adjustments and so on). I would therefore encourage Dr. Wilson, and perhaps other members of the chiropractic community who share his obvious passion for the profession and interest in providing quality patient care, to support or ally themselves with like-minded clinicians and individuals familiar with research methodologies in order to author case studies, case series

or to conduct the kind of practice-based studies he describes in his letter that are suitable for publication in peer-reviewed journals such as the JCCA. The overall net result would be the strengthening of the evidence-base of our profession: A goal, I believe, we all ultimately share.

Reference

1 Cooperstein R. On Diversified Chiropractic Technique: core of chiropractic or 'just another technique system?" J Chiro Humanities 1995; 5(1):50–55.

Dr. Brian Gleberzon, DC
Associate Professor, CMCC

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

To the Editor:

"The academic legitimization of chiropractic: the case of CMCC and York University," (JCCA 2002; 46(4):265–279) suffers from a host of difficulties and inaccuracies that could seriously affect its conclusions. For this reason, we have decided to enumerate and to respond to a few of the most egregious of these.

J. Paul Grayson attributes "politics" as the primary motivation behind the opposition to chiropractic at York University, that all disagreements between evidence-based and alternative medicine boil down to "turf wars." This is untrue. There are many compelling reasons why the Faculty of Pure and Applied Science (FPAS) rejected any form of merger with CMCC. It is not "medical sovereignty" that leads major universities all over the world to reject mergers with chiropractic colleges, but rather the failure of the chiropractic community to adopt a science-based approach in general.

For evidence that Canadian chiropractic is not unscientific, Grayson relies on an opinion of John Tucker that only 5% of chiropractors are "straights." Yet a survey by Biggs et al. (JCCA 1997; 41(3):145–154) demonstrates that fewer than 19% of Canadian chiropractors hold "scientific views," while 22% espouse views similar to D.D. and B.J. Palmer. Fold in other (chiropractic) survey results (e.g., "Job Analysis of Chiropractic in Canada", 1993, National Board of Chiropractic Examiners), that a significant number of contemporary Canadian chiropractors (most of whom were educated at CMCC) employ pseudoscientific modalities in their practice, continue to treat infants and children for a host of conditions that pediatricians dismiss as useless, and call for choice in vaccination – an official CMCC policy – and you have the tip of a proverbial iceberg that should immediately sink any serious merger discussions in an academic context.

We also stress that some of Prof. Grayson's historical reflections are very misleading. For example, the impetus for affiliation discussions was provided by CMCC and *not* York University. Prof. Grayson speculates wildly about a critical FPAS Council vote, intimating that the 30–13–1 vote to reject any type of affiliation with CMCC was not representative of actual sentiment within the Faculty. Here he is correct; a full vote would have seen a much more stinging rejection based on departmental votes that had taken place earlier within the Faculty.

Prof. Grayson flippantly dismisses the evidence cited in a letter provided by the Department of Physics and Astronomy by quoting a response from the School of Physical Education, Kinesiology, and Health Science which called the letter "anecdotal, fraught with selection bias, outdated, from non-refereed source, or just plain irrelevant." What he fails to mention is that a great deal of statistically significant, unbiased, current, refereed, and relevant evidence was presented testifying to the dubious nature of aspects of contemporary chiropractic, evidence that not a single merger proponent refuted in a scholarly manner during the "opposition phase" of the affiliation proposal.

It is distressing to us that even now, as is demonstrated by Prof Grayson's paper, misinformation, misperception, and misattribution prevail, in place of a serious attempt to understand the true nature of the opposition to the CMCC affiliation at York University.

M. De Robertis, Professor and Graduate Programme Director, Department of Physics and Astronomy.

J. Alcock, Professor, Department of Psychology.

D.K. Böhme, Distinguished Research Professor, FRSC, Department of Chemistry.

S. Jeffers, Associate Professor,
Department of Physics and Astronomy.

To the Editor in reply:

Thank you for the opportunity to respond to the comments made by De Robertis et al. on, "The Academic Legitimization of Chiropractic: The Case of CMCC." I will address each point in turn.

1 There is some evidence supporting the efficacy of chiropractic, there is some that is not so supportive. In view of conflicting evidence, we rely on our biases to make decisions. The decisions made by some scientists at York not to support an affiliation between CMCC and York were based, in part, on notions that allopaths are the experts in all aspects of health, i.e., 'medical sovereignty'. As a result, they accepted the arguments of some allopaths that were hostile to chiropractic. If advancing this argument means that I view politics as the prime motivation behind opposition to chiropractic at York, so be it.

2 I do not rely on the numbers of 'straights' vs 'mixers' as proof of the scientific validity of chiropractic. In fact, I don't really address the scientific stature of chiropractic. I do note that articles in various journals, such as *Spine,* certain chiropractic practices have been found to be efficacious. Nothing more. My reference to straights and mixers was in a footnote explaining why some chiropractic colleges in the US prefer not to associate with universities.

3 My source for saying that York approached CMCC this time round was Jean Moss, President of CMCC. Her assessment was not contradicted by individuals in the President's office at York who I asked to confirm that I had my facts right.

I don't know why reference is made to the fact that those voting in Science not to house CMCC represented a minority of scientists. I never claimed that were more to have voted that the decision would have gone the other way.

4 There may indeed be some good evidence against chiropractic. My point is that some of those opposed to affiliation appear to have been unable to distinguish between good and bad evidence.

J. Paul Grayson
Professor, School of Social Science
Atkinson Faculty, York University

To the Editor:

I commend and thank Dr. Grayson for his cogent and honest assessment of the negotiations between CMCC and York University. He had a front-row seat for this four-act play (Greek tragedy?) and it takes not only insight but courage to express the views he has. Would that many more of his colleagues had possessed these two qualities.

I also had a front-row seat for this drama, and my views are sympathetic to his, but also slightly different. One of Dr. Grayson's key points is that the so-called 'Gang of Four', in taking up the mantle of opposition to the affiliation, represented the antagonistic view of orthodox or "official" medicine, particularly, as he says, because there is no medical school at York. In other words, with no doctors on campus, these four had to jump into the breach to provide what would be perceived to be the traditional and expected medical resistance.

It is clear that this clique was influenced by a small number of MD's, notably Stephen Barrett and Murray Katz. Both of these long-time medical opponents appeared on campus at separate forums to express their views, and it is unreasonable not to suspect that they colluded with the Gang of Four around those appearances. As well, it is highly likely that each of these men provided material support for the battle: Barrett's web-site was cited frequently by the Gang; Katz's presentation notes were circulated, and the tone of each of these MD's was reiterated repeatedly in the Gang's own presentations and materials.

But the question is, did this kind of influence, and the sentiments it supported, fully explain the motivation and the actions of the York opponents? Was it just a matter of their acting as a mouthpiece for medical opposition and did they take their marching orders from the traditional "medical playbook"? I think more was at work.

While it is true that no MD's were directly available on campus to mount an opposition of their own, it was always striking that the leaders of this opposition were an astronomer, two physicists and a psychologist. Their common source was the Skeptical Society, one of whose Board members is Dr. Barrett. I began to read their journal, the

Skeptical Inquirer, and it became clear to me that what these professors were really doing, on behalf of their Society and the University, was defending science and its role at a modern university. Or at least, their view of it.

Historically, criticism of the chiropractic profession has been mounted chiefly by medical opponents, so it is understandable that one would describe such criticism in generic terms as "medical". In Canada, this criticism has been directed towards and has appeared in conjunction with the advancements of the profession in the areas of inclusion in Medicare, legislative and regulatory developments, participation in WCB's and other insurance plans, etc. There is also no question that medical opposition occurred against the previous attempts by CMCC to develop affiliations with universities in Ontario. No one could forget the role of Dr. Betty Stephenson in this respect. But none of these developments had gone as far as the one with York. Since 1996, the battleground has been the university environment, not the public domain, and, for the first time, university-based science faculty were drawn into the battle against affiliation.

My thesis is simply this: the Gang of Four perceived chiropractic as unscientific and, therefore, a threat to the integrity of science and to their reputation as scientists, both within the campus and in the scientific community at large. They saw themselves as defenders of science in a way that I would suggest was much broader and deeper than can be explained simply as traditional "medical" opposition.

One of the simplest ways to defend this thesis is to examine the view of medicine, specifically, and health care, in general, which was manifested by this group. I was always impressed by how naïve this was. These people seem to have adopted what I call the "mythology" of medicine as a totally scientific enterprise, with maximal standardization; in other words, as the 'gold standard' of health care. We would frequently remind them that only a minority of medical procedures (in the early 1990's this was cited as 15%; lately, it is a larger percentage) have been scientifically proven. We would remind them that all of health care is also an art and that chiropractic, unlike medicine, but far more like most other health care professions, included a wide range of approaches and many differing philosophies.

Their attitudes towards modern developments in complementary and alternative medicine were atavistic and completely out of step with the public's views (see: Eisenberg et al., and others for scientific data on this). They often sounded like pseudo- "Chicken Little's", crying that the sky would fall down. I say "pseudo" because the sky has already fallen and everyone else is moving on. They had a chance to seize the future, but they clung in horror to the past.

That a psychologist would hold this narrow "medicalized" view of health care was always very puzzling to me, given the incredible diversity of diagnostic and therapeutic approaches (and controversies) which exist in that profession. That an astronomer and two physicists could hold these narrow-minded views was understandable, only in that they have no training or expertise in this area. Unfortunately, humility was not one of their strengths, and they didn't let their lack of standing in this area get in their way.

I was one of only two CMCC representatives, along with Dr. Moss, to attend the Faculty Council Meeting of the Faculty of Pure and Applied Sciences (FPAS) at which they voted to reject affiliation. Once we were given the floor, a scientist rose and asked me, "what is the theory of chiropractic?". I first replied by asking, "what is the theory of medicine?". Then I explained that chiropractic science is based on many theories. For example, we use Newton's F = MA. Anyone ever giving or receiving a manipulative thrust knows that. I'm sure that the questioner had been previously told that there was, in fact, only one theory of chiropractic, and that it was developed in 1895 and that all chiropractors hold to this theory. Unlike in their "real" areas of science, no advancement in this field could be possible (or permitted?). My answer was likely received as disingenuous, at best, or, at worst, a lie.

In the York Senate Forum meeting, a faculty member asked the CMCC panel, "how do I get a cold?". I replied, "because you didn't wash your hands". My questioner appeared to be puzzled (and irked!). I told him that, in winter, we tend to stay indoors with many other people, the nasovirus is picked up on our hands from this close contact, transferred to the nasal area (I didn't specify how) and it develops an infection in the nasal mucosa.

On only one occasion, a faculty member rose and said about the modern chiropractic profession, "look folks, we're not talking about the phlogiston theory here; these people are a modern profession which has been recognized by governments for decades". These, and many other incidents, convinced me that what the York faculty per-

ceived was a deep and profound threat to their notion of the nature and integrity of science.

We were told that several faculty groups were quite favorable to affiliation, including the Fine Arts Faculty, with their oft-injured dancers, the Nursing School and others. When push came to shove, and these groups remained silent, we asked ourselves why this had happened. I believe that they deferred to the "scientists" in their midst. This says some very interesting things about the hierarchy of knowledge and the politics of academia at a liberal arts university. The scientists automatically assumed, and were granted, a position of dominance and authority. All "non-scientists" (but non-thinkers, too?) deferred to them, even when their appreciation of logic and a wider range of humanistic themes would have made their contribution invaluable.

When the small committee from FPAS issued their report on chiropractic, it was taken, even within the science faculty, as the authoritative word on the subject – "these scientists must know what they're talking about". If anyone had bothered to read this screed they would have found a document not worthy of their first –year students. Of eleven references cited in this report, eight were from internet sites. None of the 25 years of scientific conferences in chiropractic was mentioned. None of the scientific journals or texts in the profession were mentioned or cited. Scientific studies were cherry-picked to portray only a negative view of chiropractic – something one would never expect from objective and unbiased "scientists". Statements made by chiropractic academics were taken grossly out of context to denigrate the profession. Unscientific anecdotes and emotional opinions abounded.

No, the real message in this drama was not the impact of medical opposition, but the role that those purveying scientific authority can play in our society, even when it is practiced most unscientifically.

The Gang of Four played the strongest card they had. Dressed in the priestly robes of their caste, they warned the masses that the chiropractic heathens would defile their temple: "and their people grew fearful and cast out the disbelievers!".

York University does not have a chiropractic school today because a tiny cabal of small-minded faculty practiced their religion – scientism – to the hilt. They did so with all of the prejudice, vitriol and skull-duggery that other religions have brandished whenever they have been threatened. Professor Grayson and his colleagues need to ask, "what does this say about York University?".

Howard Vernon, DC, FCCS
Canadian Memorial Chiropractic College