Donald Campbell Sutherland DC, LLD, FICC, chiropractic statesman and diplomat.
JCCA 1999; 43(3):183–188.

To the Editor:

It was heartwarming to read the tribute to Dr Donald Sutherland in the September issue.

Your readers may also be interested to learn that Dr Sutherland was the first person ever honoured by the World Federation of Chiropractic for outstanding contributions to the international development of the profession. This was partly because of his efforts to establish a world chiropractic organization in the 1960s as mentioned in your article.

The World Federation of Chiropractic gives a maximum of three special honour awards at its Congress every two years and recipients to date have been:

1991 • Donald Sutherland, DC, Chiropractor, Canada
• William Kirkaldy-Willis, MD, Orthopaedic Surgeon, Canada
• Heinrich Buchbinder, Esq, Lawyer, Switzerland
1993 • Felix Bauer, DC, Chiropractor, Australia
• Walter Wardwell, PhD, Sociologist, USA
• George McAndrews, Esq, Lawyer, USA
1995 • Scott Haldeman, DC, MD, PhD, Chiropractor & Neurologist, USA
• KazuyoshiTakeyachi, DC, Chiropractor, Japan
1997 • Akio Sato, MD, PhD, Neurophysiologist, Japan
1999 • Andries Kleynhans, DC, Chiropractor, Australia

David Chapman-Smith
Secretary-General, WFC

Adverse effects potentially associated with the use of mechanical adjusting devices: a report of three cases.
JCCA 1999; 43(3):161–167.

To the Editor:

Case reports are an important contribution to the scientific literature. They are especially useful for identifying complications and risks of treatment, particularly if these events are rare or generally not well recognized. Unfortunately, the quality of case reports of complications following spinal manipulative therapy is poor. Fewer than 40% of the cases involving manipulative care have any description of the manoeuver.[1] Co-morbid factors in the patients, pre-incident status etc. are rarely reported. In general, information that might be useful for risk management is lacking.

Drs. Nykoliation and Mierau[2] while attempting to provide such information, are hampered by an imprecise thesis. It is not clear if these reports deal with incompetent treatment or with modality-specific iatrogenesis. The treater in the first case was found to be negligent, apparently due to a lack of clinical competence. The persistent, useless treatment in the second case appears due to poor case management skills rather than the mobility used to treat the patient. Indirect risk, as identified by the authors, is more probably a result of the practitioner's clinical skills (or lack of them) than a result of mechanical adjusting devices.

Neither Case 1 or 3 clearly demonstrate the relationship of treatment using an adjusting instrument with the subsequent adverse event. In Case 1, there is some doubt with regards to what exactly the treatment involved, as per the patient's claim of a "twisting motion". In Case 3, manual manipulation was done within one week and the instrument treatment was preceded by cervical traction. The lack of a clear mono-causal event, which is problematic in other reports, is not discussed by the authors.

What they do discuss appears rather disjointed: the use of 'excessive force', 'fail-safe' mechanisms, record quality, training and the implication that these instruments are novel and untested. Apart from the items taken from the cases themselves, it is unclear what evidence the authors are using to support these opinions.

This mix of fact and opinion obscures the valuable aspects of this report. Any treatment has an associated risk. The paradox of proposing that spinal manipulation (regardless of technique) has the capacity to influence healing, yet is devoid of risk is simplistic and irresponsible.

On an editorial note, I was astounded to see the use of initials for the chiropractors and patients in this report. This is inappropriate and is in contravention of the standards the JCCA is supposed to utilize.[3]

Cameron McDermaid, DC
Toronto, Ontario

References

1 Haldeman S, Kohlbeck FJ, McGregor M. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999; 24(8):785–794.
2 Nykoliation J, Mierau D. Adverse effects potentially associated with the use of mechanical adjusting devices: a report of three cases. JCCA 1999; 43(3):161–167.
3 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. JAMA 1977; 277(11):927–934.

To the Editor in reply:

Thank-you for providing us with the opportunity to respond to Dr. McDermaid's comments. We agree with most of Dr. McDermaid's comments – it seems he simply wants to reiterate (using different language) many of the main themes of our paper. His main point of contention is that he believes that much of what we say is more a matter of our own opinion rather than evidence-based.

We have two points of clarification that might help Dr. McDermaid and others to better understand our article. Firstly, the issues raised in the paper (such as the assertion that the "use of excessive force", "fail-safe", "record quality", "training", and "implications that MADs are novel") are NOT merely expressions of our opinion. Rather, ALL of these issues were raised, at one point or another, in the data that we analyzed in the formulation of this paper.[1] As the purpose of case reports is to raise new and interesting issues for the profession to further test and scientifically explore, we believe that reporting about these issues is important and valid. If the issue of direct versus indirect complications appears to confuse the facts within the paper, it is because that is how these cases presented themselves, not because we have taken the time to add our own opinions at will.

Secondly, Dr. McDermaid's letter implies that, by using initials for the chiropractors and patients, we have in some way contravened editorial standards, and more importantly, may not have fulfilled our obligation to confidentiality. His assertion in this regard is incorrect. We went to considerable lengths to protect the confidentiality of the parties involved in these cases – including CHANGING the initials of all the parties involved, and using the acronym "MADs" instead of naming any devices or manufacturers. We do not know what JCCA's standard is with respect to this issue, but as our paper was peer-reviewed and then accepted for publication, we assume our measures to ensure the confidentiality of the individuals involved were considered appropriate from the editor's perspective.

While discussing the topic of confidentiality, we should mention that we have had several requests from practitioners for the transcripts of Case One and Case Three. We obtained these documents from sources in the chiropractic insurance industry, and our understanding is that those cases, and other cases like them, are part of the public record. However, because our only aim is to report to the profession issues raised by these cases, to further ensure confidentiality of those involved in these cases we have decided not to be involved in distributing these cases. We are advising those individuals with an interest in cases such as these, to obtain information about adverse effects from chiropractic insurance sources directly.

We would like to reiterate that in our view, chiropractic treatment is safe in the majority of cases. Adverse effects, particularly vertebrobasilar artery insufficiency, seem to be rare, random events that are unpredictable, and not proven to be associated with one form of manual therapy more than any other.[2] The chiropractic profession must therefore approach the issue of potential adverse effects in a mature balanced manner, taking into account our limited understanding of the facts associated with these potentially tragic events.[3] We agree with Dr. McDermaid that stating a treatment approach is devoid of risk is "simplistic and irresponsible".

Jim Nykoliation, BSc, DC, FCCS(C)
Dale Mierau, BSPE, DC, MSc, FCCS(C)
Saskatoon, Saskatchewan

References

1 Nykoliation J, Mierau D. Adverse effects potentially associated with the use of mechanical adjusting devices; a report of three cases. JCCA 1999; 43(3):161–167.
2 Haldeman S, Kohlbeck F, McGregor M. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999; 24(8):785–794.
3 Cote P. Screening for stroke: let's show some maturity! JCCA 1999; 43(3):72–73.

To the Editor:

It seems that the more things change the more they stay the same in Canadian chiropractic. In the past, Nykoliation has expressed his view on Activator methods in JMPT in letters to the editor.[1] Although the authors state, "the intent of this article is not to identify MADS as dangerous," it comes across as such. I do not think a quality paper should come from selected pieces of information from trial transcripts. I have requested copies of the transcripts to see how selective they were in this process.

In regards to case one, it would seem the largest component for the case was the poor record keeping and substandard history and examination procedures, which of course does not relate to this doctor's choice of treatment techniques. It should be noted here that instrument adjusting (activator) involves a certain level of expertise for it to be safe and effective as does any other quality chiropractic technique. There are protocols and procedures, which are outlined in the activator textbook.

In case two, as it is purely anecdotal it does not merit comment, although it may have been included as the authors required an example for the "indirect complications" category defined in table one.

In case three, it appears that cervical traction and thoracic SMT were applied, yet the author states, "it is fairly clear the MAD was the only treatment provided and allegedly caused the incident." In this case, three procedures were performed, yet the authors wish to place full blame on the one procedure.

It is also interesting that the authors correlate a low number of MAD complications being a result of underreporting and data collection rather than the possibility they may indeed be safer. Also as an activator practitioner I do indeed "actually touch the patient" and know the state of the patient prior to the thrust being delivered. In terms of the "fail-safe mechanism", the activator has settings to regulate the precise force that is delivered. Perhaps the researchers can develop a fail-safe mechanism for the wrist, elbow and shoulder of the SMT practitioner so there may be some quantification of the thrusts being delivered to the patient during a manual adjustment.

In conclusion, I do not think activator is a "novel and untested therapeutic approach." In fact the authors would be well served to examine how much research has been done by Activator Methods in comparison to what is currently being done. Hopefully my colleagues can someday change their agenda and move chiropractic forward in both Saskatchewan and Canada.

T.J. McKay, DC
Calgary, Alberta

Reference

1 Nykoliation J. Letter to the editor. JMPT 1992; 15(3):210–212.

To the Editor in reply:

Dr. McKay believes that we have some kind of agenda against MADs, and therefore the conclusions reached in our article are not valid. We are sorry he feels that way, but we deny any such agenda; our efforts at protecting all parties involved have already been described. We wrote the article simply to point out to the profession the possibility of a safety issue that (so far) appears to have been overlooked.

The various co-morbidities that Dr. McKay mentions were acknowledged in the paper, and in our response to Dr. McDermaid. We have nothing further to add, other than to remind the reader, that no matter what the interpretation of the confounding issues might be, the courts in both Case One and Case Three found the practitioner at fault, and the MAD as the treatment that caused the injury.

Likewise, we have little to add to our comments about a "fail-safe" mechanism already described in the paper. The fact that Dr. McKay reaches out and touches someone in his office does not alter the concern raised about the possibility of excessive pre-load force applied by the MAD practitioner. We believe that further exploration of this concern is warranted.

Dr. McKay raises the issue of credentialization by private technique purveyors. Standards of care and who within the profession should credentialize such standards, needs to be addressed by the profession. There is little support for the idea that individual technique purveyors credentialize their own product.

We are grateful that Dr. McKay has an interest in further investigating the issue of MADs and the risk of complica-

tions from their clinical application. We look forward to seeing his findings published in peer reviewed journals.

We thank-you for allowing us the opportunity to respond to this letter.

Jim Nykoliation BSc, DC, FCCS(C)
Dale Mierau BSPE, DC, MSc, FCCS(C)
Saskatoon, Saskatchewan

Chiropractic in the next millennium.
JCCA 1999; 43(4):201–202.

To the Editor:

I was distressed to read David Peterson, D.C.'s commentary, "Chiropractic in the next millennium" (JCCA 1999 [Dec]; 43[4]: 201–202), in which he advocates "core non-negotiable values that as chiropractors we all agree on." Among these supposedly "non-negotiable values" Dr. Peterson includes "vertebral subluxations."

It is my understanding that "subluxation-simplex" is a widely acknowledged finding in spines, about which there is little dispute, but no established clinical significance. The VSC, on the other hand, is an unsubstantiated (largely untested) hypothetical construct, which proposes a clinically significant relationship between the subluxation-simplex and pathophysiology and/or end-organ dysfunction and/or symptoms. To the best of my knowledge, controlled trials demonstrating a relationship between subluxation-reduction/elimination and any subsequent improvement in health or relief of disease do not exist (at this time).

Whichever Dr. Peterson's meaning, I can see no logical reason for the chiropractic profession to make a (non-negotiable) commitment to subluxation. Such commitment is the opposite of the skeptical attitude of science, where theories are not accepted until they have survived very rigorous challenges (experiments), and even then are subject to revision or rejection if new data and/or better theory emerges.

I would hope that the president of the Chiropractic Foundation for Spinal Research would reconsider his rigid adherence to unproved concepts like the VSC. We need more investigation of chiropractors' traditional adjustive targets, rather than non-negotiable adherence to unsubstantiated hypotheses.

Joseph C. Keating, Jr., Ph.D.
Professor, Los Angeles College of Chiropractic
Homewood Professor,
Canadian Memorial Chiropractic College

To the Editor in reply:

I am also distressed to receive Joseph Keating's letter regarding my inclusion of the vertebral subluxation as a core value or non-negotiable for the chiropractic profession. It is obvious that Dr. Keating entirely missed the point of my discussion and in fact his rigid stance is an example of the mindsets that are driving the divisive science versus philosophy wedge into the profession.

My point was that if we hope to move forward united as a profession we need to establish common ground and principles that we as chiropractors can agree on. This may require some softening of strongly held viewpoints on all sides. The alternative is the ultimate division and further fragmentation of chiropractic.

It is academically debatable whether or not the vertebral subluxation is the best description of what chiropractors treat, however, it has been and continues to be an integral part of chiropractic philosophy and chiropractic terminology. If Dr. Keating is that distressed with the term I suggest he discuss it with his own college president, Dr. Reed Phillips who I assume signed the Association of Chiropractic Colleges' Chiropractic Paradigm in July 1996 which states under the heading of **Subluxation** in article four:

"Chiropractic is concerned with the preservation and restoration of health and focuses particular attention on the **subluxation**.

A **subluxation** is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.

A **subluxation** is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence."

Let's work to build our future together and not waste

time debating the semantics which will only divide us further.

David Peterson, D.C.
Calgary, Alberta

Chiropractic – positioning in the evolving health paradigm (Commentary).
JCCA 1999; 43(3); 136–141.

To the Editor:

The commentary by Dr. Doug Pooley was an interesting perspective on the so-called "manpower crisis" facing chiropractic in Canada. Although certainly the numbers of chiropractors are increasing the "crisis" label may be premature and alarmist.

Specifically, I would like to comment on Dr. Pooley's charge to the licensing bodies (pg.138). As a regulatory board Chair and former Registrar, I must point out that to take Dr. Pooley's advice would be outside of the responsibilities of regulatory or licensing bodies and thus unenforceable. Manpower is a professional issue and must be handled within the profession, not through restricting competent chiropractors from obtaining licensure. The responsibility of licensing bodies is simple ... to ensure public protection from unqualified or otherwise harmful practitioners. To limit the licensure of chiropractors based on an arbitrary number per population is not competency based and thus is not within the mandate of the regulators. Besides, who is going to decide on the best number – a professional who would like an exclusive market or the public who will be provided with more competent DC's from which to choose their care? As long as a standard of competency is ensured, the public will undoubtedly be the beneficiary of having choice in chiropractic services.

Wanda Lee MacPhee, D.C.
Chair, Nova Scotia Board of Chiropractors

To the Editor in reply:

I would like to thank Dr. MacPhee for allowing me opportunity to more fully explain my position with regards to the impending "manpower crisis". Recent study by the Canadian Chiropractic Association has demonstrated unequivocally that the profession is facing a dramatic rise in the number of practitioners entering practice, over the next ten or so years. This is not conjecture. The numbers of Canadian students currently enrolled in U.S. colleges, combined with those enrolled at CMCC and UQTR will potentially add upwards of 50% more chiropractors into the Canadian marketplace over the next 5 years alone.

Now, add the realities that: 1) utilization has increased only modestly over the last several or so years: 2) there is less available government funding for Chiropractic, and 3) the flood of other complementary and natural health care providers entering the health care marketplace. I would suggest that the facts point to the following as being a strong potential scenario:

– Greater competition for a shrinking wedge of the health care pie. (more practitioners entering into both the back pain and general natural health care marketplace i.e. massage therapists, naturopaths, homeopaths, natural therapists, reflexologists etc.)
– Potential for price cutting among chiropractors, often creating a "survival of the cheapest" scenario. (Simple mathematics demonstrates that if you divide lots more chiropractors into a modestly growing market, somebody goes home with less). I don't see this as good business.
– Creative marketing schemes. Most new chiropractors come out of college with huge debts. These debts have to be serviced and in an exceptionally competitive market, potential for desperation. History has demonstrated repeatedly that desperation often leads to less than acceptable professional conduct.
– All of the above serves to erode credibility with the public and other related health professions, and potentially relegate us again to the fringes of health care, a position which we have fought for over a hundred years to work through.

Now, if you do not see the storm clouds forming on the horizon, perhaps you should look again. To state that "***the public will undoubtedly be the beneficiary of having choice in chiropractic services***," because there are more chiropractors would be akin to saying that more doctors makes for better health. There have been studies that have indicated otherwise. Purchasing health care services is not

like buying mittens, where the more stores selling mittens makes for better consumer choice and better buys. The health care market has to be stringently monitored to ensure the consumer, who for the most part, is forced to trust that services offered are fair and appropriate, is not taken advantage of.

To the issue of which body should be responsible for addressing this impending manpower crisis; this issue has been treated by the various political bodies within the profession, like a scene from Abbott and Costello's "Who's on First". It is most definitely the responsibility of the licensing bodies. It has been my experience to date that nobody really wants to deal with this issue, each political body within the profession taking the Pontius Pilate attitude, of attempting to wash their hands of the issue, claiming that it falls outside their respective jurisdictions.

I would like to note, that when medicine and dentistry were faced with a "manpower" problem, it was the regulatory bodies that took action to limit billing numbers, and restrict foreign graduates. Whether the chiropractic licensing boards choose to see it as their responsibility or not, for reasons mentioned previous, this is potentially both an issue of public safety, and professional conduct. No other representative body within chiropractic has the ability or authority to deal definitively with these issues. As such, if you do not currently have clear authority in this area, you now have a responsibility to secure it. Let me assure you, that if this issue does in fact mature to crisis, both the public and the profession will be looking to you for the answers to why control was not exercised when it should have been.

"Responsibility is a pair of shoes that always seems to fit the other man better" – Will Rogers

Douglas L. Pooley, DC
St. Thomas, Ontario