Philosophy of chiropractic: lessons from the past – guidance for the future. JCCA 1990; 34(4):194–205.

To the Editor:

Dr Donahue has no doubt provoked much discussion in professional circles with his article on the "Philosophy of Chiropractic" JCCA 1990; 34(4):194–205.

I must agree with him on many aspects of his paper. Indeed his call for raising philosophical debates beyond the level of "peptalk" is timely. In the last few years there has been a greater willingness to discuss chiropractic philosophy. Initially this has revolved around its negative aspects. While chiropractic needs to promote itself as a "profession" this is likely to continue.

My two comments about Dr Donahue's paper reveal the close link between the defense of chiropractic as a profession and the acceptibility of philosophical debate.

Firstly with regard to the comment that chiropractic:

"Should remain a primary portal of entry for the health consumer."

I agree that this should be possible. But we should look at the legacy of this objective. It is my opinion that by supporting "prime contact status" there has been a depletion of the resources of this profession to the extent that the clinical sciences have failed to develop positively. This sad state of affairs has provided a fertile ground for entrepreneurs to promote flimsy procedures theories based, at best, on uncontrolled single case studies.

The renaissance of "straightish" philosophy is a reflection of the profession's need to redefine itself in todays world to reflect the aspirations of its practitioners, researchers, academics and students.

And secondly the comment that:

"The general consensus seems to favour remaining a separate and parallel profession to medicine." I submit that this sentence is contradictory because "medicine" is a generic term.

If chiropractic *can* be defended as being separate from medicine then it *must* also be parallel. This strengthens the argument against chiropractic because *parallel* implies parallel on *all* aspects of health care including the unquestioned treatment of visceral disorders and treatment of trauma.

I support chiropractic becoming a limited discipline because if chiropractic theory is right: i.e. "the body heals itself" once optimal spinal musculoskeletal function is achieved (through subluxation reduction?) then the treatment of visceral diseases is subsumed within the goal of optimising spinal function. I am lead to conclude that separate and parallel are not realistic options to advance the profession. Such a choice is most likely to result in diminishing the role of chiropractors in the community. Other options which are more realistic would be for chiropractic to become a medical specialty such as dentistry. Such an option is an imperative since medicine is developing its own specialty of musculoskeletal medicine so that not only are we alternative but also duplicated.

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To the Editor in reply

I appreciate Dr Bryner's remarks on my paper and his posing some thought-provoking opinions.

Dr Bryner's opinion, that by supporting "prime contact

status," has led to a "a depletion" of the profession's resources such "that the clinical sciences have failed to develop positively," is dubious. This is no substantial connection (in terms of "resources") between the nature of "contact status" and science activity.

By "resources" I assume is meant money, in particular, but also man-hours, brain-power etc. The problem with this reasoning is that chiropractors have squandered their resources at all sorts of bogus seminars, on worthless books etc. These wasted resources are separate from those utilized in "supporting prime contact status." The real problem with the lack of development of our clinical sciences is largely a philosophical one.[1] On the whole, chiropractors (and their institutions) do not have a good philosophical grasp of the purpose and use of science. Such a "grasp" comes from an understanding of philosophy of science. Therefore, even if the profession had unlimited resources, it would still result in the same paucity of clinical science.

Unlike Bryner, I believe clinical entrepreneurs have historically filled a void. Considering the poor state of our colleges over most of the profession's history, chiropractic would not have survived without technique systems. It is easy to blame technique "gurus" for a lack of scientific data but what clinical science (and in what clinically useful format) did the colleges typically provide? Too often the colleges provided a hodge-podge of ways to adjust, diagnose etc. but without an underlying system to make it all work well in the field. Without a technique system to guide him/her, the chiropractor was very likely to fail in practice. In many ways, chiropractic technique systems are necessary heuristic devices. Naturally, today, we must expect and demand proper research into techniques. But, we can hardly expect chiropractors to be part of the process and utilize their "resources" in support of clinical science if they are functional scientific illiterates.

Historically, because of the attacks by organized medicine, chiropractic has had to be a political animal first. And, without "prime contact status," chiropractic would not exist today. In the first decades of this century, chiropractors had to compete for patients in a very different health environment. Patients suffering from a subluxation would likely interpret their symptoms in ways that are foreign to us today. For example, what today are seen as musculoskeletal problems would, in those times, have been interpreted by patient and doctor alike as a visceral, humoral or digestive condition. Intercostal neuritis would have been interpreted as a heart condition; sciatica was rheumatism; headache was "poor" blood. Therefore, early chiropractors could not have "limited" their scope and survived. One unfortunate result of our political activities is that our successes in that arena have led to the belief most of our answers are political (some obviously are) or require better public relations. Joseph Keating, Ph.D. has shown how "uncritical rationalism" and "uncritical empiricism" were used in the political arena to good effect.[2] Unfortunately, as Keating notes, these two misguided "philosophical" approaches have been our scientific undoing both in the colleges and in the field. Chiropractors, lacking adequate scientific training, fail to understand the difference between the quasi-science of uncritical empiricism (e.g. untested but biologically plausible theories) and real science.

I do not understand Bryner's point about "straightish" philosophy. Is he saying this philosophy is a useful "reflection of the profession's need to redefine itself?" If so, I think not. If the point is that this "renaissance" is an honest but misguided attempt to resurrect some badly needed professional meaning, I agree.

As to the second quote of mine, relative to my use of the word "medicine," I assumed the meaning was clear from the context. I meant "main-stream medicine." Except in certain limited, and usually stipulated senses, when we use the word "medicine," in the United States at least, we mean main-stream (often allopathic) medicine. Obviously, yes, "medicine" can refer to generic medicine of which chiropractic is a part.

I am puzzled by what Bryner means by the "argument against is strengthened," if chiropractic assumes a parallel stance relative to main-stream medicine. What argument? . . . and, by whom? And, why must parallel imply parallel on *all* aspects of health care? If our profession rejects surgery, for instance, what "parallel" could there be to most types of surgery? Furthermore, if our profesison accepts the "limits of matter" as a point of demarcation between its "scope" and main-stream medicine's, what parallel option need it develop for many types of trauma cases?

I cannot fathom why Bryner feels the need to limit the profession. Why shouldn't we maintain our legislative leeway for future scientific development and growth? Such doors, once closed, will be very difficult to reopen. We can stay as "limited" as we want until such times as our expertise and desire leads us to expand our "parallel" activities relative to main-stream medicine. At any rate, the public largely recognizes and uses us as a profession limited to certain musculoskeletal conditions. While it's sensible to build on this foundation, there is no need to be limited by it in the future. After all, what if present-day "chiropractic theory" is wrong about the importance of the nervous system, in a wide variety of visceral diseases? Why shut the door on better and/or alternative theories in the future?

What is to keep medicine (especially physiatrists and physical therapists) from continuing their development even if we do join the "medical club" as a limited specialty? Their "inside" position could easily dampen and eventually minimize our efforts to become a specialty.

What is most troubling is that Bryner is surrendering the chiropractic paradigm/perspective without its hardly being tested.[3] What makes anyone think our theories, much less our paradigm, would last five minutes if it were incorporated into the medical field. Main-stream medicine, however powerful, has no monopoly on truth or science.

I believe Bryner and I both feel that chiropractic has come to a time when she faces some hard decisions that will effect her very existence. Chiropractic needs sound philosophical thinking to

pull it through. Whatever we do, it won't be easy. I happen to believe in the chiropractic paradigm/healing perspective. I refuse to surrender it for limited medical status or any other second-rate role. As my old basketball coach used to say: "When the going get tough, the tough get going." We chiropractors have proven our political toughness over the years. I just wonder if we'll demonstrate the intellectual toughness we'll need to pull us through this time around.

References

1 Keating JC, Sawyer CE. Which philosophy of chiropractic? J Manip Physiol Thera 1988; 11(4):325–328.
2 Keating JC. Rationalism and empiricism vs. the philosophy of science in chiropractic. Chiropractic History 1990; 10(2):23–30.
3 Coulter ID. The chiropractic paradigm. J Manip Physio Ther 1990; 13(5):278–287.

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Systems for classifying the acceptability of clinical treatment methods. JCCA 1991; 35(1):13–16.

To the Editor:

I found Dr Keating's paper (JCCA, Vol. 35, No. 1, March 1991) to be thought provoking; he quite rightly asserts that no method can rigorously simplify the fundamentally human activity of evaluation. I am intrigued by his "multicomponent classification system" and would like to respond to his call for discussion by commenting on two of the major issues that he addresses.

We should all appreciate that Keating has clearly delineated the beginnings of empirical science with his "clinical-experimental" category; this is important for emerging scientific disciplines like chiropractic. For me the toughest problem faced in classification reduces to a question of whether or not a system of evaluation should identify differing levels of being "unsubstantiated". In my personal interpretation of the model produced at WSCC, I feel that most of Keating's "quantitative pre-experimental" classification criteria fall within our "measurable observations" section. During the creation of the original model at WSCC, we did wrestle with an empirical path to "provisional acceptance", but elected to employ a rationalist approach to achieve this interim status; we believed that provisionally accepted ideas ought to possess a measure of basic science consistency. I submit to Dr Keating the concept of *differing levels* of our "experimentation and testing" as a solution to the empirical route to knowledge. Should there be a path to provisional acceptance for procedures that have not outright failed a simple yes or no discrimination at experimentation and testing? Might there be a provisionally acceptable state for procedures that only have a limited pool of controlled studies? This has been an ongoing concern of a group of us at WSCC, and we are entertaining a modification in our original schema to address this problem.

My second point revolves around the consensus process. I believe that the profession should be *very* careful in going down what Keating terms a "clinical use/acceptance" pathway. We have in the healing arts and sciences all too often seen the potential folly in affirmation by consensus (e.g., the use of procedures and medications found to be ineffective although in widespread use). Having said this, I agree with his suggestion that "extensiveness of use" be somehow incorporated into a classification process . . . afterall, is it not the purpose of classification to identify the status of a particular procedure? We must simply be careful. We must all clearly recognize that extensiveness of use is not a form of scientific validation, and I am sure that Keating would strongly agree that the use of a particular procedure may well have no relationship to its clinical-experimental status.

In the end, I am greatly stimulated by Dr Keating's attempt to formulate a multicomponent classification system. And, although I would like to see his scheme a little "tighter" (with specific requirement protocols), his offering that addresses philosophical, scientific, and social issues should make the profession pause and think. Chiropractic must expeditiously develop a way of knowing itself and evaluating its own new (and old) ideas.

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To the Editor in reply

My thanks to Mr. Kaminski for his thoughtful reply. I am essentially in agreement with the comments he makes. I would merely add that the classification schemes I offered are intended more as a descriptive organization of the judgements/labels already being applied to various chiropractic methods, rather than as a suggestion of the classifications that ought to be made. Indeed, there may well be additional dimensions along which treatment procedures might be grouped, and there may be additional sub-categories that need to be added (or deleted). My principal concern and motivation for submitting the manuscript has been the indiscriminate mixing of dimensions in characterizing the status of various chiropractic methods.

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