THE CHIROPRACTIC REPORT

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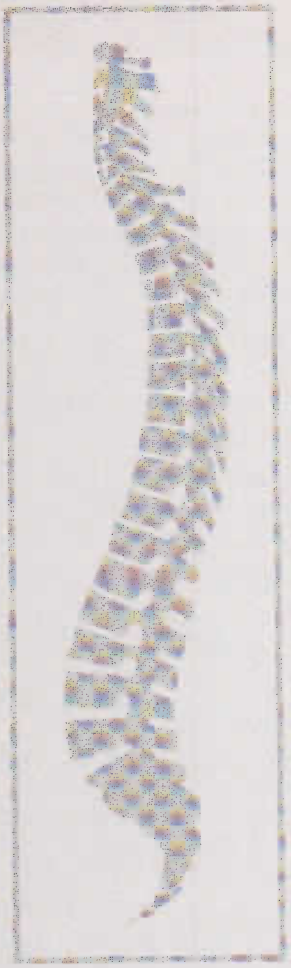

Points

• The 'Back Power Program' by David Imrie MD and Lu Barbuto DC has just been re-published in the U.S. in paperback (John Wiley & Sons, New York $9.95). It is expressly endorsed and sponsored by the U.S. National Safety Council and the American Chiropractic Association. The program has been such a success that the book has been made a Dividend Selection by the Book-of-the-Month Club.

This program, which combines chiropractic and medical principles for the prevention and management of back problems, focuses on function rather than pain and is now in wide use in industry in the United States and Canada. It was first published in 1988. (Stoddart Toronto. See review in May 1988 issue of The Chiropractic Report, Vol. 2 No. 4).

• How do you measure the functional status of patients with low back pain? Richard Deyo MD MPH addressed this subject at the Conference on Validation of Chiropractic Methods held in Seattle March 2-3, 1990 – and a paper summarizing his expert and readable views appears in the August 1990 issue of Chiropractic Technique (Vol. 2 No. 3:127-137. This is a reprint from the Archives of Physical Medicine and Rehabilitation 1988; 69:1044-1053).

Deyo, Director, Health and Safety Research and Development Department, Seattle VA Medical Center, Washington, has become one of the most prolific and

continued on page 3.

MEDICAL REFERRALS – Signs and Symptoms of a New Era

A. Introduction

1. The relationship between medicine and chiropractic is still colored by the rhetoric and practices of days gone by, but medical acceptance of chiropractic has risen dramatically during the past ten years.

A new study by Patel-Christopher MD at the University of Toronto[1] reports that in the province of Ontario (population 9 million, 1700 chiropractors):

• A clear majority of MDs in family practice (62%) are now referring patients to chiropractors.

• The rate of referral is steadily increasing.

• 9.5% (1 in 10) of these MDs receive chiropractic care themselves. Those that do not refer feel a "definite need" for more information on chiropractic and for "a more positive and improved relationship."[2]

2. In some jurisdictions the level of cooperation will be higher, others lower. Either way this new survey will be of interest because it addresses factors that promote or limit referral of patients between chiropractic and medicine, and most of these are universal.

Accordingly this Report discusses the Ontario study, then comments on factors relevant to improved understanding and cooperation.

3. The time is right for such a discussion, given the wide publicity accorded to the trial recently published in the British Medical Journal (June 1990)[3] concluding that chiropractic management of back pain, especially severe and chronic pain, was markedly more effective than medical and physiotherapy management. (For full discussion of the British trial see the July 1990 issue of this Report).

Nearly all MDs place the interest of their patients above interprofessional rivalry, and many will be encouraged to refer patients for chiropractic treatment now that chiropractic has opened itself to independent scientific scrutiny and produced such impressive results. To quote two respected voices:

• A Lancet editorial[4] written following review of the BMJ trial asks whether such a "strong and clear advantage for patients treated with chiropractic" requires "revision of the conventional medical view of chiropractors", and answers yes – "chiropractic treatment should be taken seriously by conventional medicine, which means both doctors and physiotherapists."

• In the U.S. the Harvard Medical School Health Letter (September issue)[5] gave the BMJ trial results front page treatment. Describing the trial as "tightly designed" and "carefully executed", it reports:

"... the new study, which was larger than previous ones and involved longer periods of follow-up, supported treatment in chiropractic clinics as more effective than in medical clinics."

Improved standards in chiropractic education, practice and research in the past generation have plainly been factors in growing cooperation. The BMJ trial will enhance that process. However old habits die hard and some members of each of the chiropractic and medical professions will require attitudinal adjustments if patients are to get the care they deserve.

B. Ontario Study

4. Patel-Christopher's study, entitled "Family Physicians and Chiropractors: A Need for Better Communication and Cooperation"[1] was completed in May 1990 for her postgraduate certification in family practice at the University of Toronto. It appears to be the most thorough survey of referral patterns between medicine and chiropractic yet performed.

• The study included two surveys in October 1989.[6] The first was of 99 MDs in family practice (response rate 42.4%), and was designed to "reveal the referral patterns of family physicians to chiropractors" in Ontario.

• The second survey, of 80 chiropractors (33.8% response rate), had a wider aim – "to gain an understanding of the chiropractic profession", including referral patterns.

• To be representative the surveys included practitioners in rural, small town and urban settings.

Results relevant to referral

5. a) 61.9% of MDs surveyed referred patients to DCs. However nearly half of these (42.3%) had only been referring for 1-5 years.

b) Interestingly, referral rate was slightly higher amongst MDs who graduated before 1960 (60%) and between 1960 and 1980 (65%) than those who graduated in the past 10 years (53.8%).

Whatever the factors, referrals are coming from MDs regardless of age and length of

time in practice.

c) 7 in 10 (69.2%) of MDs referring had increased their rate of referral during practice.

d) 87.5% of those referring referred 1-5% of patients, the great majority of whom had musculoskeletal pain – about half acute, half chronic.

There were very few pediatric referrals, children comprising only 2.4% of all referrals.

e) Geographical area did not influence referral patterns. However proximity of MD to DC was a highly significant factor. "All MDs with a DC or massage therapist at their place of work referred to a DC."

MDs in solo practice tended to refer more often than those in group practice.

f) The survey identified "the belief that DCs treat organic disease through manipulation" as "the major drawback to the acceptance of chiropractic treatment."

How significant is this? The most usual reasons given by MDs for discouraging referral of patients appear in Table 11 – reproduced as Figure 1.

It will be seen that for those MDs currently referring or open to referral – i.e. those most disposed to cooperation – 82.8% are critical of the claims of chiropractors to treat too wide a range of conditions including organic disease. (Fig. 1 Part 2a and b).

The next most frequent concern – high call-back – is only 18.2%.

g) Other factors cited that discouraged referral fall into two categories:

i) Matters arising from lack of information and communication. For example:

• *Chiropractors are not scientific*. This claim has been rejected by modern government inquiries into chiropractic.[7,8]

• There is now more evidence supporting chiropractic management of back pain, which comprises approximately 80% of chiropractic practice, than any medical approach.[9]

• *Patients are over-xrayed*. The evidence is that, for similar conditions, medical patients receive more frequent and higher x-ray exposure. The only large government study of x-ray utilization rates in Ontario was initiated because of indiscriminate over-use in hospitals,[10] and a recent British study reported the staggering fact that 89% of patients attending the orthopaedic clinic at the Royal Infirmary, Glasgow had unnecessary repeat spinal x-ray exams.[11]

• *DCs give bad information*. There is no evidence to support this perception. On the contrary, it was a major finding of Cherkin Ph.D. and MacCornack Ph.D. in 'Patient Evaluations of Low Back Pain Care from Family Physicians and Chiropractors'[12] that a clear reason for high patient satisfaction with chiropractic care is the level of good information given by chiropractors, leaving patients able to better understand and manage their conditions.

These are matters where perception and reality differ – where there is lack of understanding and communication.

ii) Other market factors. For example:

• *Costly to patient*. In some circumstances in Ontario there is no direct cost to the patient on referral for physiotherapy, whereas there is a direct charge for part of the cost of chiropractic care.

• *Bad experience with DCs, and high call back*. Some chiropractors over-treat. Some are so fervent for chiropractic that a cooperative relationship is difficult. If an MD has bad experiences on his/her first attempts at referral this will plainly discourage further efforts at cooperation.

Fig. 1: Reasons Why MDs Discourage the Use of DCs

Reason	Response
1. **Always discourage the use of DCs**	17.1%
a. Bad experience with DCs	28.6%
b. DCs are not scientific	28.6%
c. Physiotherapy is better	14.3%
d. DCs should not treat organic disease	14.3%
e. DCs don't help enough	14.3%
f. Costly to the patient	14.3%
g. Patients are over x-rayed	14.3%
h. High call back of patients	14.3%
2. **Sometimes discourage the use of DCs**	26.8%
a. DCs good for limited conditions	54.5%
b. DCs should not treat organic disease	14.3%
c. High call back of patients	18.2%
d. Bad experience	9.1%
e. Only refer to respected DCs	9.1%
f. DCs use herbal medicine	9.1%
g. DCs give bad information to patients	9.1%
h. Patients are over x-rayed	9.1%
i. Patients are over manipulated	9.1%

• *Availability of perceived better alternative care*. It is of interest to observe that no MD surveyed who was referring patients to chiropractors saw physical therapy/ physiotherapy as a comparable service, or better. (See Fig. 1 Part 2). However 14.3% of those *not* referring to chiropractors did.

Virtually all chiropractors surveyed (96%) identified "lack of information on chiropractic" or "lack of communication between MDs and DCs" as reasons why more MDs did not refer. As can be seen above that is partly correct, but gives too little recognition to other market factors.

MD suggestions

6. MDs generally expressed a "definite feeling of need ... for the development of a more positive and improved relationship" with chiropractors. Specific suggestions by MDs included:

• More training about chiropractic in medical school. (In some North American medical schools there is now a health team segment in the curriculum – audiologists, chiropractors, dentists, midwives, optometrists, and others are invited to present lectures on their professions, where they fit into the health team approach, and when and how to refer patients. Such initiatives should be encouraged).

• More joint medical and chiropractic meetings. (Many practitioners are doubtless unaware of how many joint meetings there are today. Anyone interested is highly recommended to attend a meeting of the American Back Society which has achieved success in bringing together leading professionals from all disciplines with an interest in management of back pain. Upcoming meetings are in Toronto (May 1991), San Francisco (December 1991) and New Orleans (May 1992). Further details from the ABS, 2647 East 14th St., Suite 401, Oakland, CA 94601 U.S.A., Tel: 415-536-9929, Fax: 415-536-1812).

• More visits by MDs to chiropractic offices to gain a better understanding of what chiropractors do.

This is recorded as a common suggestion by MDs surveyed. Chiropractors would obviously do well to oblige.

Conclusions

7. Many interesting aspects of the surveys have not been discussed here. For example,

continued on page 4

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respected researchers into back pain during the past decade. His latest trial, published in the New England Journal of Medicine, reports that TENS has no therapeutic value beyond placebo effect. (Deyo RA, Walsh NE et al (1990) 'A Controlled Trial of TENS and Exercise for Chronic Low Back Pain', N Engl J Med 322:1627-34).

It is obviously important that leading medical spinal researchers are familiar with chiropractic and its research effort. It is good, therefore, to see that Deyo is one of the expert panel members chosen by the Consortium for Chiropractic Research and RAND for a panel assessing the appropriateness of chiropractic manipulative therapy for low back pain as part of the CCR/FCER standards of care project.

(Other panel members are Tom Bergmann DC, Peter Curtis DO, John Frymoyer MD, Scott Haldeman DC MD Ph.D, Tom Hyde DC, John Triano DC, Sam Weinstein DO and Sam Wiesel MD.)

• Sam Wiesel is Professor and Chairman, Department of Orthopedic Surgery, Georgetown University Hospital, Washington DC. He is a prominent spinal surgeon and researcher, and his extensive publications include research suggesting that about 40% of people over age 40 have disc herniations but remain pain-free and healthy. Abnormal pathology alone is insufficient cause for surgical intervention. ('A Study of Computer Assisted Tomography: The Incidence of Positive CT-Scans in a Asymptomatic Group of Patients', Spine 1984, 9(6):549-551).

Wiesel is one of the keynote speakers at the 1991 World Chiropractic Congress in Toronto, April 30-May 5, 1991. (See advertisement). He will be speaking on the differential diagnosis of spinal disorders.

• With the legal merger of Australia's two national chiropractic associations on September 21, 1990 chiropractic in Australia is in strong shape to meet the future.

The new national association is called the Chiropractors' Association of Australia. The former organizations were the Australian Chiropractors' Association (traditionally comprising chiropractors trained in North America and latterly the Phillip Institute School of Chiropractic in Melbourne), and the United Chiropractors' Association of Australasia (traditionally comprising chiropractors trained in Australia – at the Sydney College of Chiropractic and various earlier institutions for chiropractic and/or osteopathic education).

Consortium for Chiropractic Research

The Foundation for Chiropractic Education and Research (FCER), established in 1944, remains the profession's major research foundation in the United States. It is supported by, but is legally independent from, the ACA which provides approximately 20% of donation income. Steve Wolk Ph.D is its current Executive Director.

FCER is now managing the comprehensive standards of care research being conducted by the RAND Corporation in conjunction with UCLA and the Consortium for Chiropractic Research. (This process involves analysis of current data, much new research, and expert panel consensus meetings. It will take several years and cost $2-3 million. At its 1990 AGM the ACA authorized expenditure of a further $250,000 for this continuing work).

The Consortium for Chiroractic Research (CCR), which generated the intial momentum for and is engaged in much work on this ambitious project, was only founded in 1985. It is much newer than FCER but already a major force in chiropractic research.

• Initially it was primarily Californian and named the 'Pacific Consortium for Chiropractic Reseach'.

• It was jointly founded by the research arm of the California Chiropractic Association (the California Chiropractic Foundation) and the six west coast chiropractic colleges – with the aim of producing a strong and coordinated research base through combined resources.

• Its new name reflects the fact that it has become a national foundation, with chiropractic college, state association, and individual DC members throughout the US.

For further information contact Robert Jansen, Ph.D., Executive Director, CCR, 1095 Dunford Way, Sunnyvale California, 94087. Tel: 408-983-4067.

Benefit of a Chiropractic Evaluation – A Striking Example

'Mechanically Induced Pelvic Pain and Organic Dysfunction in a Patient without Low Back Pain', Browning JE (September 1990) JMPT 13(7):406-411. The last issue of this Report (September 1990) looked at the well documented case of an elderly man under medical, optometric and chiropractic care who regained his vision because his optometrist considered a chiropractic evaluation. The chiropractor, of course, also had a significant role.

This case report, one of a series of similar cases submitted by Browning during the past two years, involved a 39 year old woman who had suffered chronic pelvic pain and multiple organ dysfunction for over 20 years – since age 18. It is noted:

• She had a lengthy history of severely painful menstruation, continuous diarrhoea, recurrent bladder and vaginal infections and anorgasmy. Because of her difficulties she had three complicated pregnancies, including one terminated by spontaneous miscarriage at 5-1/2 months.

• Misdiagnosis of her problem between 1969 and 1985 resulted in 13 operations including an appendectomy, a partial hysterectomy, 5 bladder surgeries and 3 exploratory bowel surgeries.

• Apparently because of the absence of back pain as a symptom, none of her many medical specialists considered a spinal examination.

• The patient was referred to Browning by a former patient who had received relief from similar pelvic pain and organic dysfunction.

• Following examination the chiropractic diagnosis was central L5 annular protrusion with bilateral lower sacral nerve root compression, and secondary pain and organic dysfunction.

• On a treatment regime of daily distractive decompressive manipulation, cryotherapy and use of rest, exercises and a lumbosacral appliance, "this patient exhibited rapid and complete recovery of her symptoms ... although (they) had been of a severe and long-standing nature."

Most of the patient's symptoms – which are itemized in the report – showed initial response by two weeks. Normalization was between 4-10 weeks depending upon symptom.

many surmise that chiropractic is a more closed profession than medicine, with lower educational standards.

This study reports that only 1 in 5 chiropractors (19.2%) have a relative in the profession, whereas 1 in 2 of MDs (53.7%) have a relative in medicine, and Patel-Christopher, a recently trained MD in Toronto who has made a close study of medical and chiropractic training in her city, concludes:

"MDs and DCs use very different modes of treatment. However, *both professions are very similar with respect to their educational background and their clinical training*. Demographic characteristics were not significantly different between the MDs and DCs." (pg.58).

8. On referral, this study shows that a majority of MDs are now referring patients for chiropractic treatment, makes it clear that the process is relatively new and that there is great scope for increased cooperation, and clearly identifies factors that inhibit cooperation.

It is strongly in the patient's interest that there be better cooperation. How can this best be achieved?

C. Promotion of understanding

Scope of Practice

9. The Ontario study, in identifying 'treatment of organic disease by manipulation' as the major barrier to cooperation and referral, and in putting this issue far above all others, merely confirms long standing evidence. Critics of chiropractic before government inquiries have always centered their argument against the profession on treatment for conditions remote from the spine, usually with good effect. Thus a recent Australian government inquiry:[8]

a) Divided chiropractic practice into Type M ("disorders whose symptoms are mainly local pain either of spinal origin or in closely related areas such as headache") and Type O ("concerned with organic or visceral disorders such as peptic ulcers and hypertension").

b) Was strongly supportive of chiropractic education and practice and management of Type M conditions, which made "public funding of (chiropractic services) an attractive proposition".

c) Then concluded, however, "the continued claim by chiropractors to be able to treat Type O conditions is a major obstacle to us making any recommendations for public funding of chiropractic services in general."

As a result, funding for chiropractic was recommended in the context of public hospitals and community health centres only.

10. What should chiropractors do in this area, which involves so few of their patients and creates such a barrier?

The profession can *justify* its claims, and it is noted:

a) All claims on the potential scope of manipulative care made by the chiropractic profession are today made by leading figures in the field of manual medicine – for example Greenman (United States),[14] Stoddard (United Kingdom),[15] Eder and Tilscher (Germany),[16] and Lewit (Czechoslovakia).[17]

b) The government commission that investigated chiropractic and the scope of practice issue most thoroughly, in New Zealand in 1978/79, concluded:

"On the basis of their clinical experience chiropractors claim that by restoring proper mechanical function to a malfunctioning vertebral joint by means of manual therapy a wide variety of Type O disorders will sometimes be relieved. The Commission is satisfied on the evidence that this may in fact happen, though it seems impossible to predict on the basis of any presently available scientific knowledge when and why such a consequence will follow and in what type of case."

"... there ought to be intensified research into why spinal manual therapy sometimes has the effects it appears to produce. It is no answer to accuse chiropractors, ... to try to explain away their results ... there is the clearest possible need for a much closer degree of cooperation between doctors and chiropractors."[18]

(The NZ Commission, on evidence from chiropractors, MDs, and patients, supported chiropractic management of Type O conditions but on the basis of concurrent medical care).

c) There are now careful studies and/or case reports showing successful chiropractic management of diverse conditions such as infantile colic,[19] pelvic organ dysfunction,[20] hypertension,[21] dysmenorrhea,[22] and vision disorders.[23]

d) Modern chiropractic does not purport to treat hypertension or colic or peptic ulcer, and sees the division between Type M and Type O disorders as artificial and unacceptable. Chiropractors diagnose and correct dysfunction in joints and related tissues, which they call subluxation. Most of their patients have Type M symptoms, some have Type M and Type O symptoms, virtually none have Type O symptoms alone. Clinical experience is that many Type O symptoms may be related to spinal joint dysfunction (subluxation) through various neurological mechanisms.

For a more detailed explanation of chiropractic views see the chapter by Wiles in the recent text 'Chiropractic Management of Spine Related Disorders'[13] – extracts of which appear as Figure 2.

11. Thus the claims of chiropractic can be *justified*. However the issue is not justification – but *communication*. What the Ontario study shows is that, despite the best arguments, any effort to explain a chiropractic role in management of organic conditions will generally prove a barrier to understanding and cooperation.

Given this, should chiropractors communicate any claims outside musculoskeletal conditions to MDs? In answering this, consider these central points:

a) Approximately 90% of chiropractic practice involves patients presenting with musculoskeletal pain and/or headache. This percentage has steadily increased during the past decade.[24]

b) Practical experience suggests – there are no precise statistics on this – that the majority of the other 10% of patients first presented with musculoskeletal pain or headache. They experienced other benefits – often unexpected – and continued with chiropractic treatment, or referred family or friends, for such other benefits.

c) There is no research establishing that chiropractic management of Type O disorders is consistently effective. (Indeed most chiropractors do not claim it is. They are removing spinal functional lesions to produce health benefits that remain experimental in many cases).

d) As the Ontario study reports, in general MDs are not going to refer patients other than those with musculoskeletal pain and headache.

12. On a basis of logic and common sense one is forced to conclude that discussion of the potential scope of chiropractic care for organic conditions and general health is bound to be counter productive. It will result in chiropractors receiving far fewer referrals, managing fewer patients generally – and thus fewer with organic problems. (A significant proportion of patients that would have been referred with musculoskeletal pain would have received benefit not only for their back pain or headache, but other conditions).

As a result patients and the profession lose both ways.

13. In truth, until medicine has established broad trust in

chiropractic in the now non-controversial area of skilled manipulation for musculoskeletal pain (i.e for the next ten years) only patients can communicate effectively concerning impact on organic conditions. Credible patient testimony will arise where the referring MD has been watching and monitoring the case.

Even then chiropractors must be qualified in their claims, and suggest 'probabilities' rather than 'certainties', and quickly support their position with the literature that does now exist.

Health Team Concept

14. Inter-referral of patients requires a clear understanding of respective roles. An MD who refers will not direct how to examine or treat – that is the chiropractor's area of expertise. But he/she will need to know that:

a) The patient, who is with the chiropractor on a specialist basis as with referrals to a neurologist or orthopaedic surgeon, remains under his/her general medical care.

b) There is mutual respect for each other's practice and skills.

This is fundamental. A chiropractor who expresses a competitive attitude, suggesting to patients for example that they should generally see a chiropractor first for all health care or that aspects of medical practice such as use of medication or inoculation are wrong, cannot expect referrals and cooperation. Likewise a chiropractor will not refer to an MD openly critical of chiropractic.

(In the Ontario study, which showed a majority of MDs referring to chiropractors and good cooperation, virtually all chiropractors (92.6%) acknowledged "a place for the use of either anti-inflammatory agents, muscle relaxants and/or analgesics" in the medical management of some of their patients).

c) There will be appropriate brief professional correspondence and reports concerning referred patients. (For a good review, with sample correspondence, see 'Medical-Chiropractic Correspondence' by Cassidy DC, Mierau DC et al).[25]

Communication

15. The Ontario study gives valuable suggestions – especially since they come from the MDs desiring better communication (see para 6 above). Other thoughts:

a) Be understated with good information, rather than overstated with little or no literature support.

b) For the benefit of patients, potential patients, and your practice, make the conscious decision that education of local MDs, especially family physicians and orthopedic specialists, is your personal responsibility.

Send good research, speak during rounds at a local hospital, invite them to see what you do in your office. As suggested, except in special circumstances of trust and understanding, limit yourself to neuromusculoskeletal disorders.

Like the attorney in court, and all professional communicators, choose language, appearance and methods most comfortable and thus convincing to your audience. Primary use of neutral language (such as 'chiropractic manipulation for vertebral dysfunction') will prove to be better than chiropractic terminology ('adjustment of subluxation').

The recent British Medical Journal trial is so important that you should have a copy of the paper as published. This, ideally with a summary or other comment, should be included with any correspondence you have during the next several years on the effectiveness of chiropractic management of back pain. While there is other good research this is the major work. Which country you are in is immaterial. Today there is one global health science literature and the British Medical Journal has universal respect.

Fig. 2

The following quotation is from 'Visceral Disorders Related to the Spine' by Michael Wiles DC FCCS(C), Chapter 14 in 'Chiropractic Management of Spine Related Disorders', an impressive new text by Meridel Gatterman DC, William & Wilkins, Baltimore 1990. For further comment on management of visceral disorders see this text and the March 1987 issue of The Chiropractic Report (Vol. 1 No. 3).

Manipulative care and adjunctive therapy for musculoskeletal conditions are discussed throughout this book. For conditions relating to the viscera the (chiropractor) must answer three questions.

1. *Are the visceral symptoms related segmentally to the observed subluxation?* If not, the patient still requires chiropractic care for any subluxation found on examination, but should be referred to practitioners who deal specifically with the presenting pathology or pathophysiology. An example is a patient with severe dysmenorrhea who is found to have subluxations of T1, T4 and T5. These levels are unlikely to be related to pelvic symptoms, and this patient would be referred for allopathic consideration, as well as being treated chiropractically for the asymptomatic subluxations.

2. *Are the segmentally related visceral symptoms due to visceral pathology?* If so, then the patient should be referred for allopathic consideration as well as treated by chiropractic ... to relieve segmental reflexes of sympatheticotonia.

.... If no visceral pathology is found and visceral symptoms are considered to be physiological or functional in nature, then an aggressive course of chiropractic care may be initiated. An example is a patient with severe dysmenorrhea who has been examined for pelvic pathology (with negative results) and who is found to have subluxations of L1-2 and L4-5.

3. *Is manipulative care contraindicated?* This topic is covered elsewhere and is of great relevance when treating patients with visceral disorders. For example, manipulation may be indicated for thoracic subluxations in the otherwise healthy spine of a patient with pancreatitis, ... but contraindicated due to the clinical condition of the patient. Note, however, that this is a very individualized clinical decision of the chiropractor and that neither febrile illness, visceral disease, or debilitation are necessarily contraindications to manipulative therapy.

An important distinction must be made between treating visceral disease and treating patients with visceral disease."

A Case Example

"A patient presents with neck pain who also happens to have lung cancer. On examination, subluxations are found at C5-6 and T5-6. He complains of gastrointestinal symptoms of heartburn and esophagitis since undergoing radiation treatment.

First, are the symptoms related segmentally to the subluxations? In the cervical area, yes, but the thoracic subluxations are asymptomatic.

Second, are related visceral symptoms due to visceral pathology? Yes, esophagitis in this case is due to radiation exposure. This patient will be under the primary care of an oncologist.

Third, are there any contraindications to manipulation? This requires careful clinical and radiographic evaluation. Neoplasm of the vertebrae or related structures is a contraindication to manipulation. However, this patient may have cancer limited to the lung. If so, such a patient should not be denied care simply because he has cancer (which does not involve the spine). The care of this patient would therefore be primary care from the oncologist for cancer and esophagitis, secondary care from the chiropractor for neck pain and cervical subluxations (assuming no local contraindications), and asymptomatic thoracic subluxations (assuming no local contraindications). This latter treatment may have a beneficial healing effect on the postradiation esophagitis. Such a patient can, and should be treated chiropractically. This chiropractor is not treating cancer, but a patient with cancer who happens to have other problems as well."

Wiles proceeds to a review of research, principles and practice with respect to the gastrointestinal, cardiovascular, and respiratory systems.

(There is a quite new and compelling burden on all chiropractors to keep current with the literature. The revolution of the past decade has seen more clinical research and quality texts published than in the previous history of the profession).

c) Use every opportunity for constructive education now that there is a convincing literature base. See criticism of chiropractic, even specifically of your practice, by a local MD as an opportunity to promote understanding. If a patient reports criticism, or there is disparagement by an MD in the media, educate rather than admonish. Be prepared to frankly acknowledge that there have been insupportable claims and conduct by some in the profession – as in all professions. This will indicate a sense of balance, and will make your positive comments more credible. No organization of people is worthy of unqualified support.

d) Be ready to demonstrate your clinical skills to local MDs, ideally to individuals or small groups in your office. This may not have been wise advice in the past but this is a new era.

Research results in favour of chiropractic manipulation and against surgery, medication, bedrest,[26] TENS[27] and other medical management[28] mean that MDs are increasingly looking for skilled manipulative services for their patients. This trend will balloon during the years ahead.

Others purport to have similar or better manipulative skills, and lack of exposure to chiropractic means that many MDs may believe them. The most thorough independent inquiry into chiropractic concluded:

"Chiropractic is a branch of the healing arts specializing in the correction by spinal manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level."[29]

The British Medical Journal trial agrees. Chiropractors need to demonstrate their skills for the average MD to appreciate the level of chiropractic training and skill, to feel comfortable about referring patients, to allow these patients to benefit from chiropractic care – and to accept chiropractic within the health care team in a way that will allow the profession to maintain and consolidate its leading presence in the rapidly expanding field of spinal manipulative care.

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1 Patel-Christopher A (1990) 'Family Physicians and Chiropractors: A Need for Better Communication and Cooperation', U of Toronto, thesis, unpublished.

2 Ref 1 supra, p.60.

3 Meade TW, Dyer S et al (1990) 'Low Back Pain of Mechanical Origin: Randomised Comparison of Chiropractic and Hospital Outpatient Treatment, 'Br Med J 300:1431-37.

4 Editorial (July 28, 1990) 'Chiropractors and Low Back Pain', Lancet 336:220.

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