



## VIEWPOINT

# Are They Just Words?

By Christopher Kent, D.C.

A disturbing trend is the willingness of some in chiropractic to abandon chiropractic terminology as well as chiropractic analytical strategies. The generic moniker "spinal manipulation" or "spinal manipulative therapy" is becoming a replacement for the term "chiropractic adjustment." What's wrong with that? They aren't the same thing!

A popular definition of "manipulation" is "a manual procedure that involves a directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit."<sup>1</sup> Furthermore, the neurological implications of vertebral subluxation correction are not addressed in this definition. Also excluded are techniques which do not involve high velocity thrusts in joints taken to tension.

Proponents of "generic" terminology claim that it facilitates communication with those outside the profession, and obviates "confusion" when dealing with legislators and researchers. I submit that the opposite is true. Use of imprecise terminology causes confusion by blurring the lines between chiropractic and other professions. Failing to clearly state how our philosophies and techniques differ from others has resulted in serious "real world" consequences.

Let's look at some examples. When many of us were still neophytes in this profession, "compromise" Medicare language was drafted and passed into law. It provided for "manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist." The common-domain term "manipulation" was used, rather than the specific term,

"chiropractic adjustment." The law did not explicitly state that only a chiropractor could provide that service. Instead, "manual manipulation of the spine to correct a subluxation" was classified as a physician's service. The predictable result of this folly is today's reality.

Because of this imprecise language, MDs and DOs may also provide this "physician's service." And the profession is now involved in the HCFA lawsuit — a financial black hole with no resolution in the palpable future — that's draining precious resources that could be used to support our colleges, research efforts, and public awareness programs.

Another popular excuse is that we need to modify our lexicon to get a "foot in the door." By now, I hope that the profession has learned that all a foot in the door brings is a gnarled, bloody, bruised foot! Kindly consider the language of the DoD bill.

The DoD bill, much lauded by ACA and ACC, and proposed as a model for all federal legislation, DOES NOT mandate direct access beyond the demonstration project, DOES NOT explicitly include care for vertebral subluxation, and limits us to care of neuromusculoskeletal conditions.

The fruit of this folly is that except for a handful of demonstration sites, the services of a chiropractor are available ONLY BY MEDICAL REFERRAL. The military's perception of chiropractic is horrifyingly narrow. See <http://www.chiroweb.com/archives/21/02/02.html> "Most sites still utilize a referral system. In which the medical doctor makes an initial diagnosis and then refers the patient to a chiropractor for

additional care." What training does an MD have in chiropractic assessment methods? And what about the handful of sites that offer direct access? A potential patient may see a chiropractor for "musculoskeletal complaints." Note that the "neuro" prefix is gone, and subluxation is never mentioned.

The consequences of imprecise terminology also adversely affect chiropractic research. A grave error is made in many studies of the effects of "manipulation" by lumping all "hands on" techniques together, while failing to address key issues, such as the examination criteria used to determine the presence of "manipulable lesions," and how the investigators determine that the "manipulative treatment" was successful.

Would it not be absurd for medicine to test the efficacy of drug therapy for a given disease without defining the diagnostic criteria for the disease and specifying which drug is given and at which dosage? It is no less absurd to collectively refer to all chiropractic adjusting techniques as "manipulative treatments" while failing to define the technique used, the force applied, the direction of the force, and the criteria for pre- and post-adjustment analysis. Why substitute a novel, confusing, inaccurate term such as "manipulable lesion" for vertebral subluxation?

Research designs based upon the haphazard application of ill-defined interventions based on unreliable criteria can hardly be considered "scientific." In his book, "How To Lie With Statistics," Huff observed: "Permitting statistical treatment and the hypnotic presence of numbers and decimal points to befog causal relationships is little better than superstition...scantier evidence than this — treated in the statistical mill until common sense can no longer penetrate it — has made many a medical fortune and many a medical article in magazines, including professional ones."<sup>2</sup>

Chiropractic is not a subset of medicine. Chiropractic is concerned with the detection and correction of vertebral subluxations. The courts and legislatures have, with few exceptions, maintained that chiropractic is not medicine, but is a separate and distinct science.

As such, it has different objectives which necessitate different outcome assessments. Chiropractic and medicine share the objective of promoting human health. Their respective strategies for doing so, however, are radically different.

Some might argue that research is research, and that the same designs may be used by all scientists. That is precisely the point. As they say in the computer world, "garbage in — garbage out." Competent research designs are dependent upon an understanding of the basic sciences, a working knowledge of contemporary analytic procedures, and an understanding of chiropractic philosophy. Appropriate outcome assessments must be employed, based upon an understanding of what the objectives of chiropractic care are. Interventions must be clearly defined. Criteria for the successful (or unsuccessful) application of an intervention must be defined.

What fruit has been borne by the allopathic research programs currently underway? The aberrant perception by students and some chiropractors that chiropractic is a subset of medicine, and that adjusting is a subset of manipulation? The perception that chiropractic care is temporary analgesia at best, and placebo therapy at worst?

The value of chiropractic research lies in its potential to improve our clinical strategies, and to provide us with a scientifically sound basis for making claims to the public and the scientific community. We cannot dismiss meaningful differences in culture and objectives as "just words."

The folly of doing so is eloquently refuted by medical anthropologist E. A. Morinis. "Only the chiropractic philosophy significantly distinguishes the chiropractic practitioner. And yet the philosophy is kept hidden away. It has done so in fear of being labeled quackery and this was undoubtedly a good strategy to follow at one time. The public knows next to nothing of chiropractic philosophy of healing and its mechanisms: If hospitals offer spinal manipulation, a chiropractor offers nothing else. This distortion of the chiropractic tradition can only be overcome by a re-evaluation of the place of theory in

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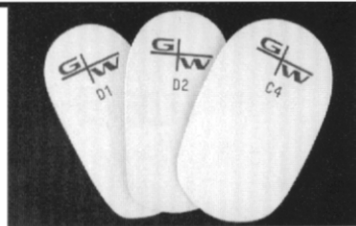
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