



World Chiropractic Alliance

Responding to Eight Chiropractic Issues

Issue 1: Do vertebral subluxations exist?

One of the more controversial issues involving chiropractic is the existence of vertebral subluxations. A few people maintain there is no evidence for subluxations and even go so far as to give the impression that "belief" in the vertebral subluxation is limited to some "fringe" group within the chiropractic profession.

Nothing could be further from the truth.

In the United States alone, there is ample support that the vertebral subluxation is a very real and verifiable entity. State laws, the US Federal Government, the World Chiropractic Alliance, the Council on Chiropractic Practice, the International Chiropractor's Association, the American Chiropractor's Association, the Federation of Straight Chiropractic Organizations, and the Association of Chiropractic Colleges **all** define the responsibility of chiropractors as the detection and correction of vertebral subluxation and its resultant neurological interference.

The chiropractic guideline document: *Vertebral Subluxation in Chiropractic Practice*, produced by the Council on Chiropractic Practice (CCP) was reviewed by an independent research agency (ECRI) which is a Collaborating Center of the World Health Organization. Based on this review it was accepted for inclusion in the National Guideline Clearinghouse of the Agency for Health Care Policy and Research of the United States Federal Government.¹⁻³

The CCP and its official published documents were accepted for inclusion in the Healthcare Standards Database and the printed version of the *Healthcare Standards: Official Directory*. Healthcare Standards is a comprehensive list of published standards, guidelines recommendations, position papers, policy statements, technology assessments, and other authoritative documents. This is the World Health Organization's official healthcare standards and guidelines archive.

The existence of subluxation is in accordance with the published paradigm statement of The Association of Chiropractic Colleges, which was accepted and signed by every Chiropractic College President in North America.⁴⁻⁶ This statement has been endorsed and/or adopted by every major national and international chiropractic organization in the chiropractic profession including:

- ◆ The World Chiropractic Alliance
- ◆ The Council on Chiropractic Practice
- ◆ The Council on Chiropractic Education
- ◆ The International Chiropractor's Association
- ◆ The American Chiropractor's Association
- ◆ The World Federation of Chiropractic
- ◆ The Congress of Chiropractic State Associations
- ◆ The Association of Chiropractic Colleges
- ◆ The Foundation for Chiropractic Education & Research
- ◆ The Federation of Chiropractic Licensing Boards

- ◆ National Board of Chiropractic Examiners
- ◆ The National Association of Chiropractic Attorneys

The ACC defines the purpose, principles and practice of chiropractic as the finding and reduction of vertebral subluxations, which will prevent and restore health by removing interference to the body's inherent recuperative powers. This document, among other things, states that chiropractic as a profession "focuses particular attention on the subluxation."

The assessment and management of vertebral subluxation is either taught as part of the regular curriculum of chiropractic colleges in North America or as part of their post graduate programs. All of these programs, including the general curriculum of the chiropractic colleges and the post graduate programs, are approved and Accredited by the Council on Chiropractic Education which is subject to the rules and authority of the United States Federal Government's Department of Education. These schools also hold accreditation through various local and regional accrediting bodies. The Council on Chiropractic Education, mentioned above, accredits all of the chiropractic programs in the United States and has reciprocal arrangements with accrediting bodies in Europe and Australia. According to the Policies document of the CCE:⁷

"The Council on Chiropractic Education (CCE) accepts the physiological principles of organization in living things and the manifestation of the self-regulatory mechanisms inherent in the body.

CCE accepts that the nervous system is vulnerable to disturbances resulting from derangements of the neurobiomechanical system, including the vertebral column and vertebral subluxations.

The educational process should be a reinforcement of the validity of the basic principles of chiropractic and an encouragement to the student to apply those principles in his or her clinical programs, with emphasis given to detection and correction of derangements of the neurobiomechanical system, including vertebral subluxation."

The American Medical Association, in its *Guides to the Evaluation of Permanent Impairment*, lists the following as acceptable means to rate impairment:⁸

- Impairment due to loss of muscle power and motor function,
- Impairment due to abnormal motion of the spine,
- Impairment due to loss of motion segment integrity,
- Impairment due to disc problems,
- Impairment due to pain or sensory deficit,
- Impairment due to segmental instability.

These are, in fact, components of the Vertebral Subluxation Complex.

The Guidelines for Evaluation and Management Services published by the Health Care Financing Administration of the United States Federal Government and the American Medical Association (May 1997) outline what an objective examination should consist of and these include commonly used neuromusculoskeletal exam procedures within chiropractic such as: postural analysis, palpation, assessment for subluxation, range of motion and assessment of muscle tone. All of these are used to assess and manage subluxation.⁹

The Federal Government of the United States specifically defines what chiropractors do as the detection and correction of subluxation under Medicare and Federal worker's compensation laws. Common to all state statutes is the adjustive process being utilized to reduce subluxations and the resultant interference to nerve transmission. No less than 38 states employ the term adjustment in licensing laws in reference to the procedures applied by chiropractors. Eighteen state statutes additionally include the concept of

manipulation, 34 states contain specific references to responsibility for neurological complications of biomechanical origin (subluxation) and over half the chiropractic profession practice in these states. In addition, 11 states specifically discuss the concept of subluxation in their statutes by using the term and for those that do not specifically use the term there is an implied understanding of the concept in their statutes.

The existence of subluxation and its acceptance is spelled out in explicit detail by published policy statements of chiropractic organizations as well as federal and state laws regulating the practice of chiropractic. The epidemiology of subluxation has been researched since the inception of chiropractic over 100 years ago with basic science and clinical research to further elucidate the nature of it continuing to this day.

A few individuals within the profession contend that the existence of subluxation is questionable and have chided the profession for not addressing their contention. While most acknowledge that certain individuals and groups within the profession do make such an assertion, such contentions are not taken seriously. The above review of the subluxation within the chiropractic profession, government, state law, chiropractic educational bodies and scientific literature serves as evidence of its entrenched status. Further, according to Rome there are 296 variations and synonyms of subluxation used by medical, chiropractic and other professions leading him to remark "It is suggested that with so many attempts to establish a term for such a clinical and biological finding, an entity of some significance must exist."¹⁰

According to Kent's paper *Models of Vertebral Subluxation* the term subluxation has a long history in the healing arts literature and it may be used differently outside of the chiropractic profession. The earliest non-chiropractic English definition is attributed to Randall Holme in 1668. Holme defined subluxation as "a dislocation or putting out of joint." In medical literature, subluxation often refers to an osseous disrelationship which is less than a dislocation. However, B.J. Palmer, the developer of chiropractic, hypothesized that the "vertebral subluxation" was unique from the medical use of the term "subluxation" in that it also interfered with the transmission of neurological information independent of what has come to be recognized as the action potential. Since this component has yet to be identified in a quantitative sense, practitioners currently assess the presence and correction of vertebral subluxation through parameters which measure its other components. These may include some type of vertebral biomechanical abnormality, soft tissue insult of the spinal cord and/or associated structures and some form of neurological dysfunction involving the synapse separate from the transmission of neurological information referred to by Palmer.¹¹

As noted, chiropractic definitions of subluxation include a neurological component. In this regard, Lantz stated "common to all concepts of subluxation are some form of kinesiological dysfunction and some form of neurological involvement."¹²⁻¹⁴ In the position paper of The Association of Chiropractic Colleges they define subluxation as follows:

"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."

The ACC goes on to state:

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

Other concepts of vertebral subluxation consider it consequent to a neurological response to physical, emotional, or environmental stress. The neurological response may precipitate or be precipitated by misalignment(s) between articulations of the spinal column or its immediate weight bearing components of the axial skeleton. The integrity of the nervous system is diminished as changes occur in morphology/oscillation/tension of the tissues occupying the neural canal and/or intervertebral foramina.

In a survey of North American Chiropractors completed by the Institute for Social Research at Ohio Northern University and published in 2003 their research found that:

- 88.1% of chiropractors stated that the term vertebral subluxation complex should be retained.
- 89.8% stated the adjustment should not be limited to musculoskeletal conditions.
- The respondents rated the subluxation as a significant contributing factor in 62.1% of visceral ailments.
- 93.6% recommend maintenance/wellness care
- 76.5% Teach a relationship between spinal subluxations and visceral health
- 88.6% stated thermography was appropriate for use in practice

The researchers concluded that any differences in practitioners' attitudes were associated with four variables:

- The chiropractic college attended
- Whether or not the chiropractor had chiropractic treatment prior to college
- The number of patients the chiropractor treats each week
- The chiropractors self rated philosophy (broad, middle or focused scope)

They further concluded:

"The profession as a whole presents a united front regarding the subluxation and adjustment."¹⁵

The natural history of vertebral subluxation

Another claim that is occasionally heard is that the natural history of vertebral subluxation is unknown. In fact, we know a great deal about the natural history of vertebral subluxation.¹⁶⁻¹⁷ This knowledge is based on a combination of basic science, clinical research, technique, objective assessment of physiological function/structural changes and quality of life issues. These parameters overlap with various models of vertebral subluxation that practitioners choose to address in clinical practice. In this regard there are two components of subluxation that are common to all models. These components are Kinesiopathology and Neuropathology.

Kinesiopathology deals with issues related to misalignment and/or abnormal motion and neuropathology deals with the neurological changes related to the abnormal motion and/or misalignment.

In discussing kinesiopathology the most significant basic science information relative to this is Wolf's Law, which states:

As bones are subjected to stress demands in weight bearing posture, they will model or alter their shape accordingly.¹⁸

Wolf's Law has a less well-known corollary for soft tissue called: Davis' Law that states:
Soft tissue will model according to imposed demands.¹⁹

These two Laws form the foundation of the rheology associated with subluxation and these rheological properties are essential elements in the epidemiology and natural history of vertebral subluxation, which must be considered with regards to care planning, especially in regards to those involving structural changes. Rheology is the study of the change in form and the flow of matter including elasticity, viscosity and plasticity. The longer a subluxation is allowed to set in the further along the path of immobilization degeneration the subluxation is allowed to progress.

The extent of immobilization degeneration and the patient's individual ability to reverse it may be a determining factor in the frequency of the initial care plan and its duration. This will also affect long term care whether from a palliative or wellness perspective once a substantial correction has been made.

The other significant basic science issue related to frequency and duration of care has to do with neuroplasticity. This has to do with the nervous system's propensity to undergo "plastic" changes and learn to habituate a response and is a fundamental aspect of the nature of self-regulating repair processes that use the plasticity of the nervous system as it's conduit. In order to overcome plastic neurological changes that have set in secondary to subluxation the nervous system will need to "rewire" in order to create new plastic changes for the better. This may necessitate frequent adjustments and other inputs into the CNS over a long duration in order to make these changes.

This neuroplasticity and the accompanying rheological changes discussed above secondary to subluxation are what need to be overcome in order for the patient to have a reduction in vertebral subluxation.

The natural history of spinal degeneration secondary to pathoanatomical aberrations is well entrenched, not only in the chiropractic literature, but also within the broad domains of biomechanics and spinal pathology.

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Issue 2: Informed Consent

A medical witness in a chiropractic case once testified that:

"When a member of the public consults a chiropractor, there begins a relationship which must have at its core the benefit of the patient above all else. There is a power differential in such a circumstance. A patient is in a dependent position and surrenders her personal agency in trust to the caregiver that the diagnostic and therapeutic procedures employed will be appropriate and safe, and that the nature of the professionalism to be offered will embody a surrender of personal gain priorities by the care giver for that trust afforded by the patient and to her benefit above all else. There is implicitly an assumption that information given in such dependent circumstances will be reliable, up to date and appropriate."

What this witness actually described is an old, outdated model of informed consent that is inherently paternalistic. This "professional" model of informed consent emphasizes what doctors think is important to discuss with patients rather than what the patient wants to discuss or wants disclosed.

This paternalistic professional model urges doctors to practice in accordance with what is accepted as proper by a responsible body of health care providers in the relevant clinical specialty.

The more current model of informed consent to use is known as a patient-centered approach.¹⁶ This approach encourages doctors to consider the patients needs and priorities when discussing their healthcare options with them. This patient centered approach demands that doctors ask patients what they want from treatment as they discuss treatment strategies.

In addition to fostering patient autonomy, this approach helps protect patients, whose objectives may differ from the assumptions made by the doctor. This approach requires doctors to acknowledge patients as partners with different but equal expertise.

Further, it is important to point out that consent is a process that gives patients the opportunity to express concerns about treatment. Inherent in this process is the approach of sharing information with the patient as opposed to disclosing information. This allows a shared partnership between the patient and healthcare professional to develop where the patient and the professional meet as equals but with different expertise.

Patient-centered consent must be founded on the patient's objectives. In order to do this the practitioner must find out about patients' individual needs and priorities since their beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. Patient-centered practice requires doctors to offer patients an opportunity to participate in a shared decision making process about treatment options. Doctors can then be guided by what patients want, rather than by professional assumptions about management of a disease.

Ultimately, it is for patients and their doctors to decide if a treatment is appropriate and this forces doctors to be creative in order to respond with appropriate strategies.

Such a process has been taught and encouraged within the chiropractic educational setting for many decades.



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ISSUE 3: Thermal Scanning

The literature supports the use of thermography in chiropractic practice including the existence of normative data and reliability studies.¹⁻⁴⁰ Furthermore, according to the CCP guidelines:

Temperature reading devices employing thermocouples, infrared thermometry, or thermography (liquid crystal, telethermography, multiple IR detector, etc.) may be used to detect temperature changes in spinal and paraspinal tissues related to vertebral subluxation.

The measurement of paraspinal cutaneous thermal asymmetries and other measurements of anomalies have been shown to be a mode of sympathetic nervous system assessment, which may be used as one indicator of vertebral subluxation. Demonstrable changes in thermal patterns have been observed following chiropractic adjustment. Thermocouple instruments have been shown to demonstrate an acceptable level of reliability and clinical utility applicable to the assessment of vertebral subluxation related temperature changes.

Normative data have been collected concerning the degree of thermal asymmetry in the human body in healthy subjects. These values may serve as one standard in the assessment of sympathetic nerve function and the degree of asymmetry as a quantifiable indicator of possible dysfunction.

The ICA practice guidelines⁴¹ additionally support the use of thermal scanning in chiropractic practice:

Temperature reading devices

Highly significant temperature changes have been noted in spinal and paraspinal tissues following a chiropractic adjustment. Hand-held thermographic devices "have been evaluated and shown to have moderate to excellent inter-examiner reliability over short time durations."

Early chiropractic investigators recognized three basic physiological concepts that underlie the value of cutaneous thermography:

>> the body is segmented into "dermatomes";

>> side-to-side skin temperatures are generally symmetrical unless dysfunction exists; and

>> any anomalous deviation from a gradually increasing paraspinal skin temperature from S-2 to C-1 may be indicative of the vertebral subluxation and other malpositioned articulations and structures or other dysfunction.

1. Thermocouple: The use of thermocouple instrumentation in chiropractic practice is well established.

2.

a. Single-channel (e.g., chirometer)

b. Dual-channel (e.g., Neurocalograph (NCGH), Thermoscribe, Analograph)

The dual probe devices give a bilateral comparative temperature reading of the paraspinal tissues. However, the instrument requires skin contact.

16.6.1. **Rating:** Established

Evidence: E, L

2. Infrared Thermography

Infrared instruments detect and record changes in temperature rapidly and require no skin contact, and are relevant to chiropractic practice.

1. Single-channel (dermathermagraph) double-channel (e.g., Accolade, Tytron C-2000, VT 2000)

16.6.2. **Rating:** Established

Evidence: E, L

B. Multi(channel (e.g., Visitherm II)

16.7.1 **Rating:** Established

Evidence: E, L

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ISSUE 4: Can Chiropractic Promote Health?

Since many DCs have witnessed first-hand the benefits of chiropractic, they often educate patients about the need for subluxation correction to promote and enhance health and wellness.

This type of patient-education approach has at times been attacked by those who see chiropractic solely as a treatment for specific disease conditions. These critics claim there is no evidence to support the contention that chiropractic can promote health.

However, a review of the literature shows a number of significant studies and documents available that easily refute that unfounded contention.

The 1996 Paradigm Statement by the Association of Chiropractic College includes a section titled "Health Promotion" where it states that:

"Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices."

Another key aspect articulated in the ACC document concerns case management issues. It outlines, in a generic way, how chiropractors conduct themselves on a clinical level:

"Doctors of Chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and, when appropriate, collaborate with and/or refer to other health care providers."

Chiropractic clinicians have a distinct manner in which they utilize the information, feedback and empirical results each patient case accumulates. For this reason, chiropractic care, especially subluxation based care, is not linked to various diseases or conditions the patient may or may not have, before or after care has initiated. The World Health Organization defines health as being "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Given this broad definition of health, epistemological constructs borrowed from the social sciences may demonstrate health benefits not disclosed by randomized clinical trials. Health benefits such as improvement in self-reported quality-of-life, decreased health care costs, behaviors associated with decreased morbidity, and patient satisfaction may be evaluated using such methods.

This performance-based domain focuses the doctor-patient relationship on the standards set by personal baselines and establishes guidelines for the utility of various chiropractic techniques. This type of chiropractic care is in a context with other non-invasive disciplines and is stratified into discrete application-based domains across a spectrum of parameters related to well-being.

Techniques and methods for correcting subluxation must be judged on their intended outcome and most if not all chiropractic techniques have some physiological and/or structural outcome that measures their results.¹ Further, some techniques have as their goals - improvement in quality of life, an improved sense of well-being and a better sense of relationship with the patient's environment and society.

Several studies warrant further discussion in this context. Blanks, Schuster and Dobson published the results of a retrospective assessment of subluxation-based chiropractic care on self-related health, wellness and quality of life.² This is the largest study of its kind ever undertaken regarding a chiropractic population. After surveying 2,818 respondents in 156 clinics, a strong connection was found between persons receiving chiropractic care and self-reported improvement in health, wellness and quality-of-life. 95% of respondents reported that their expectations had been met, and 99% wished to continue care.

Coulter et al performed an analysis of an insurance database, comparing persons receiving chiropractic care with non-chiropractic patients. The study consisted of senior citizens over 75 years of age. It was reported that the persons receiving chiropractic care reported better overall health, spent fewer days in hospitals and nursing homes, used fewer prescription drugs, and were more active than the non-chiropractic patients.³

Rupert, Manello, and Sandefur surveyed 311 chiropractic patients, aged 65 years and older, who had received "maintenance care" for five years or longer. Chiropractic patients receiving maintenance care, when compared with US citizens of the same age, spent only 31% of the national average for health care services. There was a 50% reduction in medical provider visits. The health habits of patients receiving maintenance care were better overall than the general population, including decreased use of cigarettes and decreased use of nonprescription drugs. Furthermore, 95.8% believed the care to be either "considerably" or "extremely" valuable. Rupert reports that 79% of chiropractic patients have maintenance care recommended to them, and nearly half of those comply.⁴

In an online survey with 3018 respondents by Miller, 62% responded affirmatively when asked, "Although you feel healthy, would you follow your family member's lead and visit a doctor who focuses on wellness and prevention just so you can stay feeling that way?"⁵

Three additional studies have addressed this issue. One of the studies consisted of a three arm randomized clinical trial with two control groups (one of which was placebo controlled).⁶ This was a single blind study utilizing subluxation-centered chiropractic care implemented in a residential addiction treatment setting. A total of 98 subjects (14 female and 84 male) were enrolled in the year and a half study. 100% of the Active (chiropractic) group completed the 30-day program, while only 24 (75%) of the Placebo group and 19 (56%) of the Usual Care group completed 30 days.

The Active group showed a significant decrease in anxiety while the Placebo group showed no decrease in anxiety. The frequency of visits to the Nurse's station was monitored during the course of the study and among the Active treatment group only 9% made one or more visits, while 56% of the Placebo group and 48% in the Usual Care group made such visits. This poor performance by the placebo group suggests that the chiropractic care had no positive placebo effect.

Treatment was five days per week over a period of 30 days, for a total of 20 treatment encounters. Therefore, a 100% retention rate was achieved in a residential treatment setting using subluxation-centered chiropractic. The possible mechanism for such a response is elaborated on in an earlier paper by Holder et al, in which they describe the Brain Reward Cascade in relationship to vertebral subluxation and its role in resolving (RDS) Reward Deficiency Syndrome.⁷

A third study by Blanks et al. looked at the degree to which chiropractic intervention affected a change in a healthy lifestyle. The study found that chiropractic care users do tend towards the practice of a positive health lifestyle, which also has a direct effect on reported improvements in wellness. These empirical links are relative to the sociodemographic characteristics of this population and show that use of chiropractic care is an aspect of a wellness lifestyle.⁸⁻⁹

There are numerous studies on chiropractic care in general and chiropractic care directed at reduction of vertebral subluxation that have demonstrated positive effects on physiological outcome measures.

In a review of literature related to objective physiological changes following chiropractic care, Hannon discusses more than twenty studies documenting objective health benefits in subjects who were specifically described as "asymptomatic," "healthy," "normal," or "free from physical injury." Nearly an equal number of studies were found documenting objectively measured health benefits in subjects in which no symptomatic presentation was described.¹⁰

Chiropractors have historically recommended initial care plans that involve a high frequency of visits as well as extended care plans of long duration to encompass corrective care and wellness based care. Care plans that do not base care solely on the presence or absence of symptoms have as their basis some very fundamental scientific laws that govern the connective tissue and neurological responses to abnormal biomechanical loads and neurological interference while also addressing the quality of life issues discussed above. The goal of care becomes the reversal of these insidious processes and an enhanced sense of well-being so that any judgment of that care must take into consideration those outcomes as well as outcomes related to the technique being applied.

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Issue 5: Diagnosis of Vertebral Subluxation

Some critics maintain that the diagnosis of vertebral subluxation and measurement of its reduction cannot be done. Numerous issues related to this have already been discussed. What these critics really refer to is, in more modern terms, the concept of *Outcome Assessment*.

Vertebral subluxations have general effects on the mechanics and physiology of the spine and body:

- A. Immediate local effects which may include irritation, inflammation, and degeneration at the vertebral level.
- B. Mechanical effects which include aberrations in motion, posture and overall mechanical function of the spine.
- C. Physiologic effects which especially include disturbances in the nervous and circulatory systems.

These general effects of the vertebral subluxation are focused into five categories with specific outcomes measures that are used to determine whether or not the patient is getting better, staying the same or getting worse in terms of their subluxation outcome. All of the following are taught in the curriculum of accredited chiropractic college programs:

1. Spinal Kinesiopathology which generally refers to the abnormal position and motion of the vertebra involved in the subluxation. Outcomes assessment parameters here would include:

- Palpation analyses
- X-ray analyses,
- Computed tomography
- MRI imaging
- Postural aberrations
- Goniometric assessment,
- Videofluoroscopic analyses
- Range of motion assessment
- Leg length check analyses.

2. Neuropathophysiology refers to abnormal nervous system function which is the most significant component of the vertebral subluxation. Assessment criteria here would include:

- Somatic pain
- Paresthesia, hyperesthesia, hypesthesia through case history and questionnaire determination
- Somatic motor assessment through muscle analyses and complete neurologic assessment of the neuraxis as well as complete afferent and efferent assessment.

- MRI and CT Scans provide evidence of nerve structural damage which correlates with the neuropathophysiologic component.
- Visceromotor determinations via heat sensitive devices, thermography and thermometry.

3. Myopathology refers to the abnormal changes in muscle function due to the vertebral subluxation. Outcomes assessment criteria here include:

- Palpation
- Dynamometer testing
- Surface EMG
- Neuropressure algometry and pain sensitivity,
- Range of motion determination
- Paraspinal tissue compliance

4. Histopathology represents the abnormal changes to soft tissues involved in the vertebral subluxation. Assessment protocols here primarily include the determination of disc and ligament-integrity by means of X-ray and other imaging methods.

5. Pathophysiology refers to the generalized abnormal changes generated in the spine and body as a consequence of the vertebral subluxation. Spinal pathophysiology is assessed primarily through radiographic, and other imaging determinations of bone degeneration.

The basic chiropractic analysis consists of manual palpation of the bony elements of the spine, manual assessment of the motion of the spine and individual vertebra, and palpation of the numerous muscles which attach and control spine and vertebral motion.

Additional analytic tools for the field chiropractor would include X-ray, devices to assess spinal and vertebral motion and posture, as well as instruments used to assess muscle function and skin temperature.



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ISSUE 6: Council on Chiropractic Practice

The need and value of chiropractic guidelines is universally accepted, and the most widely accepted and endorsed guidelines is the one developed by the Council on Chiropractic Practice Guidelines

The only other set of guidelines to achieve widespread distribution is the so-called "Mercy Guideline," which failed to gain acceptance or endorsement even by the organizations that launched and sponsored it (The Congress of Chiropractic State Association).

The most obviously flaw in the Mercy guidelines was that they were not evidence based. They were a consensus document and they were not developed by "academic" chiropractic. They were developed by those in the profession who had an interest in marketing chiropractic to insurance plans and for those within chiropractic who worked within the insurance industry scrutinizing chiropractic insurance claims. The Mercy document was wholly rejected by the profession and was even removed from the National Guideline Clearinghouse because it did not meet the guidelines set down by the Federal Government as a legitimate guidelines document.¹⁻²

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ISSUE 7: Journal of Vertebral Subluxation Research

There is a critical need for valid, scientific chiropractic research and one of the more distinguished journals is the *Journal of Vertebral Subluxation*. Despite its rigorous adherence to scientific protocol, and its large editorial board which provides peer-review of all articles, JVSR has been the target of attacks from critics of subluxation-focused practices and those who champion that type of practice. At times, the criticism is of the malicious, ad hominem type that hardly deserves rebuttal.

An example of this type of spurious attack is the statement made by a medical expert witness in a case brought against a subluxation-centered doctor of chiropractic. This doctor wrote, in part:

"The *Journal of Vertebral Subluxation* research itself is another example of the VS group's attempts to legitimize the illegitimate. Its an electronic pseudoscientific version of a supermarket tabloid: the editor has no science background whatever and, although the editorial board changes frequently, few show any evidence of even the most primitive intellectual activity."

The facts are that the *Journal of Vertebral Subluxation Research* is a peer reviewed, indexed, scientific journal that began publication in 1996. The journal is indexed by the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MANTIS and by the Index to Chiropractic Literature.

The Editorial Board consists of a number of well respected and world renowned researchers, academicians, medical physicians, chiropractors, attorneys and health policy experts. The Board includes individuals who have worked within the National Institutes of Health, the Max Planck Institute for Brain Research, the Department of Anatomy at Harvard Medical School, contributing author to the AMA Guides for Permanent Impairment, the discoverer of the opiate receptor, an Oxford Scholar, current and past Directors of Research at chiropractic institutions, several current and former faculty from chiropractic institutions, and two former chiropractic college presidents.

It is hard to fathom how anyone can state that these individuals lack "intellectual activity."



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Issue 8: Chiropractic for children

The issue of chiropractic for children has been hotly debated, with many chiropractors and their patients promoting the use of subluxation-correction as a way to ensure that all children have the greatest chance for healthy, happy lives. On the other end of the spectrum are those who state that children under a certain age should never be given chiropractic care or, at best, for an extremely limited number of "treatments."

As one "expert" stated, "Manual care of infants should generally only involve a course of care involving one or at most a few treatments and treatment in excess of this may well be detrimental." This expert cited, as his evidence, a book by Dr. Claudia Anrig, past president of the International Chiropractic Pediatric Association, noted lecturer in the area of pediatric chiropractic and editor of the textbook, "Pediatric Chiropractic."

Yet Dr. Anrig, when told of this case, was emphatic in her disputation of the "expert's" interpretation of her work.

"Regarding the care of an infant who has torticollis and plagiocephaly which was trauma introduced. There is "no formula" of care for the presence of subluxation and their manifesting disorders. Each patient and their outcome are different. There are many factors that contribute to outcome -- severity of trauma, chronicity, parent involvement, and environmental factors (home life) to state a few.

The statements made by the opposing side would not reflect my opinion or other leaders in the profession regarding the care of children. I would never suggest that a 'few adjustments' could resolve a trauma case, and to suggest that over a few adjustments could be 'detrimental' concerns me about the experts clinical background.

The opposing side may have picked through the textbook to find what he wanted to find. For example he probably went to Dr. Peter Fysch's chapter 14, page 619- 620. On page 620 it is stated under the heading of Acquired Torticollis, "A positive response is usually seen after the first adjustment unless a great deal of chronicity is present". What would be missing is the line before, "Older children with acquired torticollis....." Dr. Fysch's statement was in regards to an older child not an infant/trauma case.

Other places in the book which the opposing expert might have attempted to distort would have been from Dr. Carol Phillips chapter. She presented case studies regarding the care of infants with torticollis and their outcome after receiving chiropractic adjustments and craniosacral therapy.

Page 438-439 this case was an infant torticollis with irritability; Page 444-448 this was congenital torticollis case; Each of these cases did not reflect the presentation of plagiocephaly."¹

In her textbook, *Pediatric Chiropractic*,² Dr. Anrig writes:

The frequency of care should be individually assessed. The vertebral subluxation complex in its earliest stages may not manifest as a clinically symptomatic disorder. Objective findings, not necessarily a symptomatic picture alone, should be the criteria for its identification. The rendering of spinal adjustments in the young may be one of the most effective forms of contributing to the prevention of spinal dysfunction and other health disorders.

Dr. Anrig goes on further to explain the phases of care in her text:

"It is during this time that the doctor can inform the parents of the three general phases of chiropractic care. Relief care which is the rendering of care until relief or stabilization of the condition is achieved. This varies from several weeks to several months. Visits are usually more frequent in the beginning and decrease as objective findings diminish. Reconstruction/rehabilitative care is the delivery of care to alter more permanently the biomechanical structure of the spine. Frequency of visits varies depending on many factors; objective findings for biomechanical changes, age, lifestyle habits.

The third phase has been called by the following names: prevention or wellness. This program is the rendering of spinal adjustments when subluxations are present to allow the developing spine and its influence on the nervous system to have optimum function during the course of the child's developmental process. This program is similar to the preventive approach of dentistry. The evaluation of the spine will be generally more frequent than in dentistry due to the ongoing stresses and vulnerability of the spine. The frequency rate will be greater if the child is going through a stage of increasing repetitive falls or stresses to the spine. The purpose is to evaluate the spine and to adjust if objective findings are present. It is negligent for the chiropractors to space out the visits when objective findings and lifestyle warrant more frequent evaluation."

Dr. Anrig goes on to recommend a frequency of chiropractic evaluations ranging from immediately after birth and then every 2-4 weeks in the *non-traumatized* infant. Dr. Anrig's recommendations in a non-trauma case coupled with Dr. Souza's recommendation that treatment in a more difficult case such as congenital torticollis may take up to one year³ clearly demonstrate that chiropractic is reasonable for children and that it is impossible to impose "cutter cutter" standards as to the number of visits needed to achieve maximum benefit.

Additionally, there are numerous position and policy statements by the World Chiropractic Alliance and the International Chiropractors Association which support the use of chiropractic for children, without the arbitrary limitations that some critics would like to see imposed.⁴⁻⁵

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