REFLECTIONS

R. J. WATKINS, D.C.

In 1928 I first became acutely aware of chiropractic. My mother was having adjustments and improving rapidly after years of gall bladder trouble. She had previously been the receptionist for an MD so had the best medical care. Yes, I was astonished at the variety of conditions which improved with chiropractic care. At that time most chiropractors palpated well and adjusted major subluxations regardless of the previous diagnoses. They were not treating diseases in any manner. Someone asked "Is chiropractic good for asthma?" "No it is bad for asthma but good for the patient." The history of the dramatic chiropractic results from 1910 until World War II staggers the young minds of today. There is a reason why many present chiropractors do not accept really sick persons but accept mostly strains and sprains. This is deplorable because chiropractic grew up on the recoveries of the medical failures. Of course it is not a panacea but precise subluxation correction is the difference in recoveries of a wide gamut of diseases.

One problem is the connotation of the word diagnosis. Most persons want a label, a big diagnosis, a fashionable name to tell the neighbors. 5ome want a diagnosis more than they want relief. It was more fashionable to have a "slipped disc" than a sprained back. Now a "carpal tunnel syndrome" sounds great but the related mid-cervical subluxation is often missed by the chiropractor who is concentrating on the single "infallible" diagnosis. Most persons still do not realize that a patient can have six different diagnoses at once, all valid but totally different. The calcified subdeltoid bursitis is good for attention in any crowd but the "crick" in the neck that perpetuates it is too low brow to mention. Tietze's syndrome is an exotic label, but the ones I have seen cleared quickly by precisely adjusting Tl-2 even though the subluxation was too minimal to be seen on any X-ray film. The "trick knee" with "torn meniscus" rates higher than an L4 subluxation on many totem poles. Even the chiropractic college faculties have fallen for this erudite status to the extent that many have forsaken nerve tracing and have never learned to "seek the subtle subluxation." Such neglect of these fundamentals has left a gap in clinical efficiency. Many critical subluxations are being missed.

The current fascination with orthopedics, orthopedic testing and sports injuries has thrown many chiropractors off course. Certainly a sprained knee is sore, swollen and hot but the healing is grossly delayed by the L4 subluxation which was usually caused or aggravated concurrently by the same injury. One lad came grudgingly on crutches unable to bear weight on such a sprained knee which was almost untouchable. Immediately after L4 was adjusted the knee could be touched. It was still swollen, red and hot but he stood on it gingerly and said "It is sore but the sharp pain is gone." Fourteen hours later he walked in with the swelling 80% gone. No therapy was used, no ice and no bandage. For examination I had him remove the elastic bandage and leave it off because that impeded circulation. He said "I don't believe it." I Said "You don't have to believe it, just enjoy it."

Yes, ice packs to reduce swelling and tape to limit injurious motion are useful but many have become fascinated with such first aid and forgot to "Seek the subtle subluxation," or at times the gross and obvious subluxation which is usually the concurrent double injury. The concept of "double injury" with the peripheral joint damage and the concurrent spinal sprain causing a subluxation directly related to the injured area has not been adequately stressed in the sports injury classes. The double diagnosis, the related subluxation is not emphasized in the diagnosis classes or in the pathology classes as it was when I was a student in the late 30s. These classes were taught by chiropractors who had years of experience with many pathologies which are avoided by the recent graduates. Those of us who have done first aid

duty at track meets have often had participants brought in with a “pulled groin muscle”. They asked for ice and tape as others had done. By promptly adjusting the subluxation of L4-5 the problem cleared within two minutes so that they could walk comfortably. The “torn ligaments” in the knee and the “torn meniscus” made similar three minute recoveries compared to the three month recovery usual with the best physiotherapy but no spinal adjustment. General lumbar manipulation will not do this job but precise adjusting of L4-5 will do it in most instances. Therefore I commend the profession on enriching the curriculum but I deplore the abandonment of our fundamental strong points in favor of imitating others who know nothing of precise palpation and precise adjusting of subluxations. There has been too much neglect of precise nerve tracing. Yes “trigger points” and “acupuncture points” have been mentioned but seldom have they become a part of nerve tracing according to Grey’s Anatomy. More intense correlation in this area will greatly improve our clinical results. This helps to pinpoint the KEY subluxation for precision adjusting. It helps to avoid the general shotgun approach.

Another fallacy often heard is “We have done no research.” Of course there were no chiropractic articles in Index Medicus. They were not welcomed. Nor were there any older osteopathic articles included then. Anyone perusing D.D. Palmer’s book of 1910 can see that he had done much investigation in many information sources and had tested the practicality of his own original ideas. He was doing continual research and did write up many reports. Louisa Burns and C.P. McConnell had done much research into subluxation pathology induced in animals and in man. Dissection findings were published from 1905 to 1910 in Osteopathic literature. At the request of Solon Langworthy, a DC of 1906, Swanberg researched with many dissections and published two books, THE INTERVERTEBRAL FORAMEN and THE INTERVERTEBRAL FORAMINA IN MAN. Palmer College had compiled data on voluminous clinical results published by J.N. Firth. The B.J. Clinic in the 40s & 50s published extensive data with certified medical diagnoses before and after adjustments. Carl Cleveland Jr. published data on induced subluxations in rabbits and cats with dissection findings in 1965. Yet much of this was rejected as being “biased.” Every investigation is inherently biased but in different directions and to different degrees. In the mid 30s J.R. Verner wrote SCIENCE & LOGIC OF CHIROPRACTIC after dozens of mini-seminars with a group of chiropractors who were asking a prominent professor of clinical neurology for his explanation of chiropractic results. In 1940 Fred Illi and Joe Janse did extensive sacroiliac research and found an intracapsular interosseous ligament previously undescribed and still not in the anatomy books. However the anatomy books do now describe the synovial membrane and do allow some sacroiliac motion.

In 1948 at CMCC we did several series of X-ray studies on normal spinal motion but lack of outside interest discouraged publications. Kapandji’s current book shows almost the same findings despite his ambiguity on sacroiliac motion. His book is now generally used. CMCC studies with cineroentgenographic examination and concurrent parallel skin temperature graphing in 1964 revealed the first indications of reversal subluxations. When first published there was no previous reference known. Since then there are hundreds of articles in roentgenological and orthopedic literature. However, many orthopedic men call this reversal of Occ-C1 during neck flexion the normal. Why? Since 90% of severely whiplashed patients do show cervical reversal subluxations and since 90% of the orthopedic patients so examined did have whiplash injury then it becomes a “statistical normal.” This does not make it the normal at all since reversal subluxations are not present in uninjured persons. Reversal subluxations can be altered with chiropractic care but rarely by other methods. Hence it is helpful to read all research papers with caution.

Of course there has been much chiropractic research. Certainly there is a need to spot check the past research and to continue with still more advanced research. Applied neurophysiology is still virgin

territory with its vast scope. THE AUTONOMIC NERVOUS SYSTEM by Albert Kuntz, vol.3 had over 130 pages of bibliography. Yet many teachers have never heard of it. Efforts are commendable in that direction to recheck Kuntz data. Much of the valid most recent research makes D. D. Palmer sound right up to date.

However the final decision on chiropractic efficacy is NOT in legal chambers, not in political caucuses nor in Journals of Physiology. Rather it is in the hands of the patients who definitely know their good results without any lawyer's opinions and without any "medical" approval. We must make our own valid standards, not just imitate others who are often taught that subluxations do not exist or at least have no effect.

It is good to see insurance equality laws and good to see more widespread interest in chiropractic science and in chiropractic art. However the great clamor to become orthodox is a mixed blessing. Too often we have thrown out the baby with the bathwater. Like the osteopaths we can have quicker general acceptance (by AMA) by abandoning our heritage of handling nearly every pathology IF we "treat" only musculoskeletal disorders (strains & sprains). Then where do the distraught sick people go who have had inadequate relief elsewhere? Peptic ulcers, dysmenorrhea and pneumonia are much easier for a chiropractor to handle than is sciatica. They also have much quicker and more dramatic recoveries. Yet many younger chiropractors will send them elsewhere. This is a situation which I deplore. If the chiropractic "orthopedist" who has the right to that specialty will only send the sick patients to another chiropractor who handles all subluxations then I would be much happier. Our specialty is the diagnosis and the adjustment of subluxations and of their relationship to the patient's complaint. Diagnosis of the ulcer is important but diagnosis of the related subluxations is even more important to the patient and to the chiropractor. Certainly we must recognize the ulcers, but we must also find the subluxations and then correct them. The ulcer healing is a good side effect of the adjustments.

One other mixed blessing is the curriculum change over the years. In the late 30s we went directly into clinic handling outpatients at the beginning of our second year. We studied the deeper details of the basic sciences later. Certainly we had a solid core of enough anatomy, physiology, pathology and diagnosis with simple spinal technics to adequately manage average patients. Working in the clinic reinforced the fundamentals which became automatic. The exceptions, the special situations and the complex technics came later in the course as they might be needed. At present the clinical material is introduced so late that the students seem to forget why they came to college. They have learned all the "irreversible" pathologies and having little experience with hearing of or seeing such recoveries with adjustments. The students are often afraid to touch a sick patient. There is a better sequence and we are trying to swing the pendulum toward it.

Every basic science presentation can and should have clinical emphasis. The chiropractic management of any malfunction is based upon applied neurophysiology. By knowing the multiple innervations of the stomach it is easier to see the subluxations. With ulcers these subluxations are not subtle. Hence the mention of specific cases during all diagnosis classes was routine when I was a student. Pathology classes included case management to a lesser degree. We did not dwell upon the medical management but rather upon the chiropractic management in all diagnosis classes. Students and their families were patients in the clinic and they discussed results from the first week as new students. So the basic sciences were learned concurrently with chiropractic management. This was done at increasing depth each year. Hence it seemed much easier to learn the subjects together than it did separately. I look forward to increasing integration of all courses for maximum practicality. Yes I see more research results

in neurophysiology each year. When D.D. talked about trophic nerves there was no approval by physiologists. Now there are entire sections on neurotrophic problems. D.D. Palmers intuitive understanding is more up to date and is more acceptable now than it was 80 years ago. The brain research institutes are discovering more about the “quality” of the nerve impulse every year. The allopaths have been denying this but are now having to accept what we have been working with for years. So let our research be directed into the areas of the subluxation and its far reaching ramifications. Some have called this the subluxation complex. It is much more than just the “Little Bone-Out of Place.” Some have called it the subluxation plus the associated neuropathy- However, just because some of us cannot find the “subtle subluxation,” the concurrent injury with the sprained ankle, knee or shoulder does not mean that there is no subluxation. The subluxations with glomerulonephritis or with peptic ulcers are much more obvious. With appreciation of advances in details of knowledge but with caution on abandoning sound tradition we can and will make further improvement in real clinical efficiency.